

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

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Version 3
August 20, 2018

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Respectfully,

Egbert, Gideon & Chambers.

A
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Y
Z

Alderman	Sylvester	13
Angelo	Battista	385

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

Berger or Alois Dorsenbach –	Oscar	33	(from C & C Hospital, St Paul).	
Baker	John	105		
Brown	John	241		
Brainerd	Wm P.	269		
Burns	Edward	333		
Bjornstad	Olaf	345		

Coughlin	James #2	5	Here twice before
(Coughlin	John) correct name	–	"
Chase	Bird E.	141	Has been at Independence, Iowa
Christensen	Ole	129	
Christiansen	"	"	
Coon	William C.	141	2nd ad time – was at Peter.
Conn	Clark	"	"
Conners	William	153	
Clason	Franklin E.	237	2nd ad.
Colby	Wm C.	249	

Dossenbach	Alois	33	
(Oscar Berger)			
Dodds	Charles	225	

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

Ek	Andrew	49		
Ebersold	John	177	Transferred from Fergus Falls –	
Elias	Henry	273		
Elliott	Wm N	317		
Erickson	Adolph	353		

Fredrickson	John	29	
Flanagan	John J.	113	
Florin	Joseph	305	
Finn	C. J.	397	(al. Charles Sylvester)
Fasenmeyer	Adolph	325	(was at Independence, Iowa).
Furness	Chas E	357	

Gschnatt	Karl	57	
Goebel	George	149	
Gould	Orramel	217	2nd ad. here
Gray	Thomas G.	285	
Gieske	August C	313	
Gurney	John	341	

Homme	Gunder G.	21	here before Feby 3/89 — July 8/89.
Hauson	Martin #2	45	
Henninger	Julius W.	89	
Holy Joe (or Frank Kiebel)		289	3d admission

Irish	Eugene	197		Johnson	Emil	93	

Kinney	Herbert A.	69	
Kaufmann	August	169	
Kirchner	John	221	
Kathe	Christ	261	

Lampeland	Gilbert	25	
Littel	Edward	101	was in Oregon '92 - 93
Lang	Charles	125	(has been in Workhouse)
Larson	Ellwig E.	65	
Lorimar	Peter	145	
Lehman	Sadie	253	
Lambrecht	Carl	281	2nd ad.
Larson	Gust	321	(was at Danville Ills.)

K L M Mc N O P Q R S T U V W Y Z

Marshall	Charles	9
Meyer	August	85
Mauge (or Mouge)	Fred	121
Monette	J. Andrew	157
Masten	George	161
Murnane	Jeremiah	209
Marchand	Pierre Sr.	257
Masich	Joseph	277
Mullen	John #2	381

Mc Michael	George (M)	173	3rd ad. Iowa
Mc Cloud	Jonas J.	233	Old Soldier

Nelson	J. (Nels J.)	373

Olson	Lewis #3	61
Oakes	Theodore L.	361
Oldenroth	Gustav	365

Paulson	Ole. A.	37	
Pauzer	Charles	73	
Pierce	George L.	81	
Pegachink or Pogatshnick	John	245	
Peterson	August[n]	77	
Peterson	Peter[n]	201	
Peterson	Mathias[n]	213	5th ad. here.
~~Peterson~~		~~245~~	

Quimby	Fred	329

P
Q
R
S
T
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V
W
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Reynolds	James	97		
Rice	James	133		
Roseth	John	193		
Riebel	Frank (Holy Joe)	289	3d ad.	
Ryan	Michael #2	369		

Simpson	Christ	53	
Schnatt	Karl	57	
Schneider	Caspar	109	
Simle	Ole	117	
Sejkora	Joseph	181	
Schultz	August	205	
Sackett	Guy	229	
Schultz	Dominick	265	3rd ad.
Sylvester	Charles	297	(al C. J. Finn).
Steiger	Adam	301	(3rd ad): (three as Inebriate)
Skelinski	Henry	309	

Tierney	John	17
Telkie	August	189
Talbot	Milton	349

Vanderworker	Charles	1					

Vick	Edward	137					
Vestrum	Andrew	165					
Walker	John	185					
Wakla	Hank	293					
Walter	Henry	377					

Personal and Medical History of

Personal and Medical History of *Charles Vanderworker*

EBERT, FIELAS & CHAMBERS, DAVENPORT, IOWA

Whole No. 4787.
Residence, Kalmar Township, Olmsted County, Minn
Date Admission, 3rd January 1896.
Admitted by Dr. A. J. Shelbourne Hour, 12 M.
How Sent, Thomas Fraser, Jo P. Olmsted County
Sex, Male
Age, — 16 —
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Laborer
Degree Education, Common School
Profession Religion, Yes: Methodist.
Habits, — not Known —
Nativity, Newburgh. NY. (Father's, probably Germany. Mothers, Newburgh NY
Physicians Committing, A. S. Adams and Chas. J. Granger
Correspondents, Mrs Emily Vanderworker (mother)
Mr. John Dodd 653 Ruis St. St Paul

No. for Year, 115.
Insane Relatives, None known of.
Cause Exciting, Typhoid fever
Cause Predisposing, — Do — & previous attack
Form,
Accompanying Bodily Disorder, Epilepsy (?)
Suicidal or Not, — not; but will injure others
Date of this Attack, Probably recent
Duration, — probably Short —
No. of Attack, 2nd (one in Sept 1894).
No. of Admissions, 1st
Age First Attack, about 15.
Time of Leaving, Aug. 1st. 1896
Time in Hospital, 6 mos. 29 da.
Result, Discharged Dec. 3 '97 Improved

worked for him 2 mo's 2 years — Byron Minn

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exd by Dr Herzog. Jan 3/96.

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

MEMORY:
Past Events, fairly good
Recent Events, more impaired
Special Subjects, says "has no memory of what occurs in attack"

PERCEPTIVITY:
Alert or Dull, somewhat dulled
Correct or Illusive, Correct, in the main

REASONING POWER:
Ordinary Subjects, fairly good, but slow.
Own Mental State, claims not to realize his condition
Special Subjects,

GENERAL DESCRIPTIVE REMARKS:
⊗ see attached slip

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

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, None noted
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, somewhat reticent

Personal and Medical History of *Charles Vanderworker*

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

⊗ General Descriptive Remarks.

Patient was brought in in a comatose condition, having taken an Epileptiform attack at the Court House and going into the Comatose state, remaining so, until after being brought in. He was laid, temporarily, on the floor of A.S.: was rigid: pupils dilated, Eyes closed; resisted opening them; eyes deviated to left: pupils did not react to light. The person attending him stated that he had several such attacks each day; that he did not cry out at beginning of Epileptiform attack; that he had never fallen and injured himself; that he had been watched so closely as to prevent his falling: that he had been prevented from biting his tongue by a plug between the teeth. During the Epileptiform attacks he would scratch bite & tear his clothing: afterwards would become Comatose for from 15 minutes to 24 hours.

Pressure over the supra-orbital nerves caused him to kick out vigorously & he was taken to the "infirmary ward" undressed & given Shower-bath. This soon brought him out of his Comatose state & he was put to bed & ate a good dinner. He has considerable tenderness over the 6th & 7th Cervical Vertebrae: some tenderness over the Epigastrium. He is not particularly anaemic, though undersized & muscles flabby. The history would seem to indicate Hysteria.

ably impaired. health ed. alone in skin.

How

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rently about to fall.

ing

INE,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Unknown. Comes from "Orphan's home" Mother is living in St. Paul. —
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Charles Vanderworker

ROBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4787.

Residence, Kalmar Jou

Date Admission, 3rd Jan

Admitted by Dr. A. J. Kiebo

How Sent, Thomas O

Sex, M

Age, 16

Civil Condition, Sin

Children, —

Age Youngest Child, —

Occupation, Labor

Degree Education, Com

Profession Religion, Yes: M

Habits, — Not k

Nativity, Newburgh. NY. (Fath

Physicians Committing, A S

Correspondents, Mrs Emily
Mr John Dodd

Worked for him
ab 1½ years

Byron
ruin

EXAMINATION ON ADMISSION.
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, Som

MEMORY:

Past Events, fairly goo

Recent Events, more im

Special Subjects, says · has no m

PERCEPTIVITY:

Alert or Dull, fa

Correct or Illusive, C

REASONING POWER:

Ordinary Subjects, fairly

Own Mental State, claims n

Special Subjects,

Voluble or Reticent, somewhat reticent

GENERAL DESCRIPTIVE REMARKS:

⊗ See attached slips

Personal and Medical History of Charles Vanderworker

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, Considerably impaired: health offensive: acne on skin.

WOUNDS OR ABNORMALITIES, high arched palate: teeth not shed & pegged.

TONGUE, Tremors, Slight Coatings, yellow. Clean in center: prominent papillae. Promptness Movement, Slow

PUPILS, Equality, Yes Size, Dilated

Response Light, about normal Accommodation, about normal.

SIGHT, Seems good

HEARING, " "

COORDINATION, Arms, Some impairment: Legs, Considerable impairment: has great difficulty in standing: is apparently about to fall, but always catches himself.

TREMORS, Hands, While standing Tongue, Slight

Facial Muscles, No General, While standing

REFLEXES, Patellar, 10 - Equal Ankle - clonus slight: abdominal and Other Cremasteric reflexes exaggerated

EXAM. URINE,

TAKEN,

ARTICULATION,

Slurred,

Hesitating, Yes

FACIAL EXPRESSION,

Dull & heavy: Depressed.

SENSIBILITY,

✓

HEART, Sounds are good, but somewhat weak: nose & extremities cold.

LUNGS, nothing definite shown. Glands under maxilla are swollen slightly.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,	Record Kept	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,

Unknown: Comes from Orphans home. Mother is living in St. Paul. —

Personal and Medical History of *Charles Vanderworker*

1896

This patient was received here at the hands of Sheriff C.N. Stewart, attended by John Dodd, with following history. Patient is in poor physical condition. As to history of consanguinity or heredity, nothing known. This is 2nd attack, one occurring in September 1894. Duration one week. This present attack Commenced with convulsions, with unconscious periods of 24 hours. The disease seems increasing, but variable & with rational intervals, but these do not occur at regular periods. Derangement now shown by his having epileptiform seizures; convulsions; accompanied with biting, and tearing clothing. Is disposed to injure others only in convulsive attacks. Is not suicidal, but destroys clothing. Previously, he was reckoned to be sullen. Nothing known as to any history of intemperance. After a severe attack of Typhoid fever, he would become comatose. He has not been restrained or confined. Supposed cause of the disease is Typhoid fever. He has been treated by bromides & Ergot, with digestives. Patient is unconscious at time of Examination: pupils dilated: no reflex: is very poorly nourished.

Jan 3 On admission, was put on I.W. (S.H.N.H.). Complexion dark: hair brown: eyes blue: condition of skin good: no marks scares or bruises noticed: is clean: was brought here in an unconscious state: had to be carried to the ward: was in a deep stupor: shower bath given, when he awoke & talked some). 1oo P.M. Was able to walk some, but was very weak. Answered questions asked him: breath quite offensive: Was put to bed. 130 P.M. Pulse 58 - R 16 - Temp 98 2. 4 P.M. Has been crying some: Complains of Headache & asks to see his mother: Talks rationally. Is on regular & extra diet.

" 4 7 P.M. Given Enema: bowels then moved. Jan 4/96. Very quiet during night: Slept about 7 hours. Seems quite well, this morning. 930 am. Was taken with hysterical fit: Shower-bath was administered, with desired effect. 1130 am. Bowels moved freely. 1 P.M. Has slight Cough this morning.

" 5 Jan 5/96. Slept 7 hours. Am. Bowels moved. Complains of sharp pains in Stomach, which came on since breakfast. Visited by mother. Jan 6/96. Slept quite well. Is feeling much better & pains have left him. 1 P.M. Up in roller-chair. Jan 7/96. Slept 8 hours. Appetite good: bowels

" 8 regular: he seems quite bright, this morning. 11 P.M. Soup & dressed. Jan 8/96. Restless 1

" 9 hour, slept 7 hours. Am. Complains of being sleepy. Jan 9/96. Restless 2 hours, but slept 6 hours. Seems to improve quite rapidly: converses freely. 5 P.M. Is very sleepy: retired to

" 10 bed. Jan 10/96. Slept all night. Appetite good; bowels regular, but he complains of headache.

" 11 Up (dressed) 100½ pos. Jan 11/96. Slept & rested well: is feeling quite well, this morning. —

" 12/13 Jan 12/96. Slept 8 hours: appears much better, today & talks rationally. Jan 13/96. Unusually bright, this morning. Appetite good: bowels regular: wishes to work & which he is allowed to do,

" 14 in light form. Jan 14/96. Sleeps well. Continues to improve. 530 P.M. Patient in bed and

" 15 perspiring quite freely: also crying about his mother: Complains of headache. Jan 15/96. Cried some during the night: was restless 2 hours, but slept 6 hours. Am. Soup & dressed: feeling quite

" 16 well. Jan 16/96. Slept 7 hours, restless 1 hour, last night. Eats in dining room: walks some on ward. Jan 17/96. Slept well. Am. Complains of tooth-ache: tooth extracted. Jan 18/96. Slept

" 17/18 8 hours, last night. Soup & about as usual, today. Summary: On morning of 1st day, was taken with another hysterical fit: (he was in one, when brought here): this resembled, in every respect, the condition in which he was, when time of admission. Was returned to his senses by use of cool shower-bath. Remained quiet, during day: had slight Cough at night. On morning of second day,

Personal and Medical History of *Charles Vanderworker*

1896

he complained of pains in Stomach, which lasted during day. Felt quite well on 3rd day & was gotten up in roller-chair. Felt still better on 4th day; was dressed & allowed to walk about on ward. He continued to improve until 7th day, when he again complained of headache. (Weight 100½ pds.) Again began to improve & continued to do so until Eleventh day, when he was again taken with a severe headache & remained in bed. Up & dressed, on following day & continued to do nicely. Appetite good; bowels regular throughout this period. He slept well. Temperature continued a trifle above normal. Mentally, he appears quite sound. He cried considerably on 1st & 11th Days, & was, apparently, homesick & asked to see his mother. After becoming better acquainted, he converses freely and rationally, with those about him. (see attached records). Jan 19/96. Has continued to complain of headache & of severe pain in Stomach. Was put to bed: refused supper: mustard plaster applied to Stomach.

" 20 Jan 20/96. 530 am. Had fit of hysterics: it was necessary to hold him in bed. 930 Am. Up & dressed:

" 21 feels much better. Jan 21/96. Feeling well, all day. Woke on ward. Sleeps very well, at night.

" 26 Jan 26/96. Has complained some of a sore throat: this is now better: he is still feeling well:

" 27 Converses freely & quite rationally. Jan 27/96. This morning, he became decidedly down-hearted.

" 28 Would not talk: refused breakfast & dinner: very quiet, all day. Jan 28/96. Slept well: is quite

" 29 bright and talkative, this morning. PM. Appetite good: behavior good, all day. Jan 29/96. Very bright,

" 31 and jovial, this morning. Jan 31/96. Was again taken with "Fit of hysterics": cold shower-bath had a reviving effect: he was very cross, remainder of day: complained of pains in Stomach.

Feb 1 Refused all his meals, today. 7 P.M. Was put to bed. (see attached Record). Feb 1/96. Wt 115 2 pds

" 20 Feb 20/96. Behavior has been good: habits neat: he talks rationally: physical appearance good: Gets on ward.

" 24 Feb 24/96. Very unruly; while out for a walk, this PM. refused to come in & was carried: fought very

" 25/28 hard after coming inside; then became very morose: was given cold bath, and put to bed. —

" 29 Feb 25/96. Up & dressed: behavior good: Kept in "green Bay" for a few days. Feb 29/96. Visited by friends. Feb 29/96. No change noticeable in behavior & condition. Appetite good: bowels regular.

Mar 6/13 Mar 6/96. Wt 120 pds. Mar 31/96. Physical health quite good: he sleeps well: seems quite rational.

April 2/16 Walks on ward. April 2/96. Wt 121 pds. April 6/96. Complains of feeling unwell: bowels somewhat

" 7 costive. 2nd PM. Seidlitz powder. April 7/96. No improvement noticed; to day. 1030 am. Given salts:

" 8/17 330 PM. Bowels moved. April 8/96. Feels much better. April 9/96. Has been taken pill, night & morning

" 30 on account of his bowels being so irregular. Pills now discontinued. April 30/96. General condition is about as usual.

May 1/96 to Aug 1/96 Summary Notes by Dr. Phelps. Physical condition quite good: Works upon ward: May 12 Refused breakfast noted as being peculiar & restless: Complains of pain in side: Was placed under treatment & notes kept up to May 23. Trouble seemed chiefly hysterical. Recovered, however, & went home Aug 1st 96.

Discharged.

Personal and Medical History of James Coughlin #2

Examination gives correct name John Coughlin

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4289.
Residence, St Paul. Minn
Date Admission, 4th January 1896.
Admitted by Dr. Hedgog — Hour, 7 PM.
How Sent, G. Wilbrich, Jof P. Ramsey County.
Sex, - Male -
Age, - 35 -
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Laborer
Degree Education, has a little Education
Profession Religion, Yes: Catholic.
Habits, - Intemperate -
Nativity, Devonshire, England: (that of Parents not known) -
Physicians Committing, Chas. J. Meade Asst. H. Markoe
Correspondents, - See last Commitment.

No. for Year, 117.
Insane Relatives, 1st Cousin died insane, in St Paul
Cause Exciting, Epilepsy
Cause Predisposing, Epilepsy, Drink & previous attacks
Form,
Accompanying Bodily Disorder, Epilepsy
Suicidal or Not, Not: but previous history says he is -
Date of this Attack, Jany 3/96
Duration, - one Day or so -
No. of Attack, 3rd (probably more).
No. of Admissions, 3rd (here twice before).
Age First Attack, about 28 or 29.
Time of Leaving, May 10. 96.
Time in Hospital, 4 mo. 6 da.
Result, Recovered Disc. July 30. 96.

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,

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: Same as before - drank + don't know what happened after leaving here ; worked 7 mos. without drinking - These last two times only times lost memory - Impulse suddenly came on him to drink - had not Touched a drop for some time - drank for 5 days then told foreman he would not work for a few days + landed here - Shows a vague feebleminedness - though fairly clear. Admits was not so Easy for him to learn at school as it was for the others

Personal and Medical History of James Coughlin #2

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, 168½ lbs NUTRITION,
WOUNDS OR ABNORMALITIES, Skin - Fair
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, Normal
Response Light, Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, None of note. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, O or very slight EXAM. URINE,
Other
ARTICULATION, Prompt - good.
Slurred,
Hesitating,
FACIAL EXPRESSION, Fair.
SENSIBILITY,
HEART, Normal.
LUNGS, Normal.

TAKEN,

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,") Drink
Mother or Mat. Relations, Living Healthy -
Father or Pat. Relations, Died at 78
Brothers or Sisters,

Personal and Medical History of James Coughlin #2

1896

This patient was brought here by Deputy Sheriff J.W. Kinney, attend-
-ferson, with following history. Patient is in poor physical condition. A
not known: a first cousin died insane, in St Paul. This seems to be 3rd attack
Dec 20/94); when he was at this (Rochester) hospital: duration of that attack, ap
of this attack were manifested Jany 30/96: was violent: showed hallucinatio
names & age. Disease is variable & with rational intervals. Derangement
-lusions &c. Says he is called to be a missionary: also says, he is 74 years of a
to inspire others, but not suicidal: has tried to tear his clothes. As to any specul
shown, is not known. Patient uses alcohol: is subject to Epilepsy: has bee
in straight-jacket. Supposed cause of disease is Epilepsy. On personal exam

Note × talks incessantly, gives different names & ages. Note. Patient was here twice before, under correct name of "John Coughlin": the 1st time, from Feby 18/90 to July 26/90: (see Vol 13 page 131 No 2291);
and was committed here again the 2nd " " Dec 20/94 to April 10/95: (See " 29 " 189 " 3945).
was very suicidal while in jail, just before them coming here. He quickly improved after coming here.
(form of disease, subacute mania): became pleasant & sociable: showed no delusions at
that time: worked outside industriously: gained quite markedly in flesh & physical condition
was good; also his mental state. He went home, recovered: (see attached newspaper clipping)

Jan 4 On admission, was put on B3 | G.H.R.Rpt. Complexion dark: hair brown; eyes blue: Condition
of skin good: marks on right ankle, from shaps: left hand thumb off, at first joint: bruises on
left leg: Is very dirty: behavior good. Patient was brought here in straight-jacket & straps on ankles)
" 5 Pulse 80. R 20. T 99.6. Jan 5/96. Slept quite well, last night. Am. Pulse 85 R 23 T 99 F. -
Appetite poor: cannot keep anything down: coughs a little. Behavior good: talks some; no delusions
" 6 or hallucinations noticed. Complains of pain below his left shoulder. Jan 5/96. Slept well last night.
Am. Pulse 80. T 99.4. Appetite improving: receives special diet. Behaves well: bowels moved: talks
" 7 rationally: complains some of being nervous. Jan 7/96. Slept 8 hours. Am. Pulse 74. T 99 2
" 8 Is about as usual. Jan 8/96. Again, slept well, last night. Am. Pulse 78. T 99. Appetite
" 9 good. bowels moved. Is quiet: talks rationally. Jan 9/96. Slept well; no change to note:
" 10 Transferred to B1. Jan 10/96. Slept well, last night. Am. Pulse 82. T 99.4. He is a
very quiet patient; talks rationally when addressed; no delusions noticed. Appetite fair: bowels
" 11 regular: no complaints. Jan 11/96. Slept 8 hours. Am. Pulse 90 T 98 6: no change noted in
" 18 patient's condition: Jan 18/96. During this, the 2nd week, patient's condition has seemingly
improved. He has been sleeping well, each night. Pulse & temperature, taken daily, have been more
nearly normal. Appetite has been good: bowels regular. He has talked freely & rationally: no
delusions or hallucinations has been noticed: Goes out walking daily, with the other patients and
works some on ward. Habits have been neat & tidy. Summary: has been quiet & agreeable on
ward, since admission & has given no trouble. Has made no complaints. Is somewhat anxious
to go home & says that "he now feels all right". Is pleasant in manner & talks quite freely.
" 31 Physical condition good: Mental state much improved. Jan 31/96. Behavior has been
very good: Mental talks freely & rationally: no delusions noticed: memory appears to be good: physical
condition also good. Personal appearance clean. For some days past, he has been working in laundry.

LOST HIS MIND.

John Coughlin Becomes Suddenly and Violently Insane.

John Coughlin, a young laboring man living on the West Side, became violently insane yesterday afternoon in a store on Minnesota street just after recovering from an epileptic fit. He was taken in charge by Officer Galvin and held with difficulty until the arrival of the central station patrol wagon. At the station Coughlin gritted his teeth and swore that he would "kill everybody, if he had to go to jail for 55,000 years." Five officers could scarcely keep him upon his back. Dr. Meade was summoned and pronounced Coughlin's insanity of a dangerous type, such as often follows fits of epilepsy. The mental derangement in such cases is only temporary. Coughlin was sent to the county jail where he was strapped to the floor of his cell and raved wildly throughout the afternoon and evening. He will be released as soon as he becomes again rational. He has lived many years in this city.

Where it Winter Is Felt.

Personal and Medical History of James Coughlin #2

John Coughlin

1896

Feby 1 Feby 1/96. Wt 185½ lbs. Pulse 68. March 1/96. Wt 203 lbs. P 70. April 1/96. Wt 205 pounds. —
April 30/96. He has been sleeping well: appetite good: bowels regular. Mechanic good: Mental condition
" 2 seems good: he talks freely & rationally: no delusions apparent. Physical condition is very good:
April 1 30 (patient has gained 36½ pounds in flesh since coming here). Has been working outside very indus-
-triously, for some weeks, with the Carpenter. Lately has talked of wanting to go home: habits
neat & clean. May 1/96. Wt 210 pounds. Pulse 80. May 8/96. About as last quarterly reported,
May 1/8 both mentally & physically. Works with carpenter, every day. Has lately been given "parole":
" 10 May 10/96. Was let out for a walk after supper, but did not return at bed time. Has Eloped —
Efforts to find him were without results.

Discharged

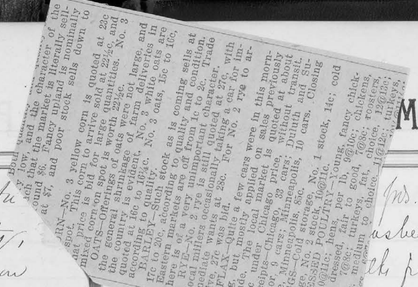
Personal and Medical History of James Coughlin #2

1896

This patient was brought here by Deputy Sheriff F.W. Kinney, attended by Robt E. Anderson, with following history. Patient is in poor physical condition. Not consanguinity, not known: a first cousin died insane, in St Paul. This seems to be 3rd attack: (one occurring in Dec 20/94), when he was at this (Rochester 1st) hospital: duration of that attack, a few months. First symptoms of this attack were manifested Jany 3rd/96: was violent: showed hallucinations: gives different names & age. Disease is variable & with rational intervals. Derangement now shown, by delusions &c. Says he is called to be a missionary: also says, "he is 74 years of age". Patient is disposed to injure others, but not suicidal: has tried to tear his clothes. As to any peculiarities he being previously known, is not known. Patient uses alcohol: is subject to Epilepsy: has been confined, for 24 hours, in Straight-jacket. Supposed cause of disease is Epilepsy. On personal Examination, he is violent, talks incoherently, gives different names & ages. Note. Patient was here twice before, under Correct name of "John Coughlin": the 1st time, from Dec 19/89 to July 28/90: (see Vol 13 page 131 No 2291): and was committed here again the 2nd " " Dec 20/94 to Apl 10/95: (See " 19 " 169 " 3945). was very suicidal while in Jail, just before them coming here. He quickly improved after coming here. (form of disease, sub acute mania): became pleasant & sociable: showed no delusions at that time: worked outside industriously: gained quite markedly in flesh & physical condition was good; also his mental state. He went home, recovered: (see attached newspaper clipping)

Note ×

Jan 4 On admission, was put on B3: G.F.R.P.Pt. Complex is dark: hair brown; eyes blue: Condition of skin good: marks on right ankle, from shackles: left hand thumb off, at first joint: bruises on left leg: Is very dirty: behavior good. Patient was brought here in straight-jacket & straps on ankles).
" 5 Pulse 80. R 20. T 99.6. Jan 5/96. Slept quite well, last night. Am. Pulse 85 R 23 T 99 2/5. - Appetite poor: cannot keep anything down: coughs a little. Behavior good: talks some: no delusions or hallucinations noticed. Complains of pain below his left shoulder. Jan 6/96. Slept well, last night. Am. Pulse 80. T 99.4. Appetite improving: receives special diet. Behaves well: bowels moved: talks
" 7 rationally: Complains some of being nervous. Jan 7/96. Slept & shaves: Am. Pulse 74. T 99 2/5.
" 8 Is about as usual. Jan 8/96. Again, slept well, last night. Am. Pulse 78. T 99. Appetite
" 9 good: bowels moved: Is quiet: talks rationally. Jan 9/96. Slept well: no change to note.
" 10 Transferred to D1: Jan 10/96. Slept well, last night. Am. Pulse 82. T 99.4. He is a very quiet patient, talks rationally when addressed; no delusions noticed. Appetite fair: bowels
" 11 regular: no complaints. Jan 11/96. Slept & shaves: Am. Pulse 90. T 98.6: no change noted in
" 18 patient's Condition: Jan 18/96. During this the 2nd week, patient's condition has seemingly improved. He has been sleeping well, each night. Pulse & temperature, taken daily, have been more nearly normal. Appetite has been good: bowels regular. He has talked freely & rationally; no delusions or hallucinations has been noticed: Goes out walking daily, with the other patients and works some on ward. Habits have been neat & tidy. Summary: has been quiet & agreeable on ward, since admission & has given no trouble. Has made no complaints. Is somewhat anxious to go home & says that he now feels all right. Is pleasant in manner & talks quite freely.
" 31 Physical condition good: Mental State much improved. Jan 31/96. Behavior has been very good: he talks freely & rationally: no delusions noticed: memory appears to be good: physical condition also good. Very neat & clean. For some days past, he has been working in laundry.



Medical History of James Coughlin #2

James Coughlin.

lbs. Pulse 68. March 1/96. Wt 203 lbs. P 70. April 1/96. Wt 205 pounds. — has been sleeping well: appetite good: bowels regular: behavior good: habits neat & clean. Mentally rational: no delusions apparent: Physical condition is very good: gained 3½ pounds in flesh since coming here). Has been working outside very industriously, for some weeks, with the Carpenter. Lately has talked of wanting to go home: habits
May 5/96 neat & clean. May 1/96. Wt 210 pounds. Pulse 80. May 8/96. About as last generally reported, both mentally & physically. Works with carpenter, every day. Has lately been given "parole".
" 10 May 10/96. Walked out, for a walk after supper, but did not return at bed time. Had Eloped - Efforts to find him were without result.

Discharged

Personal and Medical History of Charles Marshall

EBBERT, FIDLAR & OHAMBERS, DAVENPORT, IOWA

Whole No. 4290.
Residence, Dexter Village, Minnesota.
Date Admission, 6th January 1896.
Admitted by Dr. Phelps Hour, 11 Hrs Am.
How Sent, S.S. Washburn, Jo P. Mower County
Sex, Male.
Age, - 43 -
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farmer
Degree Education, not Educated -
Profession Religion, Baptist
Habits, has been in the habit of drinking
Nativity, New York (State) (Father's, the Same: Mother's, unknown)
Physicians Committing, C.H. Washburn and A.W. Allen.
Correspondents, None given in papers

No. for Year, 118.
Insane Relatives, Father
Cause Exciting, Masturbation
Cause Predisposing, Heredity.
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not stated
Date of this Attack, 2 weeks ago
Duration, 2 weeks.
No. of Attack, Not stated: weak minded for years.
No. of Admissions, 1st
Age First Attack, ?
Time of Leaving, Mar. 13' 96.
Time in Hospital, 2 mo. 7 da.
Result, Died. Apr. 30/96 Rec.

EXAMINATION ON ADMISSION.

Exam. 11 A.M. Phelps

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 a defective This is a superadded attack. Is a young man brought in by Wm. Flood - Some history of defectiveness but has been able to run farm until lately. Recently violent & confused.

Personal and Medical History of Charles Marshall

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3½ WEIGHT, 109 ½ lbs. NUTRITION,
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Promptness Movement, Fair.
PUPILS, Equality, Equal. Size,
Response Light, Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Slight EXAM. URINE,
Other
ARTICULATION, Good.
Slurred,
Hesitating,
FACIAL EXPRESSION,
Wandering & dull.
SENSIBILITY,
Arteries large & hard
HEART,
Strong & accentuated.
LUNGS,

TAKEN,

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 Charles Marshall

1896

This patient was received here at the hands of Sheriff's Deputy [illegible]. Flood with following history, which is rather meagre. Patient is in fair physical condition. There is no history of Consanguinity. No of attack not stated: patient has been weak minded for several years: his father was insane. First symptoms of this attack were manifested 2 weeks ago. Disease appears to be decreasing: not variable & no rational intervals: has loss of memory. Cause not subject insanity or derangement is now shown, is not stated. He is not disposed to injure others. Is suicidal, not stated: no filthy or destructive habits. He has been in the habit of drinking: If he has been subject to any fever disease &c or head-injury, is not known. Has not been restrained or confined. Supposed cause of the disease is masturbation. His condition requires medical care, while under treatment

Jan 6 On admission, was put on T.W. (G.H.N.R'pt. Complexion Dark: hair black: eyes blue: Condition of skin good: some scars on right side of neck: is dirty: behavior good): appears somewhat atonal & emaciated: was given bath & put to bed. Ate a good dinner & supper. Bowels moved slightly.

" 7 Jan 7/96. Restless 1 hour, but slept 7 hours, last night. Am. Appears very weak: Appetite good.

" 8 Is very quiet: makes no complaints. Jan 8/96. Restless 2 hours, Sleeping only 5 hours, last night. Condition about the same this morning. Says his bowels do not move "with ease" 12 M. bowels

" 9 moved. 3 PM. was given Seidlitz powder. bowels then moved freely. Jan 9/96. Slept 5 hours, restless 3 hours. Am. Appetite continues good; bowels not regular. Is very quiet: was given bath.

" 10 Jan 10/96. Restless 1 hour. Slept 7 hours. Condition unchanged. Wt. 95 3/4 lbs. (undressed).

" 11 Jan 11/96. Slept well (8 hours), last night. Am. Bowels moved freely. Is on regular & extra diet.

" 12 Jan 12/96. Slept 8 hours: Appetite good: bowels move regular: talks rationally when spoken to.

" 13 Jan 13/96. Condition unchanged. Jan 14/96. Seems some stronger, this morning. Sleeps well.

" 14/15 Bowels move, more regularly. Jan 15/96. Appetite & sleep good. Seems still gaining strength.

" 16/30 Jan 16/96. Given bath. No change especially noticeable. Jan 20/96. Has been sleeping quite well, each night, since last note. He is gradually gaining strength. Is very quiet. Makes no complaints. Summary: Patient's behavior has been very good, during the 2 weeks. He has been in bed, steadily, since time he was received. Appetite good, from 1st day: bowels somewhat irregular. Was quite weak & emaciated, but has been gradually gaining daily. Makes no complaints as to condition. Is never heard to speak, unless spoken to; appears quite rational in his

" 24 answers. Has averaged about 7 hours sleep, nightly. (see attached Records). Jan 24/96. Has improved some & now seems strong enough & able to be up. Has been sleeping well, nightly. Appetite good: bowels regular.

" 31 AM. Up & dressed. Jan 31/96. Seems now contended, while up. Is becoming much brighter: talks freely and

Feb 6 rationally. (~~as attached to~~ Feby). Feby 6/96. Behavior very good: talks rationally: sleeps well: seems

" 11/18 to improve daily: Feb 11/96. Much improved, physically: has worked some on ward. Feb 18/96. Appears quite strong: talks freely and quite rationally: makes no complaints. Transferred to D 3.

March/10 March 4/96. Wt 122 lbs. (has gained considerably in flesh). Mar 10/96. Appears in quite good mental condition: no delusions or hallucinations noticeable. Physical health seems good.

" 13 March 13/96. Sent home alone, today.

Discharged

Personal and Medical History of Gunder G Homme.

1899. From page 11.

Feb 1- July 31/99. (Dr Wanous) Feb. Wt. 149# Mch 17 Has considerable trouble with haemorrhoids, causing bleeding & pain. June 6. Visited by friends. June 15 Commenced to work outside June 30 stopped working. July 10. Working on farm. General condition seems good. Is demented.

Aug-1900 Jan 31/1900. (Dr Chapple) Wt. 134#. Physical condition fair. Is senile & demented & a harmless old man untidy in habits: Does no work. Feby 1/1900. Wt 141# Apl 21. Had 6 teeth extracted. June 10. Was

Feby 1 visited by nephew. June 15. Transferred to T.W. Has hemorrhoids, which trouble him considerably. Physical con-

June 10/15 dition not so good as formerly. June 17. Put on tonic. T. T. D.; also cathartics. June 18. Visited by brother.

17/18 Vaccinated: result good. July 30. Transferred to Annex July 31. Physical condition somewhat improved: other-

July 7/30/31 wise, no change. Is demented and quite senile. Bowels inclined to be constipated & hemorrhoids trouble him considerably. Quite steady in habits: always quiet & well-behaved: answers questions fairly well.

Aug 1/29 Does no work: wanders about ward aimlessly. Augt Wt 139#. Aug 29. Visited by nephew.

Sept 10/1901 Transferred to D 3. Jany 31/1901. Very little change. Is troubled considerably with hemorrhoids.

Jan 31 Is rather anaemic, and senile in appearance: habits untidy, but is very well behaved.

Feby 1 Works on ward. Answers questions, but talks little. Feby. 150# May 1. 144# Augt 1. 140#

Nov 1 Nov 1. 149#. Dec. Transferred to T.W. Dec 3. Operated on by Dr. Wanous for haemorrhoids.

Dec 3 1901 Recovery normal - without incident - Jany 9/01. Transferred to D 3. July 31. No change

Jany 9/01 of importance, during year: rather feeble, physically & senile. Quiet & quiet: answers ordinary

Augt 1 1902 questions sensibly: works a little on ward. Augt 1/02. 140# Jany 31/03. Visited by brother.

Jan 31 Remains much the same, physically & mentally. Is becoming very senile and indifferent to surroundings: somewhat untidy: works a little on ward: never causes any trouble.

Personal and Medical History of Sylvester Alderman

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4291.
Residence, High Forest Twp, Minnesota.
Date Admission, 17th January 1896.
Admitted by Dr Linton-Phelps Hour, 3 P.M.
How Sent, Jos. A. Bear. Ct. Commr. Olmsted County.
Sex, Male.
Age, 76 Years.
Civil Condition, Widower
Children, Four
Age Youngest Child, —
Occupation, Farmer
Degree Education, Common School.
Profession Religion, not a church-member
Habits, Intemperate
Nativity, Massachusetts (that of parents not known).
Physicians Committing, Chrisp. Graham and Chas. T. Granger
Correspondents, none given in papers.

No. for Year, 119.
Insane Relatives, not known
Cause Exciting, not known
Cause Predisposing, probably age
Form,
Accompanying Bodily Disorder, Some head-injury
Suicidal or Not, Suicidal & propensity active.
Date of this Attack, Two weeks ago
Duration, — Two weeks —
No. of Attack, not 1st: probably several:
No. of Admissions, 1st.
Age First Attack, — about 73.
Time of Leaving, 15th January 1896.
Time in Hospital, — 8 Days —
Result, Died. Valvular heart-Disease

EXAMINATION ON ADMISSION.

Exam. by P.M. Phelps. 1/8/96. **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: Says had paralysis 7 yrs. ago. Right hand helpless
7 senile case - feeble in mind - failing.

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 Sylvester Alderman.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, 161½ lbs NUTRITION,
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Promptness Movement, Slightly to right.
PUPILS, Equality, Right larger Size, Large.
Response Light, Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms, Tired.
Legs,
TREMORS, Hands, None noted. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred, Very
Hesitating,
FACIAL EXPRESSION,
Dull & depressed.
SENSIBILITY,
Arteries — large & tortuous.
HEART, Very bad.
LUNGS,

TAKEN,

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 Sylvester Alderman.

1896

This patient was brought here by Sheriff C. N. Stewart, with following history. Patient is in feeble physical condition. As to consanguinity or heredity, nothing known: this is not 1st attack; he has probably had several, as they have been occurring for 3 years; each of a few days' duration. First symptoms of this attack were manifested two weeks ago, by tearing his bed and clothing. Disease seems increasing, but variable & with rational interval, but these not at regular periods. Derangement now shown in that he destroys his clothing & cannot be controlled. Patient is dis-posed to injure others; also suicidal: attempted to cut his throat: propensity now active. Previously, he had shown peculiarities. There is history of intemperance in self & parents: Seven or 8 years ago, a wagon ran over his head. He has not been restrained or confined. Supposed cause of disease, not known. He has had no treatment. Is very quiet at this time, (on personal examination); talks incoherently.

Jan 7 On admission, was put on P.D.[2] (G.H.N.R.Pt. Complexion light: hair gray: eyes blue; Condition of skin poor: has hernia: is dirty: behavior good: is quite feeble). Later, moved to I.W. was weak & almost powerless: 5[30] P.M. Pulse 168 R 28 T. 99[2]. was put to bed: 6 P.M. ate a fair supper. Jan 8/96. Slept but 2 hours, restless 6 hours, last night. Am. Pulse 128 R 24 T. 99.-

" 8 Ate a light breakfast, but took a good dinner. 2[45] P.M. Given Enema; bowels then moved freely:- He has been very restless all day: required constant watching to keep him from falling out of bed. Was destructive 1 hour or so. 5 P.M. T. 100[6]. Jany 9/96. Restless 4 hours & slept only 4 hours.

" 9 Ate a fair breakfast this Am. Patient is, apparently, some stronger: is tearing bedding & continually trying to get out of bed. 8[45] Am. Was put in restraint. 12[45] P.M. Quiet, was later out of restraint. 3 P.M. appears to have hallucinations: "also imagines himself driving horses". 7 P.M. Was very quiet from 3 to 6 P.M: slept 1 hour. Jan 10/96. Restless 2 hours, noisy 4 hours, & slept only 1 hour, last-

" 10 night: was out of bed frequently. Am. Refused breakfast: 11 am. Patient is failing, gradually. Is given hot beef-tea &c: also alcohol sponge-baths & mouth often washed out. Wt (undressed) 136 lbs has lost quite markedly in flesh. 4[30] P.M. Has difficulty in swallowing: 7 P.M. Is very restless, this evening. Jany 11/96. Passed a very poor night: bowels moved slightly. Is given hot liquid

" 11 food quite often. Seems somewhat stronger this morning; still has difficulty in swallow-ing. 2[30] P.M. Bowels have moved freely. Still given beef-tea very frequently. Was again given an alcohol bath. Jany 12/96. Coughed some & was very restless, the greater part of

" 12 the night: slept only 1 hour. Was restless & noisy 7 hours. 5 P.M. Has been talking and very restless, the greater part of the day. 8[30] P.M. Is very weak tonight. Relatives notified.-

" 13 Jany 13/96 Coughed considerable during night & raised a large amount of phlegm. Slept only 2 hours: was restless 6 hours. 1 P.M. Was given whiskey-bath. 2 P.M. Condition appears about the same: he coughs a great deal. Is given frequent glasses of beef-tea.-

" 14 Jan 14/96. Coughed a great deal, during night: slept only 3 hours: was restless for 5 hours. Patient seems gradually growing worse: swallows with difficulty. 4 P.M. Visited by friends. 5 P.M. Has peculiar rattling sound in throat, while breathing. Is also perspiring freely. Jan 15/96. 12[30] Am. Is gradually failing: coughs some. 8. Am. Restless 6 hours &

" 15 slept only 2 hours, last night. Pulse 160 R 48 T. 104.8 - Was given a sponge-bath - 1[45] P.M. Is perspiring profusely: rattling in throat growing worse - 8 P.M. appears to be

Personal and Medical History of Sylvester Alderman

1896
Jan 15 rapidly failing: perspiring profusely: respiration labored. Pulse 178 R 60 T. 105[6] (8[45] P.M.) 11[30] P.M. Patient continued to sink rapidly, and died at this hour. (see ~~Attended~~ nurse's record)

- Died -

Personal and Medical History of John Tierney

EGBERT, FISCAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4293.
Residence, Brownsdale, Minn.
Date Admission, 9th January 1896.
Admitted by D. C. B. Eby Hour, 6:40 P.M.
How Sent, S.S. Washburn, Jo. P. Mower County.
Sex, - Male -
Age, - 21 -
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Laborer
Degree Education, not educated
Profession Religion, not a church-member
Habits, Intemperate (drink & tobacco-habit)
Nativity, Minnesota; (parents born in Ireland).
Physicians Committing, E. H. Washburn and Alley Macdonald
Correspondents, James Tierney, Austin Minn

No. for Year, 121.
Insane Relatives, none, but father drank.
Cause Exciting, masturbation
Cause Predisposing, probably bad habits
Form,
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, not
Date of this Attack, about a year ago -
Duration, about a year
No. of Attack, 1st.
No. of Admissions, 1st.
Age First Attack, - about 20 -
Time of Leaving, Aug. 16. 1896.
Time in Hospital, 7 mos. 7 das.
Result, Discharged. Feb. 3 '97
Unimproved

EXAMINATION ON ADMISSION.

Exam by R.M. Phelps. 11/8/96

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: Says he came here because he had granulated lids. Otherwise all right. Knows of no statement that his mind was wrong. Has been to Reform School. Feeble-minded.

Personal and Medical History of John Tierney

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 11 in WEIGHT, 167½ lbs. NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, None -
TONGUE, Tremors, Coatings, No. thick, pale. Promptness Movement, Fair
PUPILS, Equality, Equal. Size, Normal -
Response Light, Accommodation,
SIGHT, Poor. - "Granulated lids for 3 yrs back" - That is what he came for
HEARING, Good.
COORDINATION, Arms,
Legs,

BONN H. CLAYTON
422 SANTA FE CIRCLE
CHANHASSEN, MN 55317

MINNEAPOLIS MN PM 12 FEB 1981

Medical Records
Rochester State Hospital
2110 East Center Street
Rochester, MN 55901

ATTENTION:
GLORIA BEST

LUNGS, TAKEN,

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 John Tierney

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4293.

No. for Year, 121.

Residence, Brownsdale, Minn.

Insane Relatives, none, but father Drank.

Date A... Exciting, masturbation

Admit... habits

How ...

Sex,

Age,

Civil ...

Child ...

Age ...

Occu...

4291 Volume 33

FEB. 11, 1981

Pull

Medical Records
Rochester State Hospital
2110 East Center Street
Rochester, MN 55901

X 8/
3-26
D. Taylor

ATTENTION: GLORIA BEST

GENTLEMEN: send copy of Informed consent to sign request & cause of death — TT

I am studying my geneology and would like your help.

My great-great-grandfather, Sylvester Alderman, died at your Hospital January 16, 1896. I would like a copy of his Death Certificate, his "DEATH SUMMARY" and any other information relating to his parents, birth date, birthplace, relatives, or other information that could help me in constructing my family tree.

Thank you.

Yours,
Bonn H. Clayton
BONN H. CLAYTON
422 SANTA FE CIRCLE
CHANHASSEN, MN 55317

Lists - Other to reforms

Personal and Medical History of John Tierney

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 11 in WEIGHT, 163½ lbs. NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, None -

TONGUE, Tremors, Coatings, No. thick, pale. Promptness Movement, Fair

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Poor. - "Granulated lids for 3 yrs back" - "That is what he came for"

HEARING, Good.

COORDINATION, Arms,

Legs,

TREMORS, Hands, None - Tongue,

Facial Muscles, General,

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION, Good -

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,
Beats loudly. slow.

LUNGS,

TAKEN,

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 John Tierney

1896

This patient was brought here by Deputy Sheriff John Johnson, with following history. Patient is in fair physical condition. There is no history of consanguinity; no insane relatives: this is 1st attack; has not been in hospital before: first symptoms manifested about a year ago: disease appears increasing; variable, with rational intervals & he is better some days, than others. How derangement is now shown is not stated. Patient is not despised to injure others, nor suicidal, no filthy or destructive habits: no peculiarities were previously shown. Father drank & patient drinks & uses tobacco: no history of any severe disease &c: he has not been restrained or confined. Supposed cause of the disease is masturbation: he has had no treatment. Commitment of patient recommended because he wanders about & needs medical treatment, while under restraint. —

Jan 9 On admission, was put on B^{2} (G.H.76. Diff. Complexion light: hair dark: eyes blue: condition of skin good: some scars on left leg: is clean: behavior good). Jan 10/96. Slept 5 hours; restless 3 hours, last night. Am. Pulse 54. R 18. T. 98^{4}. Appetite good. Behavior good. Talks rationally; no delusions or hallucinations noticed. Makes no complaints, but he has a dry, hacking cough.

" 11 Jan 11/96. Slept 4 hours, awake & restless 4 hours, last night. Am. Pulse 60. R 18. T. 98^{4}. Patient

" 12 is very quiet & orderly: talks rationally: appetite good. Complains of sore eyes. Jan 12/96. Slept 6 hours. Am. Pulse 70. R 19. T. 98^{2}. Is clean & tidy. Goes out walking. Works onward: no

" 13 delusions noticable. Jan 13/96. Slept 7 hours. AM. Pulse 70. R 18. T. 98^{2}. Bowels are costive.

" 14 He continues very quiet; talks rationally: still complains of eyes. Jan 14/96. Restless 1 hour, but slept 7 hours. Am. Pulse 88. PM. Pulse 76. Appetite good: bowels in good condition, nur.

" 15 Jan 15/96. Slept 8 hours, last night. AM. P 60. PM. P 64. Behavior good: he talks fairly

" 16 well and rationally: still complains of eyes bothering him. Jan 16/96. Slept well last night. Am P 56. PM. P 60. no delusions or hallucinations noticeable: goes out, on grounds,

" 20 every day. Jan 20/96. Has been sleeping well, since last noted. He has been quiet and well-behaved: appetite good. makes no complaints, except about his eyes. Habits fairly clean.

" 21/23 Jan 21/96. Transferred to B^{3} (on account of a general change in Wards). Jan 23/96. No change especially noticeable: he sleeps well: behaves well & is quiet. Pulse more nearly normal. Eyes are being treated, by dropping medicine in them in Am. & Pm. Summary: Patient has been quiet & very well-behaved since admission: habits fairly neat & clean. Physical condition good: muscles well-formed & well-developed: skin good: he talks well and

" 31 rationally: no delusions or hallucinations noticeable. Jany 31/96. No change noted: sleeps

Feby 5 well: eyes treated, twice daily. Feby 5/96. Was in bed the 3^{d} & 4th inst: complained of faintness, dizziness, and sick headache (3^{d}. P 96 R 22 T 99^{6} (4th) P 92 R 20 T 99^{4}). ate little: Is up today.

" 18 Feb 18/96. Has been going down town from time to time, to have eyes treated by Dr. Mayo & to get some

" 24 spectacles from him. Eyes also treated here, daily, twice. Feb 24/96. Still goes to see Dr. Mayo, about his eyes.

" 25/29 Transferred to C^{3}, today. Feb 25/96. Commenced to work in the "Centre". Feb 29/96. Keeps about as usual.

Mar 1 Habits neat & clean: no delusions noticed: works in the Centre". Mar 1/96. Wt 183½ (has gained

" 30 considerably in flesh). P 78. Mar 30/96. Patient's condition seems much improved: Eyesight is better: does not complain of headaches. No delusions or hallucinations noted. Works in "Centre". has a "limited parole". Eyes are still treated some. April 1/96. Wt 183 lbs. P 82. Apl 10/96. Was

Apl 1/10

" 30 transferred to A^{1}. Apl 30/96. Behavior good: eyesight improved: habits clean. Works in "Centre": mentally, as usual.

Personal and Medical History of John Tierney.

May 1/96 to Aug 16/96 Summary Nurses Notes by Dr. Phelps. Wt. 186 lbs. Had parole after June 2nd: looked about center. In a feebleminded way seemed rather reliable. Aug 16 '96 eloped while on parole: It was not thought previously that he had any desire to leave: He was strong & able to care for himself. Had no delusions but a lack of judgement & general feebleмindedness.

Discharged.

Personal and Medical History of Gunder. G. Homme

BEBBET, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4294

Residence, Norway Co Jaramingo Pk Goodhue Co. Minn

Date Admission, 10th January 1896.

Admitted by D. Phelps Hour, 2.30 PM.

How Sent, Arch Hallen Jof P. Goodhue County

Sex, Male

Age, - 52 -

Civil Condition, Widower

Children, None

Age Youngest Child, —

Occupation, Farming

Degree Education, very little

Profession Religion, Not a Church-Member

Habits, not intemperate

Nativity, Norway: (parents also born there).

Physicians Committing, J. W. Dimmitt and N. Juell

Correspondents, none given in papers

No. for Year, 122.

Insane Relatives, None

Cause Exciting, Loss of money.

Cause Predisposing, previous attack

Form,

Accompanying Bodily Disorder, - Dizziness -

Suicidal or Not, — not —

Date of this Attack, going on one yr - 6 Years

Duration, Some 6 years

No. of Attack, 2nd —

No. of Admissions, 2nd

Age First Attack, — 46 —

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exd by Dr. Jelsog. Jan 13 96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, somewhat Confused

Quick or Sluggish, Sluggish —

MEMORY:

Past Events, Quite poor

Recent Events, " "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, Correct in the main

REASONING POWER:

Ordinary Subjects, slow

Own Mental State, realizes condition

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

~~Indifferent,~~

~~Exalted,~~

Depressed, Yes

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not, } None noted

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, Normal.

GENERAL DESCRIPTIVE REMARKS:

Patient has some oedema of ankles & eyelids: is stoop-Shouldered & beard is unkempt. Complains of pain in Stomach, with alternating attacks of Diarrhoea & constipation. Says he knows it is not quite right". Has confusion, with, at times, impulses to strike everyone near him. Does not yield to them. Shows nothing now but a dementia with melancholic features.

Personal and Medical History of Gunder. G. Homme

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS

GUNDER G. HOMME.

March 17th---A letter from T.G.Homme states that about six years ago he lost nearly all of his money and following that became mentally deranged, this being the first time anything had been noticed. Symptoms noted have been those of melancholia, quite purely so, he being able to remember and talk coherently all of the time.

TREMORS, Hands, Slight — Tongue, Slight

Facial Muscles, No — General, No

REFLEXES, Patellar, 4 - 5 - equal — EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating, Somewhat

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Some mitral insufficiency: venous pulsation: epigastric pulsation marked: atheromatous arteries.

LUNGS,

Slight dullness in left apex.



TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good, fecal kept	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, Father subject to severe headaches.

Brothers or Sisters,

Personal and Medical History of Gunder. G. Homme

Whole No. 4294
Residence, Norway Lk Kanamuiga Th Goodhue Co. Minn
Date Admission, 10th January
Admitted by D. Phelps
How Sent, Red Wing Jail
Sex, Male
Age, - 52 -
Civil Condition, Widower
Children, None
Age Youngest Child, —
Occupation, Farming
Degree Education, Very little
Profession Religion, Not a church-Member
Habits, not intemperate
Nativity, Norway: (parents also born there).
Physicians Committing, E. W. Dimmitt and N. Juell
Correspondents, none given in papers

No. for Year, 122.
Insane Relatives, None
Age First Attack, — 46 —
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam'd D. Stenzel, Jan 13 96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, somewhat confused
Quick or Sluggish, Sluggish —
MEMORY:
Past Events, Quite poor
Recent Events, " "
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Correct in the main
REASONING POWER:
Ordinary Subjects, slow
Own Mental State, realizes condition
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
~~Indifferent,~~
~~Exalted,~~
Depressed, Yes
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, None noted
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, normal.

GENERAL DESCRIPTIVE REMARKS:
Patient has some oedema of ankles & eyelids: is stoop-Shouldered & beard is unkempt. Complains of pain in Stomach, with alternating attacks of Diarrhoea & constipation. Says he knows it is not quite right". Has confusion, with, at times impulses to strike everyone near him. Does not yield to them. Shows nothing new but a dementia with melancholic features.

Personal and Medical History of Gunder. G. Homme

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6 in WEIGHT, 149½ lbs NUTRITION, Slightly impaired.
WOUNDS OR ABNORMALITIES, Small fatty tumor in abdominal wall, below umbilicus. 1st finger of left hand lost
TONGUE, Tremors, Slight - Coatings, dry red in centre: clean Promptness Movement, fairly prompt
PUPILS, Equality, Yes Size, Normal
Response Light, normal Accommodation, Normal
SIGHT, somewhat impaired —
HEARING, good, now: he says, "sometimes poor" —
COORDINATION, Arms, fair: finger to nose, eyes shut, somewhat uncertain.
Legs, fair: standing on foot, fair: standing, eyes shut, good. —
TREMORS, Hands, Slight Tongue, Slight
Facial Muscles, No General, No
REFLEXES, Patellar, 4-5 - equal EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating, somewhat
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Some mitral insufficiency. venous pulsation: epigastric pulsation marked: atheromatous arteries.
LUNGS,
Slight dullness in left apex.



TAKEN,

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, Father subject to severe headaches.
Brothers or Sisters,

Personal and Medical History of Gunder. G. Homme.

1896

This patient was brought here by Deputy Sheriff P. J. Lundquist, with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This seems to be the 2nd attack: one occurring Feby 1/89 to Feby 14/90 (?), duration one year: was then sent to this (Rochester) Hospital: was released on trial: not perfectly cured, but improved. He became, however, gradually worse, since his discharge. Disease seems increasing: variable, but he has rational intervals, not at regular periods: he seems to get worse in Change of weather. Derangement is now shown in that he is despondent: imagines that everything goes against him. Patient is not disposed to injure others, nor suicidal: no filthy or destructive habits. He has always been somewhat despondent. There is no history of intemperance in self or parents. He had convulsions when a child and ever afterwards has been troubled with dizziness. Has not been restrained or confined, but has a tendency to wander about. Supposed cause of the disease is loss of money. Has received treatment at Asylums, as above stated & has also been treated by Dr. Grinrold, of Norway, Goodhue County. At present, patient seems to realize his own condition & says that the presence of strangers frightens him: he is troubled with sleeplessness at times, has wandered away, without cause, for long distances.

Note. As stated, patient was here before, from Feby 5/89 to July 8/89. For some time, after then coming, manifested little or no delusion of fear, but was quite suspicious, imagining that people were making fun of him &c: was also childish & silly, in manner: Complained of Dizziness and dyspepsia. During April, his mental condition grew worse & he became more melancholy: Complained of faintness & vertigo. During May, he became even worse: very melancholy & stupid: Eating but little: showed "delusions of fear": worked some, later, in the kitchen & this seemed to relieve his mind a little. Patient had some heart-trouble, for which he was treated. During July, Condition improved some, but he was still childish & undecided: worked some at farm: benefitted by it: taken home by brother

Jan 10 On admission, was put on B3 (G.H.R. Pt. Complexion light: hair dark: eyes blue: condition of skin good;
" 11 no marks, scars or bruises noticed: is clean: behavior good). Jan 11/96. Slept 6 hours, restless 2
hours, last night. Am. Pulse 72 R 20 T 98.4. Appetite good: bowels regular: no cough noticed.
behavior good, but very restless: talks rationally, when spoken to: no complaints or injuries to report.
" 12 Jan 12/96. Slept only 4 hours, restless 4 hours, last night. Is restless, today. Talks but little:
" 13 memory poor: physical condition good. Jan 13/96. Restless 3 hours, but slept 5 hours.
Am. Pulse 72 R 19 T 98.6. Behavior good: he appears foolish: talks confusedly: habits fairly clean.
" 14 Jan 14/96. Slept 5 hours, restless 3 hours. Am. P 70: Pm. P 76. Appetite good: bowels in good
" 15 condition. Jan 15/96. Slept only 4 hours, restless 4 hours. Am - 72 Pm. P 68. very quiet; dull &
" 16 stupid. Jan 16/96. Restless 2 hours, but slept 6 hours, last night. Am - 70 Pm P 70. Talks
" 17 little: appears confused: goes out walking. Jan 17/96. Slept 5 hours, restless 4 hours: behavior good.
" 18 Appetite fair: bowels in good condition. Jan 18/96. Slept poorly: Eats poorly, today: Complains
" 19 of "bad stomach. Jany 19/96. Slept 6 hours. Ate very little, today. Jan 20/96. Slept 8 hours; was
" 20/21 restless 4 hours: was given powders, (every hour): ate very little: appears failing. Jany 21/96 Restless,
but slept fairly well. Ate very little, today. Transferred to B3. (on account of general change
" 22 in wards). Jan 22/96. Slept 8 hours. Am. P 78 R 20 T 99. Ate very little, today. Bowels moved.
" 23 Complains of feeling weak: restless, most of day. Jan 23/96. Slept well, last night. Ate no
breakfast. Is quite weak this Am. T 99.2. Transferred to "Infirmary Ward".

See Vol 11 page 173 to 175

Personal and Medical History of Gunder. G. Homme.

1896 Jan 23

Summary: Patient has been quiet & fairly well-behaved: habits fairly clean & neat: Physical
, but two delu- Put to bed.
last night.
2.30 4.00 5.30 pm.
ters 3 hours,
d told to do so.
. Appetite fair.
on about same.
ins of pain in
last few nights.
good, to try.
yet complains,
y. Up & dressed,
/96. Had a
quiet, but
eb 25/96. Has
better than
& sleepwell
& go home."
Physical Ap-
d good, but, for
taught & die"
d, of late.
ce able.
d the usual.
st very good,
ward. Mental

CASE RECORD.

Patient's Name G. G. Homme. Name Disease ..... Name Physician H.H.S.

1896. Date.	Temp.	Pulse.	Resp.	Medicine and Food.	Giving Baths, Enemata, Action Bowels, Kidneys, Skin and Other Symptoms.
Jan 21 - am	98.4	64	18	Regular and extra diet.	Appetite good today. Bowels moved 9.00 am. Complains of pain in stomach
" - pm	98.8	60	24		
" 5.30 pm					Bowels moved. Left 5 - P. 3.

Recorded by ..... Nurse.

Jan 31 Trans. to Annex. Very quiet & sluggish. Oct 1/96 Wt. 155.5 lbs. Is drifting along with very little change of any kind: Asks frequently to go home.

See page 175.

Personal and Medical History of Gunder. G. Homme.

Personal and Medical History of Gunder. G. Homme.

33/01/4794.

CASE RECORD.

Patient's Name G. G. Homme Name Disease ..... Name Physician H.H.H.

1896. Date.	Temp.	Pulse.	Resp.	Medicine and Food.	Giving Baths, Enemata, Action Bowels, Kidneys, Skin and Other Symptoms.
Jan. 22- am	98.8	70	20	On regular and extra diet.	Patients physical appearance is poor. Will not eat unless watched and told to do so. Appetite seems fair. Bowels regular.
" " pm	98.8	64	18		Slept 7- R. 1.
" 23- am	98.4	60	18		Appetite fair today. Complains of pain in stomach after eating. Talks irrationally. Habits clean. Bowels regular.
" " pm	99.7	66	20		Slept 8- R. 6.
" 24- am	98.9	74	22		Patients is becoming very obdurate. Will eat anything he is told to eat. Otherwise condition seems unchanged.
" " pm.	99.5	66	22		Slept 7- R. 1.
" 25- am	98.8	72	18		Appetite fair today. Bowels irregular. Lies quietly and makes no complaints.
" " pm	99.2	66	20		Slept 6- R. 2.
" 26- am				1/2 glass Hunyadi water	Appetite fair. Says he feels a pain in stomach when she eats.
" " pm.	99.2	60	18		Slept 7- R. 1.
" 30- am	98.6	66	20		Refused breakfast.
" " 12 m				Very light dinner	Bowels moved slightly this morning. Bath.
" " pm	99	56	24	Fair supper.	No albumen in urine. Bowels moved.
" " 8.20 "					Slept 7- R. 1.

Recorded by Infirmary Nurse.

Summary: Patient has been quiet & fairly well-behaved: habits fairly clean & neat: Physical Condition poor: appears run-down & weak. Mental State dull, stupid & confused, but no delu-

Jan 10 On C

" 11 mov hour beh

" 12 Jan

" 13 men Am

" 14 Jan

" 15 Cond

" 16 Slep

" 17 little

" 18 Appe

" 19 of

" 20 " 21 rest

but slept fairly well. Ate very little, today. Transferred to "Infirmary Ward" (on account of General change in ward). Jan 22/96. Slept 8 hours. Am. P 78 R 20 T 99. Ate very little, today. Bowels moved.

" 23 Complains of feeling weak. restless, most of day. Jan 23/96. Slept well, last night. ate no breakfast. Be quite weak this Am. T 99.2. Transferred to "Infirmary Ward".

along with very little change of any kind. Asks "frequently" to go home.

See page 173

Personal and Medical History of Gunder. G. Homme.

Personal and Medical History of Gunder. G. Homme.

Summary: Patient has been quiet & fairly well-behaved; habits fairly clean & neat. Physical Condition poor: appears run-down & weak. Mental State dull, stupid & confused, but no delusions or hallucinations noticeable. Jan 23/96 Cont'd. Was received on T.W. at 1¼ Pm. Put to bed 5 Pm. Temp 99⅘. Ate a light supper. Jan 24/96. Slept only 3 hours, restless 3 hours, last night 8 Am. Temp 99⅖. Is stubborn. Ate a light breakfast; forced feeding. Powders given 1.00 2.30 4.00 & 7.30 Pm. 5.30 Pm. Temp 99. Forced a light dinner & supper. Jan 25/96. Slept only 4 hours. Restless 3 hours, noisy 1 hour, during the night. Physical appearance poor. Will not eat, unless watched & fed & coaxed.

Jan 26/96. Complains of pain in stomach, after eating; bowels regular. Talks irrationally. Appetite fair.

Jan 27/96. Slept poorly, last night. Is becoming very obedient & will eat better. Otherwise condition about same.

Jan 28/96. Appetite fair today, helps quietly; makes no complaints. Jan 29/96 Still complains of pain in stomach after he eats. Jan 30/96. No albumen in urine. Has been sleeping better, past few nights.

Jan 31/96. Complains of pain in stomach, tho' bowels move fairly regularly. Appetite good, today.

Feb 3/96. Lies quietly in bed, but continually asking to get up. Appears quite weak yet complains today, of slight pain in chest. Sleeps 6½ hours, nightly. Feb 4/96 Feels much better, today. Up & dressed, part of the day. Behavior good, while up. Feb 5/96. Up & dressed 2½ hours, this Pm. Feb 7/96. Had a diarrhoea, but better today. Feb 11/96. Seems gaining in flesh & strength, gradually. Very quiet, but sleeps very poorly. 11.00 Am. Up & Dressed: behavior good. Feb 12/96. Wt 136 lbs. Feb 15/96. Has been sleeping better of late. Feb 19/96. Sleeps 7 & 8 hours, each night. Says "he is feeling better than usual". Seems brighter & more talkative, at times. Feb 29/96. Has continued to rest & sleep well. Quiet & well-behaved; habits clean. Seems quite bright. Says "he intends to get well & go home". More talkative. Is improved much. (See Nurses' Record on File, p. 10). Mar 3/96. Physical appearance not very good. Complains of stomach being out of order. Appetite seems quite good, but, for some unknown reason, he does not wish to eat. Bowels irregular. Says "he is of no use & ought to die". Works on ward: Habits clean. March 6/96. Wt 138½ lbs. Mar 27/96 More willing to eat, of late. Says "he is going to get well & go home". March 31/96. No change) Specially noticeable.

April 2/96. Wt 135½ lbs. April 15/96. Bowels somewhat costive: given salts: bowels then moved. April 30/96. No special change noticed. Physical health seems good: Appetite not very good, & he frequently objects to go to meals. Habits clean: untidy in dress. Sleeps at 8.30. Works on ward. Mental condition remains about the same.

Summary Nurses Notes by Dr. Phelps- May 1/96 Wt. 134 lbs. Patient seems rather pallid. Persists in standing about the ward. Is rather short having curvature of the spine. Answers questions but is rather feebleminded. Was rather poorly during early part of stay here & on extra diet a good deal of the time, during latter part of '96 Still refuses to eat at times. Is always depressed & always stands idly about altho. at times does some little work. The only special ailment noted is haemorrhoids, in general his physical condition continued good throughout period. Aug 1/97 Wt. 183 lbs Aug 21 Trans. to B3. Is rather confused mentally, is quiet & seemingly repressed. Dec 31 Trans. to Annex. Very quiet & sluggish. Oct 1/98 Wt. 155 lbs. Is drifting along with very little change of any kind: Asks frequently to go home.

See page 1785.

See Vol 11 page 173 to 1775 ⊗

Jan 10 On ward 3

" 11 Is working on ward. Habits clean. Eats well. Appears quite bright. Jan 12/96. Slept well, last night. Ate well, this Am. Jan 13/96. Slept well, last night. Ate well, this Am. Jan 14/96. Is working on ward. Habits clean. Eats well. Appears quite bright. Jan 15/96. Complains of pain in stomach, after eating. Bowels regular. Talks irrationally. Appetite fair. Jan 16/96. Slept poorly, last night. Is becoming very obedient & will eat better. Otherwise condition about same. Jan 17/96. Appetite fair today, helps quietly; makes no complaints. Jan 18/96 Still complains of pain in stomach after he eats. Jan 19/96. No albumen in urine. Has been sleeping better, past few nights. Jan 20/96. Complains of pain in stomach, tho' bowels move fairly regularly. Appetite good, today. Jan 21/96. Lies quietly in bed, but continually asking to get up. Appears quite weak yet complains today, of slight pain in chest. Sleeps 6½ hours, nightly. Jan 22/96 Feels much better, today. Up & dressed, part of the day. Behavior good, while up. Jan 23/96. Up & dressed 2½ hours, this Pm. Jan 24/96. Had a diarrhoea, but better today. Jan 25/96. Seems gaining in flesh & strength, gradually. Very quiet, but sleeps very poorly. 11.00 Am. Up & Dressed: behavior good. Jan 26/96. Wt 136 lbs. Jan 27/96. Has been sleeping better of late. Jan 28/96. Sleeps 7 & 8 hours, each night. Says "he is feeling better than usual". Seems brighter & more talkative, at times. Jan 29/96. Has continued to rest & sleep well. Quiet & well-behaved; habits clean. Seems quite bright. Says "he intends to get well & go home". More talkative. Is improved much. (See Nurses' Record on File, p. 10). Jan 30/96. Physical appearance not very good. Complains of stomach being out of order. Appetite seems quite good, but, for some unknown reason, he does not wish to eat. Bowels irregular. Says "he is of no use & ought to die". Works on ward: Habits clean. March 6/96. Wt 138½ lbs. Jan 31/96 More willing to eat, of late. Says "he is going to get well & go home". March 31/96. No change) Specially noticeable.

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" 21 restless, ... appears pining. Jan 4/96 restless, but slept fairly well. Ate very little, today. Transferred to B3. (on account of general change in ward's). Jan 22/96. Slept 8 hours. Am. P 78 R 20 T(o) 99. Ate very little, today. Bowels moved.

" 23 Complains of feeling weak. restless, most of day. Jan 23/96. Slept well, last night. Ate no breakfast. Is quite weak this Am. T(o) 99.2. Transferred to "Infirmary Ward".

Personal and Medical History of Gilbert Laupeland

EBERT, TIDLAN & CHAMBERS, DAVENPORT, IOWA

Whole No. 4295.

Residence, Stanyfield, Minnesota

Date Admission, 10th January 1896 -

Admitted by D. C. B. Ely Hour, 6 to P.M.

How Sent, Sheriff Olson, Dep. Dodge County

Sex, - Male -

Age, - 24 -

Civil Condition, Single

Children, - none -

Age Youngest Child, —

Occupation, - Farming (father a farmer).

Degree Education, Common School.

Profession Religion, Yes: Lutheran

Habits, Probably Intemperate

Nativity, Vernon, Minn. (Parents born in Norway).

Physicians Committing, C. L. Chambers and Chas. O. Wright

Correspondents, None given in Papers.

No. for Year, 123.

Insane Relatives, None

Cause Exciting, Probably a Drinking Scrape.

Cause Predisposing, Probably Habits

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, - Not -

Date of this Attack, About December 1895

Duration, a few weeks -

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, - 24 -

Time of Leaving, Mar. 27' 96.

Time in Hospital, 2 mo. 17 da.

Result, Dec. Apr. 30/96 Rec.

EXAMINATION ON ADMISSION.

Exam by R. M. Phelps. 1/18/96.

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: Answers at random at times as if purposely so. Looks as if he knew Seems quiet tho evidently has been veiled - Mild Maniacal Tendencies - Probably Paranoiad

Personal and Medical History of Gilbert Laupeland

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5in WEIGHT, 129 lbs. NUTRITION, Slightly impaired.

WOUNDS OR ABNORMALITIES, Scratches etc.

TONGUE, Tremors, Coatings, Promptness Movement, Prompt.

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT, Good

HEARING, "

COORDINATION, Arms, —

Legs,

TREMORS, Hands, — Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal. EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,

Looks fairly intelligent but talks at random

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Says has headaches - various feelings

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 Gilbert Lampeland.

1896

This patient was brought here by Deputy-Sheriff Joel Tucker, attended by A. C. Doggett, with following history. Patient is in a noisy & excited condition. There is no history of Consanguinity or heredity. This is 1st attack, symptoms manifested about December 1895. Disease seems increasing: not variable: no rational intervals. Derangement now shown in that he has an idea that he is in the Real Estate business & going to travel for Browning, King & Co. Is disposed to inquire others, but only when bothered: is not suicidal, nor filthy nor destructive in habits. No peculiarities were previously shown. Habits of patient are probably intemperate. There is no history of any severe disease &c or head-injury. He has not been restrained or confined. Cause of the disease is probably a drinking-debauch. He has had no medical treatment. On personal Examination, patient acts like a person who has been on a protracted spree, with whiskey and women.

Jan 10 On admission, was put on C3 (G.H.N.R.P. Complexion dark: hair brown: eyes gray: Condition of skin good: has a lump on back of head: is clean: behavior excited & is "somewhat on the fight").
" 11 Pulse 96. R 28. T 100 2/5. Jan 11/96. Slept only 2 hours, last night: restless 2 hours, noisy 2 hours. Am " 76 " 28 " 100°. Appetite fair: no movement of bowels: given medicine for same: no cough noticed. Behavior noisy: inclined to be pugnacious: he has delusions. No complaints or inquiries
" 12 to report. Jan 12/96. Slept 6 hours, restless 3 hours, last night. PM. Pulse 76. T 99.8. Behavior is a little quieter. appetite fair: bowels moved. Is still inclined to be pugnacious.
" 13 Jan 13/96. Quiet & slept 8 hours. Am. Pulse 84 T 99.8. Bowels moved. Physical Condition
" 14 Emaciated. Is on medicine. Behavior very restless. Jan 14/96. Restless 3 hours, but slept 7 hours. Am. Pulse 80. T 99.2. Appetite fair: behavior not good: habits untidy: No Complaints.
" 15 Jan 15/96. He Eats & sleeps well: makes no Complaints: behavior not good: has a scar on
" 16 face, result of a "fracas" with patient. Pulse 80. Jan 16/96. Behavior slightly improved. P80.
" 17 Complains of pains in abdomen: bowels do not move. Jan 17/96. Behavior quieter. Bowels
" 18 Constipated: given medicine: was called upon, by a friend, today. Jan 18/96. Pulse 84. Bowels have moved freely. No physical Complaints. Behavior uneasy - Patient has delusions.
" 19 Jan 19/96. Slept 7 hours, last night. Am Pulse 84. Is very restless & uneasy. Appetite fair:
" 20 Receives milk. Jan 20/96. Am. Pulse 96. Condition does not seem to change any
" 21 Jan 21/96. Slept 6 hours: was somewhat restless: Am. P84. Complains of pains in
" 22 abdomen. Moved to C1: (a general change in the wards): Jan 22/96. Slept well: Am. P88. Appetite fair: bowels moved: no complaints: behavior quiet: still has delusions.
" 23 Jan 23/96. Eats & sleeps well. Pulse 80. Behavior quiet now: Makes no Complaints: Some
" 24 mental improvement noticed. Jan 24/96. About as yesterday: Pulse 84. No delusions at present noticeable. Summary: Patient's behavior, mentality, was not good: was excited & pugnacious: after being here about 10 days, a change in it was noticed. At the present time, he is fairly well-behaved, tho' he is inclined to be nervous. No delusions now noticed. Memory very good, seemingly. Physical condition improved, since arrival. Bowels now regular: Makes no complaints. Appetite now good & he sleeps well.
" 31 Jany 31/96. no change specially noticeable. Eats & sleeps well: no complaints - Is foolish.
Feb 1/3 Feb 1/96. Wt 141 lbs. Pulse 96: (has gained in flesh). Feb 13/96. Patient is very troublesome to visitors. Behavior has been somewhat foolish, but has improved, of late: no delusions noticed.

Personal and Medical History of Gilbert Lampeland

1896

Feb 19 Feb 19/96. Behavior much improved. Eats & sleeps well: bowels regular: makes no complaints -
Mar 2 Mar 2/96. Wt 155 pounds (has gained 16 pounds in weight, since coming here). Pulse 80. -
" 27 March 27/96. Called upon by brother. Mar 26/96. Behavior still somewhat foolish
" talk quite freely: no delusions or hallucinations noticeable. Sleeps fairly well. (8 hours nights, on the average). Has been complaining some of having caught cold. Is anxious to go home.
" 27 When can get to work. Has helped willingly with work here. March 27/96. Was allowed to leave, this evening, on trial.

Discharged

Personal and Medical History of John Fredrickson

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4297.
Residence, Scandia, Washington County
Date Admission, 11th January 1896.
Admitted by Dr. Phelps Hour, 6 45 PM.
How Sent, E & J. Potts. Jof P. Washington County
Sex, Male
Age, - 29 -
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farmer
Degree Education, only attended a district school.
Profession Religion, Yes: Lutheran.
Habits, no history of intemperance
Nativity, Sweden: (parents also born there).
Physicians Committing, W. H. Pratt and T. C. Clark
Correspondents, Peter Fredrickson (Father)
Scandia, Minn

No. for Year, 125.
Insane Relatives, None
Cause Exciting, Unknown
Cause Predisposing, previous attacks
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, not; but threatens injury to others.
Date of this Attack, about 9 weeks ago.
Duration, - about 9 weeks -
No. of Attack, 3rd
No. of Admissions, 1st
Age First Attack, about 27.
Time of Leaving, May 15. 1897.
Time in Hospital, 4 mo 4 da.
Result, Died. Phthisis Pulmonalis & Potts Disease

EXAMINATION ON ADMISSION.

Dr. D. Herzog January 14/96. **MENTAL CHARACTERISTICS.**

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

MEMORY:
Past Events,
Recent Events, Not clear
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive at times

REASONING POWER:
Ordinary Subjects, Slow
Own Mental State, Defective
Special Subjects,

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

DELUSIONS:
Systematized or Not, unsystematized
Special Subjects, Dyspheria God
Transitory or Not, Seem fixed
HALLUCINATIONS: of hearing
ILLUSIONS: defective identification of people.

CONVERSATION:
Coherent or Incoherent, Incoherent
Voluble or Reticent, reticent

GENERAL DESCRIPTIVE REMARKS:
Patients behavior is peculiar: sits or lounges about in constrained positions: looks fixedly into space as if seeing something. Has constant purposeless motions, such as slowly shuffling the feet, shrugging the shoulders, moving the hands, getting up, taking a few steps & setting down again. Says "he hears voices, particularly at night"; - that he has fears that some one will come to kill him &c —

Personal and Medical History of John Fredrickson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 11in WEIGHT, 159 lbs (usual weight 170) NUTRITION, Somewhat impaired: flush over cheek bones.
WOUNDS OR ABNORMALITIES, Dorsal curvature over 11th dorsal & 1st lumbar vertebrae; scars left lateral cervical
TONGUE, Tremors, None Coatings, light coating; lips dry, Watts of tobacco. Promptness Movement, Slow
PUPILS, Equality, Yes Size, Normal
Response Light, Yes Accommodation, Yes
SIGHT, Good
HEARING, Good
COORDINATION, Arms, fairly good: finger to nose, eyes shut, refused to test.
Legs, seem good: standing & foot good.
TREMORS, Hands, None Tongue, —
Facial Muscles, none General, None
REFLEXES, Patellar, 8 - 9 - equal
Other slight ankle clonus
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
depressed & vacant
SENSIBILITY,
HEART, apex beat feeble & displaced to left
second pulmonic sound sharp
LUNGS, murmur good hyper-resonance over entire chest

EXAM. URINE,
TAKEN,

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 John Fredrickson.

1896

This patient was brought here by Deputy Sheriff Jno. Newquist, attended by P. Fredrickson father, with following history: Patient is in fair physical condition. There is no history of consanguinity or heredity. This seems to be 3rd attack: previous ones occurring in July & Aug 1894, July '95, and for last two weeks: duration of each about 2 months. First symptoms of this attack were manifested about 4 weeks ago; thought that he was in charge of a body of men & was commissioned to do something with them: was not sure what. Thought that he was the Deity. Disease seems increasing; but variable with rational intervals: but these, not at regular periods. Derangement now shown more particularly in religious subjects. He has talked about injuring others, but made no attempt to injure any one. Is not suicidal, nor filthy nor destructive in habits. Previously showed more or less religious tendencies. There is no history of intemperance in self or parents, nor of any severe disease or head-injury. He has not been restrained or confined, nor under medical treatment. Supposed cause of the disease is unknown. On personal Examination, he holds no conversation. Thinks that it is his duty to kill some of the people, in order to save the rest." Thinks that it ought to be done", but does not want to do it himself.

Jan 11 Jan 11/96. On admission, was put on B3. (G.H.R.P.of. Complexion light: hair brown: eyes blue: Condition of skin good: no marks scars or bruises noticed: is clean: behavior good). " 12 Pulse 88. R 22 T. 99.4 Jan 12/96. Restless 7 hours, sleeping but 1 hour, last night. — Am " 78 " 20 " 99. Appetite good: bowels seem in good condition. No cough noticed. " 13 Behavior good: is quiet: makes no complaints. Pm. Pulse 84 R 20 T. 98. Jan 13/96. Slept 5 hours, restless 3 hours, last night. Am Pulse 100 R 20 T. 99: Pm. Pulse 96 R 19 T. 99. " 14 About as yesterday. Appetite good. Jan 14/96. Slept 8 hours. Am. Pulse 92 R 20 T. 99. " 15 P.M. Pulse 96 R 20 T. 99.2. Is stupid & appears confused. Jan 15/96. Restless 3 hours, but slept 8 hours. Am. P 92. Pm. P. 84. Quiet & stupid: lies down a benches, most of the day. " 16 Jan 16/96 Slept 7 hours, restless 1 hour. Am. P 88: Pm. P 92: Not walking very day: appears " 17 weak & says he is too weak to walk". Jan 17/96. Restless 3 hours, sleeping 6 hours. Am P 88. Pm P 84. Appetite fair: bowels in good condition. He appears despondent. " 18 Jan 18/96. Slept 7 hours: restless 2 hours. Condition does not seem to change, in any way. " 19 Jan 19/96. Slept fairly well, though somewhat restless, last night. Pulse about normal. Am & Pm. " 20 Jan 20/96. Slept quite well: Restless during day: stupid & dull. Jan 21/96. By account of a " 21 general change in the wards, he was to-day, Transferred to B3. Jan 21/96. Slept well, last night, 23 (9 hours). Am. P 60. Pm. P 70. Jan 23/96. Slept 9 hours. No change noticed in condition. " 24/25 Jan 24/96. Slept well. Afternoon about the same. Jan 25/96. Behavior is quiet & good. He is inactive & despondent: lies down on benches, much of the day. Makes no special complaints. Summary: Patient has been very quiet: talking little: quite weak and slightly run-down, physically. Is able to go out walking, but it tires him considerably. Mentally, he is dull, stupid & confused, generally: talks none unless addressed first: " 31 answers questions rationally. No delusions or hallucinations apparent. Jan 31/96. No Change noted. Pulse R & T taken daily, have been about normal. He is still dull & stupid.

Feby 1/16 Feby 1/96. Wt 159 pds. Pulse 92. Feby 6/96. Patient is not very strong: lies down on benches, most of the

Personal and Medical History of John Fredrickson

1896

Feb 6 day: Complains of feeling tired: Eats poorly. Bowels in fair Condition. Sleeps well. Says "he is Jesus Christ". " 21 Feb 21/96. Complained of Exertion, this morning and did not get up. Ate no breakfast. P 96 R 20 T 98. " 22 q. Am. Upon ward. Feb 22/96. Transferred to T.W., at 1 P.M. Is considerably run-down. Has given " 23 bath & put to bed. Somewhat restless during afternoon. Feb 23/96. Slept only 2 hours last night. Has been " 25 quite restless all day. Coughed some in forenoon. Feb 25/96. Continues restless: does not like to remain " 26 in bed: gets out frequently. Feb 26/96. Given enema: slight movement afterward. Feb 28/96 seems some " 28 stronger: is still very restless: continually asking for clothes. Sleeps quite well. Feby 29/96. Behavior about the same, today. Considerable persuasion was necessary at meals, in order that he be made to Eat. No special Change, noticeable, in his Condition. (See nurse's records filed under 13) —

March 1 March 5/96. Very restless: out of bed frequently: never pushes to do as he is told. Appetite some better: is given " 6 Shower-baths & massage-treatment: sleeps quite well, at night. March 6/96. Wt 149 pds. March 9/96. No change " 10 noticeable: still very restless & continually getting out of bed: sleeps poorly: March 10/96. Restless and very disobedient this Am. Would not allow temperature & pulse to be taken. Refused breakfast. — " 14 11 Am. Transferred to B3. March 14/96. Very troublesome, today. Destructive: had to be held on bench " 31 by 2 nurses, for several hours this Am. March 31/96. Appetite good: bowels in good Condition: ap- parently. He masturbates frequently: has a very disagreable odor about him. Very restless, and April at times, quite troublesome. Mentally, Condition shows no change. April 1/96. Wt 145 pds. Wt 142. " 30 April 30/96. Was visited by his sister on 17th 18th 19th & 20th inst. Was very quiet & would not show much to say to her. Very obstinate. No change noticed in his Condition. Generally very stubborn. Stands on his feet all day: will not sit down unless held down. Expectorates considerable phlegm. Eats poorly. Bowels in fairly good condition. Is out on grounds daily. Patient has a weak back: Cannot stand up straight, but is always in a stooped condition, while walking or standing. (See Nurse's record on file as 13).

May 1/96 to May 5/97 Summary Nurses Notes by Dr. Phelps. Wt. May 1st 150 lbs. Complained of a weak back: Persists in standing about: Is rather dull & confused. Is untidy in habits: June 96 it was noted that he had become quite filthy in habits: was eating rather poorly. Condition during last of year changed very little: at times refused to eat: Kept upon B3. During early part of '97 had become quite filthy & untidy: In April transferred to Infirmary having a cough. Was noted as becoming tubercular & as having Potts disease: He went down quite steadily from this time: Temp. at this time about 100. During April went as high as 102.8 & patient showed the usual signs of tuberculosis: During May he failed quite rapidly & died at 10:45 on 15th Temperature was never very high. not being over 103 until the last day but he took rather slight nourishment & perhaps failed more rapidly on this account.

Died.

See letter

Personal and Medical History of Oscar Berger

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4300.
Residence, St Paul: (he is evidently an Itinerant)
Date Admission, 15th January 1896.
Admitted by Dr. Herzog — Hour, 6 Hrs PM.
How Sent, G. Wilbrich Cop. Ramsey County.
Sex, Male.
Age, 24 Years
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Laborer
Degree Education, Fairly Educated
Profession Religion, Catholic —
Habits, not definitely known
Nativity, Switzerland: (parents also born there) —
Physicians Committing, C. Eugene Riggs and A. B. Aucker
Correspondents, Victor Berger Missouri Ave (Care of Lamar Morton St Louis Mo. (bro.)
See "slips" attached, for particulars of addresses &c. V.O.

No. for Year, 128.
Insane Relatives, none mentioned
Cause Exciting, probably Typhoid fever
Cause Predisposing, - probably Habits -
Form,
Accompanying Bodily Disorder, None stated
Suicidal or Not, - Not -
Date of this Attack, December 14/95.
Duration, about one month -
No. of Attack, Not known
No. of Admissions, 1st
Age First Attack, — 2 -
Time of Leaving, July 4th 1896
Time in Hospital, 6 mo. 19 da
Result, Improved. Discharged Nov. 10'96.

EXAMINATION ON ADMISSION.

Exd by Dr. Herzog, Jany 17/96 =

MENTAL CHARACTERISTICS.

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

MEMORY:
Past Events,
Recent Events, Fairly good
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, Correct, in the main

REASONING POWER:
Ordinary Subjects, somewhat slow, but accurate
Own Mental State, realizes that he was delirious but says "he's all right now" —
Special Subjects,

GENERAL DESCRIPTIVE REMARKS:
Speaks quite rationally now, & has, every time that I have seen him. Was reported by last night, as noisy & again this morning. This afternoon, he was whistling & noisy. He recollects this & says "that was when he saw the devil" —

EMOTIONAL STATE:
Normal, Calm, at time of examination
Indifferent,
~~Exalted,~~
Depressed,

DELUSIONS:
Systematized or Not,
Special Subjects, None noted
Transitory or Not,

HALLUCINATIONS: Says "he saw the devil, last night"

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, fairly voluble

Personal and Medical History of Oscar Berger

Victor Berger, Missouri Ave, (care of Lamar Morton) St Louis. Mo. (brother): Joseph Albert (friend) South S.P. —

In conversation with George Willrich he said his real name is Alois Dossenbach.
Father's address. Joseph Dossenbach
Canton Zurich
Bezirk Horgen
Horgen Switzerland

Register No. 3062.

PITAL,

Dec 10 — 1895
Age 24 yrs.

Single, ~~Married~~, ~~Widowed~~.

Employment at time of admission, name of employer and wages None

Amount of wages due, income or other means None

Insurance or other benefits None

X Money or personal effects left in charge of Central Hotel Eau Claire Wisconsin (Manager's name not known)

Address of nearest relatives or friends Victor Berger Missouri Ave (Care of Lamar Morton) St Louis Mo. (Brother): Joseph Albert (friend) South S.P.

If in Hospital before, when? No

Cause of admission Typhoid fever.

Admitted by Dr. Aucker. Assigned to Dr. Greene

Brought to the Hospital by Private carriage.

From Dr Aucker's office

Persons in charge of patient Joseph Albert.

Cash, $ .65 Watch No. None Baggage check No. None

Other valuables 1 jack knife

REMARKS: If non-resident, state cause of admission. If hospital account to be paid, state rate, etc.

J. M. Interne

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

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4300.

Residence, St Paul: (he is evidently an Ita

Date Admission, 15th January 1896. —

Admitted by Dr. Herzog — Hour, 6 Hrs P.M.

How Sent, G. Wilbrick Cop P. Ramsey County.

Sex, Male.

Age, 24 Years

Civil Condition, Single

Children,

Age Youngest Child,

Occupation, Laborer

Degree Education, Fairly Educated

Profession Religion, Catholic —

Habits, not definitely known

Nativity, Switzerland: (parents also born there) —

Physicians Committing, C. Eugene Riggs and A. B. Ancker

Correspondents, Victor Berger Missouri Ave (Care of Kayser Martin St Louis Mo.) (Brother)

See "slips" attached, for particulars of addresses &c &c

Accompany.

Suicidal or Not,

Date of this Attack, Decem

Duration, about one

No. of Attack, Not Known

No. of Admissions, 1st

Age First Attack, — ?

Time of Leaving, July 4th 1896

Time in Hospital, 6 mo. 19 da

Result, Improved. Discharged Nov. 10'96.

EXAMINATION ON ADMISSION.

Dr. H. Herzog, Jany 17/96 =

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused, Slightly

Quick or Sluggish, Quick

MEMORY:

Past Events, Fairly good

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Correct, in the main

REASONING POWER:

Ordinary Subjects, Somewhat slow, but accurate

Own Mental State, realizes that he was Delirious but says "he's all right now" —

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

Speaks quite rationally now, & has, every time that I have seen him. Was reported last night, as noisy, & again this morning. This afternoon, he was whistling & noisy. He recollects this & says "that was when he saw the devils" —

EMOTIONAL STATE:

Normal, Calm, at time of Examination

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects, None noted

Transitory or Not,

HALLUCINATIONS: Says "he saw the devil, last night"

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, fairly voluble

Personal and Medical History of Oscar Berger.

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

Form No. 5.

Register No. 13062.

THE CITY AND COUNTY HOSPITAL,

SOCIAL HISTORY SHEET.

Hour 3.50 P M. ST. PAUL, MINN. Dec 10 1895

Name Oscar Berger Sex Male Age 24 yrs.

Nationality Swiss Color White

Occupation Laborer Religion Catholic Single, ~~Married~~, ~~Widowed~~.

Resident of St. Paul or Ramsey County for 6 months.

Former Residence St Louis Mo.

Address at time of admission South St Paul

Employment at time of admission, name of employer and wages None

Amount of wages due, income or other means None

Insurance or other benefits None

Money or personal effects left in charge of Central Hotel Eau Claire Wisconsin (Manager's name not known)

Address of nearest relatives or friends Victor Berger Missouri Ave (care of Kayser Martin) St Louis Mo. (Brother); Joseph Albert (friend) Baltic Pa.

If in Hospital before, when? No. Typhoid fever.

Cause of admission

Admitted by Dr. Ancker. Assigned to Dr. Greene

Brought to the Hospital by Private carriage.

From Dr Ancker's office

Persons in charge of patient Joseph Albert.

Cash, $ .65 Watch No. None Baggage check No. None

Other valuables 1 jack knife

REMARKS: If non-resident, state cause of admission. If hospital account to be paid, state rate, etc.

E Pm

J. B. S. Interne

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 H

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4300.
Residence, St Paul: Chi
Date Admission, 15th Jan
Admitted by Dr. Herzo
How Sent, G. Wilbrich
Sex,
Age,
Civil Condition,
Children,
Age Youngest C
Occupation,
Degree Educ
Profession
Habits,
Nativ
Ph
(

Quick c.

MEMORY:

Past Events, Fairly good
Recent Events,
Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert
Correct or Illusive, Correct, in the main

REASONING POWER:

Ordinary Subjects, Somewhat slow, but accurate
Own Mental State, realizes that he was Delirious but says "he's all right now"—
Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

Speaks quite rationally now, + has, every time that I have seen him. Was reported fast night, as noisy, + again this morning. This afternoon, he was Whistling + noisy. He recollects this + says that was when he saw the devils." —

HAL... ...ted

ILLUSIONS: ...aw the devil, last night"

CONVERSATION:

Coherent or Incoherent, Coherent
Voluble or Reticent, fairly voluble

Personal and Medical History of Oscar Berger.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, 134 lbs. NUTRITION, much impaired: pale, thin + anaemic.

WOUNDS OR ABNORMALITIES, felon on left thumb, from which we removed nail, yesterday. Abrasion on right wrist, from straps.

TONGUE, Tremors, slight Coatings, clean Promptness Movement, somewhat slow.

PUPILS, Equality, Yes Size, dilated

Response Light, somewhat sluggish Accommodation, about normal

SIGHT, seems good

HEARING, — Do —

COORDINATION, Arms, somewhat impaired: } mental tests not used, but he is unsteady of footing.
Legs, — Do — : } and in use of arms.

TREMORS, Hands, none Tongue, slight

Facial Muscles, No General, No

REFLEXES, Patellar, 10 - equal

Other Ankle Clonus: Cremasteric + other superficial reflexes exaggerated, except abdominal

EXAM. URINE,

Treatment

Tonic, with mild hypnotics.

ARTICULATION,

Slurred,

Hesitating, ✓

FACIAL EXPRESSION, Hollow-eyed + restless; staring expression.

SENSIBILITY,

✓

HEART, Sounds are sharp: somewhat rapid.

LUNGS,

Seem good on casual examination.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

Kept

Seems

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 *Oscar Berger*.

1896

This patient was brought here by Deputy-Sheriff M. R. Goss and attended by Chas. E. Sanborn, with the following history. Patient is in fair physical condition. He is evidently an Itinerant: he now comes from City & County Hospital, St Paul, where he has been since Dec 10th with typhoid fever. As to consanguinity or heredity nothing seems to be known. Not known as to number of attack. First symptoms of this attack were manifested Dec 14th when he became maniacal. Disease seems stationery; he is fairly rational, to all appearances, at times. Derangement was shown by his having delusions; also maniacal outbursts. Patient is disposed to injure others, but not suicidal. is destructive of property. We are unable to obtain any previous history, that is reliable. As to habits of intemperance &c, nothing known, nor as to any severe disease &c. Cause of disease is probably Typhoid Fever. Has been under treatment, as stated, in above hospital: —

Jan 15 **On admission** was put on B3 (G.H.N. West. Complexion light; hair brown: eyebrows: Condition of skin good: some bruises on arm: part of right ear off: is clean: behavior good). P 108 R 22 T° 100.

" 16 Jan 16/96. Restless 6 hours & slept only 2 hours, last night: Am. Pulse 104 R 21 T° 99.6. Appetite fair: bowels have moved: no cough noticed: behavior good: eats quite rationally. Nail removed from ~~right~~ left hand thumb & wound dressed. Pm. Pulse 100 R 20 T° 99.8. He makes no complaints.

" 17 Jan 17/96. Very noisy & restless & slept only ½ hours, last night. Am. P 108 R 21 T° 99.6. Is on medicine 3 times a day. Transferred to "Infirmary Ward", at 1 Pm P 96. R 22. T° 99.4 — was given bath & put to bed. Wrists & hands quite sore, as a result of being strapped. Right wrist and left thumb dressed. 5 Pm. Pulse 96 R 18. T° 99. 6 Pm. Was very quiet, during afternoon but somewhat noisy toward evening. Ate a good supper. 9.30 Pm. Was given a sleeping dose —

" 18 Jan 18/96. Behavior good. During night, has rested 4 hours & sleeping only 4 hours. Appetite good: Pm. Has been very mischievous & somewhat destructive, during day: very noisy, toward night. Bowels have moved. Jan 19/96. Was given sleeping dose & then slept 6 hours: restless 4 hours

" 19 Pm. Quiet all day: was given bath. Jan 20/96. Restless 3 hours, but slept 4 hours: Pm. Very

" 20 noisy, greater part of day & somewhat destructive. Appetite good: bowels regular: Pm. Taylor.

" 21 Jan 21/96. Restless 6 hours & slept but 2 hours. Was very noisy, during breakfast hour. He refused dinner. 1.30 Pm. Up & Dressed, & was out for a walk. 6 Pm. Also refused supper. Thumb still dressed. Jan 22/96. Restless 1 hour, slept 7 hours. Pm. Has been somewhat noisy.

" 22 Was out for a walk. Appetite good, today. Jan 23/96. Restless 1 hour, noisy 1 hour, but slept 6 hours.

" 23 Was out for a walk. Appetite good, today. Jan 23/96. Restless 1 hour, noisy 1 hour, but slept 6 hours.

" 24 Noisy & destructive, this morning. Appetite good: bowels irregular. Jan 24/96. Was given sleeping dose last night, but no effect: restless & noisy, all night: slept none. Pm. Has been noisy, greater part of the day. Jan 25/96. Slept 7 hours, last night. Is very noisy & destructive, this morning;

" 25 broke dishes. 11 Am. Transferred to B3. Jan 26/96. Slept none, during the night. Is noisy

" 26 and restless, today. Jan 27/96. Restless & noisy 6 hours & slept only 3 hours, last night. Am. P 132

" 27 Behavior as usual: habits dirty & filthy. Again, transferred to "Infirmary Ward", at 11.30 Am. was in an excited condition & was put to bed. Pm. Ate a good dinner: bowels moved freely.

" 28 Was quite noisy, during afternoon. Jan 28/96. Restless 3 hours, noisy 3 hours & slept but 2

" 29 hours, last night. Has been restless & noisy, all day. Jan 29/96. Restless 4 hours, noisy 3 hours, and slept only 3 hours. Out for a walk 2 day & was very quiet, while out. Appetite good: bowels

" 30 fairly regular. Jan 30/96. Restless 1 hour, noisy 6 hours, & slept only 1 hour, during the night.

Personal and Medical History of *Oscar Berger*.

1896

Summary: Patient's behavior, taken as the whole, has been bad. He was well behaved the first day, but quite restless, during night: very restless & noisy, during forenoon and evening of 2nd day: very quiet during the night. Quite destructive, during 3rd day & somewhat noisy, toward night: well-behaved, on 4th day: greater part of 5th day, was spent in noisy talk & destructiveness: 6th day was spent quietly, with exception of morning (1 hour): was out for a walk in afternoon & behaved very well. Was quite noisy, at times, during 7th day, until taken out for walk, which had a sedative effect. Was destructive & noisy, during 8th day & night: 9th day, quite noisy, but quiet, at night. Very noisy and destructive in morning of 10th day (Transferred to B3 11. Am): very noisy, remainder of day & all night. No change, on 11th day. Habits filthy. (Transferred to T.W. on 12th day 11.30 Am). Received there in an excited condition. Was quiet during afternoon & night: noisy all 13th day. Comparatively quiet, during 14th day: very restless & noisy, at night. Physically, he appears strong. Appetite good, except on 6th day: then refused dinner & supper: bowels have been regular, throughout: he averaged about 2 hours sleep nightly. Temperature has been about normal, throughout. — Mentally, patient seemed rational, the first 2 days, but from that time on, was seen to possess hallucinations: was "heard the devil hissing at his bed-side". He also appeared to see non-existent objects in his room. — — —

Jan 30 Jany 30/96. Vomited breakfast: quite noisy, during forenoon. Slept 3½ hours in Pm. Noisy toward evening.

" 31 Jan 31/96. Restless 1 hour, noisy 1 hour, but slept 6 hours, last night. Pm. Was quite noisy, all day and

Feby 1 destructive in the morning. Feb 1/96. Restless 1 hour, slept 7 hours. Feby 3/96. Has been quite noisy and somewhat destructive. 9.00 Am in restraint (mitts), but tears clothing with teeth. Vomited this Am (8.30)

" 6 has been fairly quiet, this Pm. Sleeps quite well. Feb 6/96. Still restless & noisy, except while out

" 9 walking. Washes & gathers dress. Sleeps well: appetite good: bowels regular: Feby 9/96. Behavior does not change: still restless & noisy: shows no signs of destructiveness. 1 Pm. Mitts were removed.

" 10 Feb 10/96. Quiet during forenoon: noisy in afternoon. Feb 11/96. Abt (undressed) 1 2 yrs.

" 14 Feb 14/96. Still noisy, at times, each day. Sleeps quite well. Appetite good: bowels regular.

" 15 Feb 15/96 Fairly quiet all day. Seems to improve physically. Feb 17/96. Quiet, all day —

" 18 Feb 18/96 10.00 Am. Up & Dressed. Fairly quiet, during the day. Feb 21/96. Condition unchanged: very noisy

" 21 at times: slightly destructive: requires close watching: will strike persons when last expecting it —

" 25 Continually talking: speech incoherent. Feby 25/96. No special change in conduct or behavior. Patient

" 26 seems to be "running down". Feb 26/96. 11.00 Am. Put to bed. Feb 28/96. Has been restless & sleeping

" 27 poorly. Out walking in Pm. Very noisy after returning: put to bed. Appetite Good: bowels regular.

" 29 Feby 29/96. Very noisy all day: destructive, at noon hour (threw tray on floor, breaking 3 dishes).

March 1 has been given hot baths. (see Nurse's Record on file. O.H.). Mar 1/96. Patient in bed: appetite good: bowels regular: very restless, & noisy continually. Given hot bath. 1.30 Pm. Quite progressive.

" 2 Removed to B3, where he spent remainder of Day & night. Mar 2/96. Transferred to B3.

" 9/5 Is on medicine. Mar 9/96. Quit medicine. Mar 13/96. Has been suffering from an ulcerated tooth:

" 16 one cheek swollen considerably: tooth extracted, today. Mar 16/96. Apparently, improving: eats

" 31 & behavior very good: works on ward, at times, when asked to. March 31/96. Behavior is bad:

very troublesome, at times: striking other patients, without cause: very sulky, & obstinate: extremely

April 1 noisy, at times. (Threw a knife at a patient, 30th & was put in the hall to eat). Sleeps very poorly.

April 1/96. Abt 147 lbs. (Has gained in 9 weeks). Prof. April 3/96. Ugly, violent & pugnacious,

" 3 most of the time: striking patients & nurses: has to be watched constantly. Is given medicine; also

" 25 shower baths: Transferred to C.E. April 25/96. Eat well: very restless, some nights & sleeps poorly.

(carried to page 37.)

Personal and Medical History of Ole. A. Paulson

EGGERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4305.
Residence, Hayfield. Minnesota
Date Admission, 20th January 1896.
Admitted by D. Phelps Hour, 11 30 Am.
How Sent, Swan Olson Jo P. Dodge County.
Sex, Male
Age, — 35 —
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Laborer
Degree Education, Common School
Profession Religion, Yes: Lutheran
Habits, Intemperate, at times.
Nativity, Norway: (Parents also born there).
Physicians Committing, J. Bennet and L. H. Vanbleve
Correspondents, (Bro) Address: Nels Paulson Hayfield Minn

No. for Year, 133.
Insane Relatives, Two uncles
Cause Exciting, unknown: (masturbation?)
Cause Predisposing, Heredity.
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, — not — (Y) (N)
Date of this Attack, Three months ago?
Duration, Three months?
No. of Attack, 3rd (Seemingly)
No. of Admissions, 1st
Age First Attack, about 30.
Time of Leaving, April 3' 96.
Time in Hospital, 2 mo. 14 da.
Result, Improved. Disc. Aug. 12' 96.

EXAMINATION ON ADMISSION.

Exam. by. D. M. Phelps 1/23/96

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: Describes a hard drunk about Christmas & suddenly falling into chill. Heart troubled him since Christmas & afraid would die. Drove off drinking & afterward brother — he thought he had better come down here. Rather dull of comprehension tho' apparently clear. Drank for 17 yrs. At times quite hard none since Xmas. Says he gets chilly - can't catch breath - falls down or has to sit down - has this every day. Is not able to give very good account for seeming lack of native intelligence.

Personal and Medical History of Ole. A. Paulson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 10in WEIGHT, 134 lbs NUTRITION, Fair.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, None - Coatings, normal. Promptness Movement, prompt.
PUPILS, Equality, Equal. Size, Normal.
Response Light, Accommodation,
SIGHT, Good -
HEARING, Good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, None. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Normal - EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Sounds quite good now.
LUNGS, Good

TAKEN,

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, died 6 yrs ago Consumption
Father or Pat. Relations, died - at 62 - fell dead suddenly -
2 Brothers or Sisters,

Personal and Medical History of Ole A. Paulson

1896

This patient was received here at the hands of Deputy Sheriff J. Tucker & attended by Nels Paulson, with following history. Patient is in fair physical condition. Parents were Cousins: two uncles have been insane: This is not 1st attack: it seems to be the 3rd one. One occurred about 15 years ago, and another, 2 years ago: duration 4 months: was not sent to hospital. First symptoms of this attack were manifested about three months ago. The disease seems increasing: variable, but not at regular periods. Derangement is now shown in the subject of suicide, but has not attempted it: propensity not active. Is not disposed to injure others: no filthy or destructive habits. No peculiarities as were previously shown. He has been intemperate, at times. There is no previous history of any severe illness or injury to head. He has not been restrained or confined: has had no medical treatment. Cause of the disease is unknown, but, on personal examination, it is found that he masturbates.

Jan 20 On admission, was put on B3 G.H.M. 1/50. Complexion light: hair brown: eyes blue: Condition of skin good: Scars on left side of breast just below the nipple: is clean: Behavior is good). Notes by Dr Phelps. "Brother says", at 18 years of age, think he was all right: then, had an attack. First attack described as acute: went to School a little, but do not think had any special trouble in learning." Pulse 88 R 20 Jan 99. Jan 21/96: Restless 8 hours & slept but 1 hour last night. Am. Pulse 78 R 22 Jan 98.8. Appetite good: ate heartily: behavior good: is rather quiet: Bowels seem in good condition: no cough noticed. Talks rationally: no delusions or hallucinations noticed. Complains of Chilliness & pains in bowels. Transferred to B3 (Agreed transfer forward, being made)

" 22 Jan 22/96. Slept 3 hours, restless 5 hours: Am. Pulse 80 R 20 Jan 98.6 Pm. P 80 R 20 Jan 99. Appetite good: bowels in good condition: he talks rationally. Complains of being cold: Out walking, today.

" 23 Jan 23/96 Slept 6 hours, restless 3 hours. Am. Pulse 80 R 20 Jan 98.6 Pm. P 80 R 20 Jan 99. Complains of cold & put hot sand-bags to feet at 1 am. Behavior good: he appears Cheerful Contented.

" 24 Woke on ward done. Jan 24/96. Hot sand-bags again applied to feet 8.30 PM. (last evening). Was restless 2 hours, but Slept 7 hours. Am. Pulse 80: Pm. Pulse 84. He talks well: no delusions or hallucinations noticed: Out walking every day. Jan 25/96. Slept 6 hours, restless 3 hours. Am. P 80 Pm. P 80. Quiet: cheerful & contented: Habits neat & clean. Jan 26/96. Slept 7 hours, restless 2 hours. Is apparently improving, every day. Am. P 70. Pm. P 72. Jany 27/96. Slept quite well. Otherwise, about as usual. Out on ward. Jan 31/96. Has continues to sleep quite well each night. Has been up & about daily: clean in & of good personal habits. Pulse has been about normal. Has not complained of Chills, as before. Has seemed to improve much.

Feb 1 Feb 1/96. Appetite good: today Complains of cold & sore throat: went to bed at 5.30 P.M.:

" 2 vomited some. Pulse 78 R 22 Jan 99.2. Feb 2/96. Slept 7 hours. Is feeling quite well this Am.

" 3 Ate well: bowels in good condition. P 72 R 20 Jan 98.8. Feb 3/96. Slept well: Pulse about normal.

Summary: Patient has been uniformly quiet & well-behaved, since coming: Quiet Cheerful & well Contented: working some & showing Considerable interest in his surroundings. Has improved perceptibly, physically; gained flesh & strength: has talked rationally and well: no delusions or hallucinations have been noticed. Feb 1/96. Somewhat restless at night, but yet sleeps fairly

" 18/20 well (4 to 7 hours each). Feby 15/96 To medicine, 3 times a day. Feb 19/96. Has kept on improving

Mar 2/20 Mar 1/96. Wt 156 lbs. Pulse 92. Mar 5/96. Medicine discontinued. Mar 30/96. appetite good: bowels in good

Personal and Medical History of Ole A. Paulson.

Mch 30 condition. Talks rationally, though a little foolishly. Seems improved mentally. Physical condition
Apl 1 fairly good: Works some on ward. Apl 1/96. Wt 156 lbs. Pulse 84. Appetite good: bowels in good order.
" 3 April 3/96. Visited by brother, & taken home by him, on trial.

Discharged.

From Folio 64 — Lewis Olson #3 — 4329.

May 1/97 & Aug 1/97 Summary Nurses Notes by Dr. Phelps. Patient upon sick ward at beginning of period: Kept in bed for some time, occasionally showing a slight rise of temperature: Rather dull & stubborn: No notable physical ailment. During latter part of '96 up & about, seemed in fairly good health: Talks some but does some little reading at times: May 6 '97 again placed on Infirmary Quite lame: right leg & thigh swollen: Slight constitutional disturbance: Remained in bed or upon infirmary during all of month of May: Quiet tho. somewhat stubborn in behavior Got up in June: Seemed rather unwilling to do so: no further notes of importance. May 31/97 Wt. 123# Aug 1/4 Trans to B3. Has been very stupid: Seems to be slightly brighter at present.

Jan 1/98 Wt. 129#. Changes very little: Seems to understand when spoken to but will talk almost none: Seems rather demented. Jan 31/99 Patient changes very little from time to time. No change noted throughout period.

Feb 1 - July 31/99 (Dr. Wamoos) Wt. 140#. Is well behaved. Clean & neat in habits: Condition unchanged from day to day. Aug 1/99 - July 31/1900. (Dr. Wamoos) Wt. 137. Quiet & well-behaved. Seldom speaks: Habits clean. Now & so works on ward: Is ugly & easily excited.

1900 to July 31 May 1 Wt. 132#. Works on ward. General physical condition good: July 20 Vaccinated result good. Aug 30 Refuses questions. Nov 1 Wt 131#. P88. Frequently heard talking to himself in loud, angry tones - Jany 1/1901. Wt 130#. Jany 31. No change in condition: still loud and noisy talking, at times, and seems much excited: Feby 1 Wt 131# P88. Mar 31 - Never talk. Comprehends dictation. Subject to "spells of excitement", when he does much loud talking to himself - May 31. Still has "spells of excitement", and becomes very much disturbed - July 31. No further change to report. Works some on ward. Habits clean - Wt 132# - Jany 31/02. Patient rather irritable: occasionally noisy & becomes excited. In fairly good health: changes little or none. (Sept 15) Trans to D. Habits quite tidy.

Aug 30 / Nov 1 / 1901 Jan 31 / Mar 31 / May 31 / July 31 / Aug 1 / 1902 Jan 31 / " 31/03 (Dr. Chapple) Patient is constantly in fear of being harmed & persecuted Almost constantly talks about imaginary people. Stays in the room most of the time; but works some on ward. Seldom causes any trouble.

Personal and Medical History of Bird. E. Chase.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4307

Residence, Holt, Fillmore County, Minn

Date Admission, 22nd January 1895.

Admitted by E. C. Eby. Hour, 3 P.M.

How Sent, E. V. Farrington, Jo P. Fillmore County

Sex, Male.

Age, 32

Civil Condition, single

Children, none

Age Youngest Child, —

Occupation, Farm-laborer

Degree Education, very limited

Profession Religion, not a church member

Habits, Not definitely known

Nativity, Rome Co. Wis. (Parents born in New York).

Physicians Committing, J. H. Phelps and G. A. Love.

Correspondents, none given in papers

No. for Year, 135.

Insane Relatives, Yes: brother.

Cause Exciting, Self-abuse

Cause Predisposing, Heredity & previous attack.

Form,

Accompanying Bodily Disorder, Weakness.

Suicidal or Not, not

Date of this Attack, about July last

Duration, about 6 months.

No. of Attack, 2nd (seemingly)

No. of Admissions, 1st here (was at Independence, Ia)

Age First Attack, about 17.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam 1/25/95 P. M. Phelps.

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:

On coming in seems a Stuporous Melancholia. Quite typically so. No any causal relation is suggested. Lies in a dull vacant looking up to us. Seeming but to know yet not saying nothing & not trying to talk. Has been in Independence

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 Bird. E. Chase

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 11 in WEIGHT, 123½ lbs. NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, Condition of skin seems dry. Looks on teeth

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT,

HEARING,

COORDINATION, Arms, will not test

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,



TAKEN,

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 Bird. E. Chase.

1896

This patient was received here at the hands of Sheriff's Deputy Edward Erickson attended by Ole Blogvedt, with following history. Patient is in fair physical condition. There is no history of Consanguinity, but some of hereditary; brother insane: this is not 1st attack: he had one 15 years ago, when he was sent to Hospital at Independence, Iowa; was discharged after sometime, cured. First symptoms of this attack were manifested about July last: had delusions in regard to being shot in head & numerous other delusions. Disease appears to be increasing; not variable: no rational interval. Derangement now & shown by delusions as many subjects. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in his habits. He has always been simple minded. There is no history of intemperance in self or parents: has not been subject to any severe disease or head injury, so far as known. Has been confined, as above stated, for several years in Independence, Iowa. Supposed cause of the disease is self-abuse. Has had no treatment, except in hospital. On personal Examination, it is found that patient has been insane several years, but has been very harmless: lately, the insanity has been more active.—

Jan 22 On admission, was put on T.W. (S.W.H. Rpt. Complexion dark: hair black: eyes blue: condition of skin good: no marks, scars or bruises noticed: is dirty: behavior good: patient is very weak & stupid). Is confined somewhat. Was given bath & put to bed. 5 P.M. Pulse 90 R 19 T. 100.2 He

" 23 refused supper: was given enema: bowels then moved slightly: Jan 23/96. Very quiet, during night: Slept 7 hours. Refused breakfast but took ½ glass milk for breakfast. Appears stupid: will not talk. Ate a fair supper: given hunyadi water.

" 24 Jan 24/96. Noisy 1 hour, restless 6 hours & slept but 1 hour last night. Eats slightly today: bowels irregular: He has "spells" of laughing. Is quite active & appears strong, when he thinks no one is near: bowels moved

" 25 slightly, by aid of enema. Jan 25/96. Noisy 2 hours, restless 3 hours, & slept only 3 hours, last night. Force is

" 26 required to get him to eat. He is very quiet. Ate fairly, today. Jan 26/96. Restless 1 hour, slept 7 hours. Appetite good & he feeds himself: bowels still irregular & he is given hunyadi water. Bowels have moved freely.

" 27/28 Jan 27/96. Slept 7 hours: appetite quite good today: no change noticed otherwise. Jan 28/96. Restless 2 hours, and slept only 4 hours: seems a trifle brighter, today: appetite good: still feeds himself. Jan 29/96. Restless 2 hours,

" 29 but slept 6 hours: appetite not very good: bowels moved slightly: faeces watery: breath very offensive.

" 30 Jan 30/96. Restless 4 hours, sleeping only 4 hours. Appetite fair, bowels loose: Condition does not seem to change.

" 31 Jan 31/96. Slept 6 hours, restless 2 hours. Appetite good: bowels not moved, today. Patient still very reticent.

Feb 1/2 Feb 1/96. Restless 1 hour, slept 7 hours. He will not talk: still appears quite silly. Feb 2/96. Restless 2 hours, sleeping 6 hours. Patient laughs & sings a great deal, while alone. Appetite keen good: bowels regular.

" 3 Feb 3/96. Slept 7 hours: Condition apparently about the same. Feb 4/96. Slept 6 hours, restless 2 hours:

" 4 slept 2 hours, during forenoon: was up & dressed, part of day: was very quiet while up.—

" 5 Feb 5/96. Noisy 1 hour restless 1 hour, but slept 6 hours: appetite good today: bowels regular: no apparent change in Condition. Was up & dressed, for part of afternoon. Is very quiet. Does not talk.

" 6 Feb 6/96. Restless 2 hour, but slept 7 hours. Condition about the same. **Summary**: Patient's behavior, throughout the 2 weeks, has been good, aside from the fact that he would not eat for the first 3 days without being forced to do so. Physically, appeared weak, until last few days, when he showed some signs of regaining strength. Up to 4th day, appetite was not very good, but quite good from that time, on. Bowels were irregular & would not move, without aid of physic,

Personal and Medical History of Bird. E. Chase

Summary Contd

until 11th day. Temperature has been about normal throughout, with few exceptions (see attached nurses records). He has averaged at 52 hours sleep, nightly. Mentally, no delusions &c have been noticed. He lies quietly & in a pathetic stupid condition, continually. Will not talk. Up & Dressed, this P.M. very quiet. Feb 7/96. Up & dressed in P.M.: sits in one place continually while up. Feb 10/96. No change noticed: sleeps quite well. Feb 11/96. Dressed up onward: is very quiet & apparently, stupid. Sleeps well.

Feb 11 - 15/17 Feb 15/96. Wt (Dressed) 123 pds. Feb 9/96. Since last note, he has been sleeping well, as a rule. Has been very quiet: has occasionally "spells" of laughing. Bowels were constipated some, but now move more regularly. Otherwise, no change noticeable. (See Nurses' record on file 12) =

Mar 1 Mar 1/96. Patient simply onward. Is very quiet. Occasionally talks to himself. Behavior good. Habits very clean but he is untidy in dress. Appetite good: bowels regular. He sleeps on 13th.

" 3/18 Mar 3/96. Condition seems unchanged. 5.45 P.M. Transferred to 13th Mar 10/96. Slept 5 hours, was restless 4 hours, last night. Mar 31/96. Patient has improved some of late. Moves about more.

" 31 April 1/96. Wt 119½ pds. P 88. April 7/96. (Dr H notes. "A decided Change since Coming onward. Is now talkative: moves about readily: keeps clothing quite neat, considering his imbecile state. Gets up at night & moves about hall: jokes with night-nurse. Still has hyposis on the upper lip, though not so bad: discharge from nose, not so bad. Dislikes to go out). —

April 1/97 - 30 April 30/96. Appetite fairly good: bowels regular. Behavior somewhat changed. Is, of late, very noisy & inclined to be pugnacious, at times. Does walking: fairly well-behaved, when not. Habits untidy.

May 1/96 to Aug 1/97 **Summary Nurses Notes by Dr. Phelps.** Wt. May 96 119 lbs. Is rather silly & demented: stands & calls out to himself: gets excited & very nervous. Condition continues same during whole of period with little change: Asks foolish questions: Is usually noisy. Wt. 117 lbs

Aug 1/97 - Aug 31/97 Wt. 117th Oct 31/97 Very demented in talk & appearance: At times rather noisy.

Jan 31/99 - Patient has changed very little in every way during intervening time. (2)

Feb 1 July 31/99. (Dr Parsons) Wt. 175th Feb 1900 Had a very noisy spell. March 14 Complains of pain in internal ear. Some suppuration: Received treatment. Improved. July 31 Behavior good. Habits good. Has delusions & illusions. Aug 1 - Jan 31 1900 (Dr Chapple) Wt. 110th

1900 - To - Jany 31 Physical examination made September 27th General health fair. Chest full. Expansion poor, but no pulmonary lesions found. Heart normal. No change during period. Very loquacious; incoherent. Has delusions & illusions: habits untidy. Works some on ward: is well behaved. Very demented & silly. Feb 1/1900 115th

Feb 1 - July 31 P 73. Feb 10 Sunday temperature 4 hour variation to 101. July 20 Vaccinated: result negative.

July 31 - Aug 1 - Sept 10 1900 Oct 31. No change. Is very demented: silly: has illusions & delusions. Is very talkative, otherwise well-behaved: quite cleanly: works on ward. Is a demented imbecile. Aug 1. Wt 111th Transferred to D. Jany 31/1901. Very little Change to be noted: works on ward: very demented, silly in manner & conversation: habits touchy. Feb 1900 Wt 114th. May 1 114th

Aug 1 1900 - Jany 31 Wt 116th Nov 1. 118th Jany 31/01 No change whatever, during year: works a little on ward talks very irrationally. Is simple in manner: fairly tidy & never causes any trouble. 120th. Jany 31/03. Has worked regularly onward, sweeping & mopping, but is quite slovenly in habits: talks in a rambling, incoherent way: silly and imbecile: Health is fair —

Personal and Medical History of Martin Hanson #2

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4310.
Residence, Albert Lea. Minn.
Date Admission, 27th January 1896. ——
Admitted by Dr Herzog Hour, 7 P.M.
How Sent, Stewart Blackmer. Jst P. Freeborn County
Sex, - Male -
Age, - 52 -
Civil Condition, Widower -
Children, None
Age Youngest Child, —
Occupation, Railroad-man: saloon-keeper: idle, last 11 years
Degree Education, limited: can read & write.
Profession Religion, Not a Church member.
Habits, has been addicted to drink for several years.
Nativity, Norway: (Parents also born there).
Physicians Committing, H.B. Wedge and E.A. Blackmer
Correspondents, George Tiller. Albert Lea. Minn

No. for Year, 138.
Insane Relatives, Not known
Cause Exciting, probably Syphilis.
Cause Predisposing, Previous attacks
Form,
Accompanying Bodily Disorder, has had Syphilis
Suicidal or Not, - Not -
Date of this Attack, 7 Days ago
Duration, - 7 Days -
No. of Attack, 3rd (Seemingly) - One, 12 years ago & Hosp.
No. of Admissions, 1st
Age First Attack, about 27(?)
Time of Leaving, April 6' 96.
Time in Hospital, 2 mo. 10 da's.
Result, Improved. Disc Aug. 13'96.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by A.M. Phelps. 1/31/96.

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: Mentally can judge chiefly by appearance. Seems senile melancholia. Looks more senile than movements show. Appears dull. Holding himself in a rather fixed but position as if paretic + demented. The very weak circulation may have a causal relation to this - at least this is suggested.

Personal and Medical History of Martin Hanson #2

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 9in WEIGHT, 164 3/4 lbs NUTRITION, Somewhat impaired
WOUNDS OR ABNORMALITIES, Skin - not very good.
TONGUE, Tremors, Coatings, Dry - probably from fasting condition Promptness Movement,
PUPILS, Equality, Equal. Size,
Response Light, Slightly sluggish Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms, Probably some incoordination - wont take or do much for us-
Legs,
TREMORS, Hands, None marked. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Normal. EXAM. URINE,
Other
ARTICULATION, Wont talk much
Slurred, Probably only senile
Hesitating,
FACIAL EXPRESSION,
Somewhat drawn - inactive - senile
SENSIBILITY,
Arteries - no atheroma noted - looks as if he might rage.
HEART, No murmurs - apex beat weak.
LUNGS, Superficially examined Short bronch. breathing only

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Head very peculiar shape
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 Martin Hanson #2

1896

This patient was received here, at the house of Deputy Sheriff E. H. Ellickson & attended by J. Ludvigston, with following history. Patient is in fair physical condition. He has had various occupations; among them that of railroad man, saloon-keeper & but for last 4 years, has been idle. There is no history of consanguinity: as to any heredity, not known. He had one attack 12 years ago; duration about a month. Not sent to hospital. First symptoms of this attack were manifested 7 days ago. Disease seems stationary: no rational intervals. Derangement now shown by delusions. Patient is not disposed to injure others: is not suicidal: propensity not active. Is filthy & destructive in habits. No peculiarities to were previously known. Patient has been addicted to drink for several years. Not subject to any convulsions &c: no head injury: has been confined for about a week. He has had Typhoid: which is probably cause of the disease. Has been under treatment by bromides, morphine, Digitalis & ergot. No further facts brought out on examination. (Note. by Dr H: had attack 12 years ago: and another 25 years ago: not so bad as now: has not drunk to excess for past 2 years:

Note.

Jan 27 has been ailing for past 4 or 5 years). — On admission, patient B3: (GH. N. Kpt. Complexion dark: hair brown: eyes blue: condition of skin good: no marks scars or bruises noticed: has rupture on left side of abdomen: is clean: behavior good). Pulse 88 R 22 T 99.4. Jan 28/96. Slept 5 hours, restless 3 hours, last night. AM. Pulse 90. R 20. T 98+ Appetite poor: bowels costive: (he was given a "dose" at 11+5 am). Behavior quiet & rather stupid: talks very little: no complaints noticed.

" 29 PM. Pulse 88 R 20 T 99: makes no complaints. Jan 29/96. restless 2 hours & slept only 4 hours, last night. Am. Pulse 80 R 20. T 98⅘. PM. Pulse 90. R 20. T 99. Behavior quiet: will talk but little: simply answer questions with "Yes" or "No". Was out walking today.

" 30 Jany 30/96. restless 2 hours, but slept 7 hours. Am. Pulse 84 R 20 T 98⅘. PM. P 88 R 20 T 99. —

" 31 Eats fairly well: Is very quiet: dull & stupid: habits neat & clean. Jan 31/96. Slept 8 hours; was restless 3 hours, last night. Am. Pulse 76 R 20 T 98⅘. PM. Pulse 80. Eats poorly: quite feeble:

Feb 1 goes out walking, occasionally. Feb 1/96. Slept 9 hours, restless 4 hours. Am. Pulse 80. PM. P 84.

" 2 Behavior, as before. Condition appears about same, from day to day. Feb 2/96. Slept 6 hours, restless

" 3 3 hours. Am. P 88: PM. P 88. No change noticed. Is stupid & dull: rather feeble. Feb 3/96. Slept 8 hours:

" 10 Am. P 80: PM P 84. Appetite good: bowels in good condition. Feb 10/96. During this the 2nd week, patient has, apparently been resting & sleeping well, 7 to 8 hours, each night. Pulse, taken twice daily, has been about normal. He has been quiet & well-behaved. Appetite is much improved: he talks very little: still dull & stupid & no improvement is noticed. Bowels move quite regularly. He goes out walking every day, but is still rather feeble & unsteady on his feet. No complaints.

Summary: Patient has been quiet & well-behaved: habits neat & clean. Is rather feeble and apparently run-down: dull & stupid. Will answer questions only by "Yes" & "No": No delusions or hallucinations noticed, but he appears confused generally. Feb 25/96. Patient remains in about the same condition, day after day. Always very quiet: will still answer questions only by "Yes" & "No" and in a whisper. Goes out walking every day & appears to be gaining strength. Habits clean: sleeps well.

" 28 March 1/96. Wt 168 lbs. Pulse 80. Mar 31/96. Very quiet: no change, specially noticeable, since

Mar 2/31 last note, except that he has improved, physically. Was recently been visited by some friends —

April 2/16 April 1/96. Wt 179 lbs. P 90. April 6/96. Was again visited by some friends & day & allowed to go home with them on trial.

Discharged.

Personal and Medical History of August Peterson #2

From 80.

1896

May 24 May 25/96. Has an enormous appetite: complains of not getting enough to eat: quite restless & talkative, all day: —

" 31 asks for his clothes. May 28/96. No change can be noticed, mentally: physical emotion seems improved. —

June 1 May 31/96. No special change: appears quite strong: says "will not remain in bed, any longer." Very restless, at times.

June 1/96. Patient in bed: on regular & extra diet: quiet & well-behaved: talks irrationally. June 1/96. Transferred to B3.

July 1/96 to Aug 1/96 Summary Nurses Notes by Dr. Phelps. Patient transferred to B3. rather restless & incoherent: requires continual watching: remained rather cranky & sullen during months of June & July. During August became even more stubborn, sluggish & untidy: Sept 3 Transferred to B3 having become filthy in habits as well as cranky in manner: September 11 Put upon Infirmary for general care & treatment; under which he quieted down & became a little more quiet & manageable altho not especially well. Latter part of period has been quite imporently silly in behavior & altho not exactly violent or very troublesome is quite demented. Is untidy & unreliable in every way.

Aug 4/96 Wt. 148#. Usually restless - goes out with crowd. Will bump his head against wall & stamp on floor & do various demented & peculiar things. Jan 20/98 Trans. to Infirmary Jan 25 Has been lying quietly in bed: very perverse in behavior Rather untidy & inclined to be violent. Jan 28/98 Operation of circumcision performed under Ether - Feb 19/98 Trans. to B3. Still very stupid & stubborn

Nov 11 Trans. to B3. Jan 31/99 Intervening notes show no special improvement or change: Has to be watched: Will often bump his head on floor.

Feb — July 31/99. Wt. 141#. Is demented, slouchy & dirty: Extremely noisy at times. March 18 Attempted to elope while out walking, also attacked nurse. May 20, Attempted to elope while out. Aug 1 — Jan 31/1900. Wt. 167 Has become more demented: is filthy in habits & very

1900 — To — Jan 31 stubborn & pugnacious when molested. Very noisy at times, will not dress or undress himself: Physical healthy fairly good. Feb 2/1900. Wt 167#. Pos. July 20. Vaccinated

Feb 2 July 20/01 result good. July 31. No change. Physical condition good. Very demented: speech irrational & incoherent. Is stubborn, pugnacious and at times, very noisy. Has to be dressed & undressed by

Aug 1 nurses: is resistive. Habits slouchy, filthy & destructive. Eats from a tray. Aug 1/1900. Wt 165#

Sept 3 Transferred to Annex. Sept 10. To D1. Sept 13. To D2. Jan 31/1901. Has become more demented

1900 — To — Jan 31 and very filthy in habits: very inactive: scarcely moves about: occasionally makes

Feb 2 1901 — May 31 an irrational remark. Feb 2 Wt 163#: May. 16# Nov 1. 174# Jany 31/02. Condition about stationary, during year: filthy & slovenly in habits: Stands against wall & slouches in corner, with a silly grin: occasionally speaking, in a very incoherent manner. Never occupied: causes no trouble: health fair.

Jan 31/03 (Dr. Chapple) Has been very quiet - inactive - filthy during whole year - Very seldom has anything to say - very demented.

Personal and Medical History of Andrew Ek

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4319.
Residence, Red Wing, Minnesota.
Date Admission, 4th February 1896.
Admitted by Dr Phelps Hour, 6.15 PM.
How Sent, Axel Haller, J.P. Goodhue County
Sex, Male
Age, - 62 -
Civil Condition, married
Children, - four -
Age Youngest Child,
Occupation, Wagon-maker
Degree Education, Common School.
Profession Religion, Methodist -
Habits, Intemperate -
Nativity, Sweden, Europe: (Parents also born there).
Physicians Committing, H.W. Jones and Geo. C. Wellman
Correspondents, Wife - 1045 East Avenue Redwing Minn

No. for Year, 147.
Insane Relatives, None
Cause Exciting, Probably excessive Drink
Cause Predisposing, Previous attack
Form, Dementia alcoholic acute
Accompanying Bodily Disorder, ? Tremor: Heart trouble (?)
Suicidal or Not, attempted Suicide by hanging 1/3/96 (alcoholic drowning to)
Date of this Attack, Jany 30 - 1896.
Duration, - about 5 Days -
No. of Attack, 2nd, Seeming by (one, 18 years ago).
No. of Admissions, 1st
Age First Attack, - 44 -
Time of Leaving, Mar. 28'96.
Time in Hospital, 1 mo. 24 dal.
Result, Disc. Apr. 30/96 Rec.

EXAMINATION ON ADMISSION.

Ex'd by Dr. Herzog Feby 6/96

MENTAL CHARACTERISTICS.

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

MEMORY:
Past Events, Good
Recent Events, Good
Special Subjects, See note

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

REASONING POWER:
Ordinary Subjects, Seems good
Own Mental State,
Special Subjects,

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

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, None noted

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, Normal

GENERAL DESCRIPTIVE REMARKS:

Patient talks rationally & intelligently on all ordinary subjects. In a long Conversation, showed no defectiveness. Arteries are slightly atheromatous; but hardly more so than could be expected in a man of his age. Heart action is not good: heard Thoracic signs of having been a Pneumatic. He has had occasional attacks of partial paralysis of the left arm & leg, for the past 4 winters. Has an incipient sign now of any paralysis; he denies attempting Suicide & says he has little or no memory of events occurring for a couple of days before Commitment. He says he had "fits" of Dizziness & attributes them to medicine he had been taking. He has been taking 2 kinds: of one, the Dose was be half teaspoonful & of the other two teaspoonfuls: he got the 2 mixed & took 2 teaspoonfuls of the stronger medicine.

Personal and Medical History of Andrew Ek

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Robert M. Phelps, Asst. Med. Superintendent.
William H. Knapp, Accounting Officer.

Rochester State Hospital.

Rochester, Minn.

Mrs Andrew Oak
1045 East Ave
Redwing Minn

Mr. Oak having been received as a patient here, we wish to secure more full information with regard to the case. Please give us as fully as possible answers to the following questions:-

1. Give approximate date of the earliest symptoms that friends or relatives can remember.
2. Did disease grow gradually or come on suddenly?
3. Was any impairment of walking or talking noticed at that time?
4. Is there any insanity in the family? Or are there nervous and hysterical manifestations?
5. Has forgetfulness or loss of memory been a prominent symptom?
6. Was there any previous attack?
7. Is there any consumption in the family?

In addition, any short description of prominent acts and of general behavior will be useful to us.

Very respectfully yours,

R. M. Phelps — Asst Supt

Was drinking the cause of his later trouble and was he about all right when not drinking?

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 a

EGBERT, FIDLAR & CHAMBERS, DAVENPORT,

Whole No.

Residence

Date A

Adr

Clea

Quick or Sl

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

d or Not,

subjects,

itory or Not,

LLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:

Patient talks rationally & intelligently on all ordinary subjects. In a long conversation, showed no defectiveness. Arteries are slightly atheromatous; but hardly more so than could be expected in a man of his age. Heart action is not good: Loud blow-signs of having been a tenor. He has had occasional attacks of partial paralysis of the left arm & leg, for the past 4 winters. There are no signs now of any paralysis. Believes attempting Suicide & says he has little or no memory of events occurring for a couple of days before Commitment. He says he had "Hell" of Depression & attributes them to medicine he had been taking. He had been taking 2 kinds: of one, the dose was a half teaspoonful & of the other two teaspoonfuls: he got the 2 mixed & took 2 teaspoonfuls of the stronger medicine.

So called & states as follows:—

Sane. 7/11-1896

Drinks for many years on & off—Never shunned any society when drunk. Has no family—Never had any insanity in family—Rent last—about 4 days—

Upper dentition at last visit & teeth missing—

Never had delirium tremens—Always moderate drinker—Has not taken any liquor for about 4 days—

Has the only two delirium—even moderate drinker—Beer drinking 2 days—4th day at noon & vomited about that time—

Kept getting worse—2 P.M. Thursday Kinsey—in barn—

by rope—in barn rope over beam—Two men

& unconscious—in evening delirium—next morning

Next day went to work—stayed in

Next day went to work—stayed in

with Lockjaw—is dying—also about being & works sick

round his neck in the stall—Thinks Father knows that

he tried suicide, although he denied it—Says mother

died two years ago & he tried to drown herself—

Personal and Medical History of Andrew K

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, 135 lbs NUTRITION, Slightly impaired: some puffiness under eyes

WOUNDS OR ABNORMALITIES, Slight ptosis of left eye: Le Stabi & Vaccagnital

TONGUE, Tremors, quite marked Coatings, Clean Promptness Movement, Prompt

PUPILS, Equality, left very slightly larger Size, Normal

Response Light, Normal Accommodation, Normal

SIGHT, Slightly presbyopic

HEARING, Slightly impaired by age

COORDINATION, Arms, Slightly impaired: finger to nose, eyes shut, fairly good.

Legs, Slightly impaired: Standing unfoot, fair: Standing, eyes shut, fairly good

TREMORS, Hands, Slight Tongue, Yes

Facial Muscles, No General,

REFLEXES, Patellar, 5 = equal.

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION, right side of face slightly smoother than left.

SENSIBILITY,

HEART, Slightly enlarged & apex beat displaced to left. 2nd pulmonic sound loud: no distinct mitral murmur

LUNGS, Slight difficulty in Respiration: few large moist rales.

EXAM. URINE,

TAKEN,

Treatment

Digitalis & nux vomica in medium sized doses

OPHTHALMOSCOPIC EXAM.,

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

Record kept

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 Andrew E.K

1896

This patient was brought here by Sheriff O.C. Lundquist, with following history. Patient is in fair physical condition. As to consanguinity not known: no insane relatives. This is not 1st attack: he had one about 18 years ago; duration temporary: was not sent to hospital. First symptoms of this attack were manifested January 30th 96, when he attempted suicide by hanging. Disease is probably increasing: variable, with rational interval, but not at regular period. Derangement now shown by attempt at suicide. Is not disposed to injure others. Has attempted suicide both by drowning & hanging & propensity now active. No filthy or destructive habits. He manifests a strong desire & disposition, at intervals, to drink liquor to excess: parents were not intemperate. There is no history of any severe disease & or head injury. Patient has been under surveillance, since his last attempt at suicide. Probably excessive drink is the cause of the disease. Local physician has treated him for alcoholism, ineffectually & excesses more frequent and health poorer than before treatment. Patient has a tremor: force & rate of heart greatly exaggerated. —

Febr 4 On admission, was put on P.3/(G.A.N. R.ft. Complexion light: hair gray: eyes blue: condition of skin good: no marks scars & bruises noticed: is clean: behavior good: is quiet)
" 5 Pulse 100. R 20 T@ 99 2/5 Feb 5/96. Slept only 5 hours, restless 3 hours, last night. Am. Pulse 76 R 20 T@ 99. Appetite good: bowels seem in good condition: no cough noticed. Behavior quiet & good: talks rationally.
" 6 PM. Pulse 80 R 20 T@ 99 6/5 Makes no complaints. Feb 6/96. Restless 2 hours, but slept 7 hours, last night. Am " 88 " 20 " 98 2/5. PM. Pulse 96 R 20 T@ 99 2/5. Eats well: behavior good: no delusions
" 7 or hallucinations noticed. Febry 7/96. Apparently slept well, last night. Am. Pulse & R 20 T@ 98 4/5. Behavior quiet. He appears contented & cheerful: makes no complaints. Goes out walking, every day. PM Pgz
" 8 R 20 T@ 99. Febry 8/96. Restless an hour, but slept 8 hours. Am. P80. PM. P88. Appetite good. bowels
" 9 in good condition. Talks well: no delusions or hallucinations noticed. Febry 9/96. Sleeps well: Pulse about
" 10 normal. (80 - 84) - Quiet: contented & cheerful: works on ward: goes walking. Febry 10/96. About
" 11 the same, from day to day. Am. P76. PM. P84. Febry 11/96. Sleeps well. Appetite good: bowels in good con-
" 12 -dition. Febry 12/96. Patient doing nicely. Talks well: no delusions or hallucinations noticed. Was visited by Son, today. (See attached Statement of Son, in reply to memoranda for particulars
" 18 of this case). Febry 18/96. Has continued to sleep 8 hours nightly, since last noted. Appetite has been good: bowels in good condition. He behaves well: is quiet: talks well & rationally: no delusions or hallu-
-cinations noticed. Goes walking, every day. Pulse has been about normal. Habits are clean.
Summary: Patient has been quiet & very well-behaved: appearing cheerful & contented and showing some interest in his surroundings: but there have been times when he was very quiet and also appeared dependent. Is apparently in good condition, physically: chest broad & well developed: is in good flesh: muscles large & well formed. Has talked freely & quite rationally. Has improved.
" 27 Febry 27/96. Medicine discontinued. Febry 29/96. Behavior very quiet: is apparently dependent:
29 talks rationally: no delusions or hallucinations noticed. Habits neat & clean: appetite
Mar 7/20 good: bowels in good condition, generally. Mar 5/96. Wt 138 lbs. Pulse 76. Mar 7/96. Patient quiet & apparently more contented. Talks well & rationally: no delusions or hallucinations
" 27 noticed. Makes no complaints. Mar 27/96. Would like to go home.
" 28 March 28/96. Was allowed to leave, this morning. Discharged

Personal and Medical History of Oscar Berger

1896 June 16.

Apr 25/27 Behavior has been good, at this date. In medicine. Apr 27/96. Complained of not feeling well. —
" 30 Temp. 99°. April 30/96. Seems to have improved some. Behavior quiet. Eats & sleeps fairly well. —
May 1 May 1/96. Wt 154 lbs. P88. Physical condition good: eats & sleeps well: behavior quiet: works on ward:
" 15 In extra diet, & also on medicine, 4 times a day. May 15/96. Received cathartic: same caused
" 16/30 patient to vomit. May 16/96. Given enema. May 20/96. was struck by patient in the mouth,
" 22/30 causing same to become slightly disfigured. May 22/96. "Ugly spells". May 25/96. Now quiet.
" 31 May 31/96. No change to note. Is quiet & fairly well-behaved. Works some on ward. —
June 1/3 June 1/96. Wt 147 lbs. P80. June 12/96. No change noticeable. Eats & sleeps well: bowels regular:
" 16 behavior fair: Physical condition good. June 16/96. Went to work in the Laundry —
" 28/30 June 28/96. Transferred to A. June 30/96. Behavior good. Works out at the Laundry.
July 1/4 July 1/96. Wt 154 lbs. Pulse 76. July 2/96. Behavior has been good & he has been working regularly at the laundry. Did not talk much. Eloped from laundry today. —

Discharged.

Personal and Medical History of *Christ Simpson*

EBERT, FIOLA & CHAMBERS, DAVENPORT, IOWA

Whole No. 4327.
Residence, Nyborg. Denmark.
Date Admission, 19th February 1896.
Admitted by Dr. B. Eby. Hour, 7½
How Sent, H. L. Buck Co. Winona
Sex, Male
Age, 27 years
Civil Condition, single
Children, none
Age Youngest Child,
Occupation, Laborer
Degree Education, Common School
Profession Religion, Not a church member
Habits, not intemperate.
Nativity, Denmark. (Parents also born there)
Physicians Committing, C. Tracy and C. B. McGaughey
Correspondents, none given in papers

No. for Year, 155

Chris Simpson
(Mrs) Sam. Nelson
577 East 9th St.
Winona
Minn

Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exd by Dr. Herzog. Feby 22/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Clear
Quick or Sluggish, Quick
MEMORY:
Past Events, Seems good
Recent Events, — do —
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, Correct
REASONING POWER:
Ordinary Subjects, Good
Own Mental State, Does not appreciate Condition
Special Subjects,

EMOTIONAL STATE:
~~Normal, Calm,~~
~~Indifferent,~~
~~Exalted,~~
Depressed, Slightly
DELUSIONS:
Systematized or Not, Systematized
Special Subjects, of persecution
Transitory or Not, fixed
HALLUCINATIONS:
ILLUSIONS: of taste
CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, fairly voluble

GENERAL DESCRIPTIVE REMARKS:

Patient is undersized; smooth faced, but of very fair muscular development. He left Denmark 7 years ago, where he had been apprenticed to his elder brother, a carpenter. He had no liking for the trade & worked in this country as oiler in the flouring mills, making just a living. He went back to Denmark a year ago. At this time he had the idea that there was something the matter with his kidneys, but it seems all right. He has been wearing a corset ever since for this trouble. He believes that the servant girl has been administering poison in his coffee having been bribed & does so by a man boarding in the house. This man has been a mystery to him as he works nights & sleeps days. He believes this man to be a doctor who is secretly experimenting on him. He thinks that if this Doctor can cure his disease he can cure any disease.

Personal and Medical History of *Christ Simpson*

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

Christ Simpson.

March 29th'96-- Mrs. Sam. Nelson writes insanity came on about one year ago this Spring growing gradually. Father very nervous but no insanity n family as far as she knows. Was some consumptiom.

1, Good.
irly prompt
has Conjunctivitis).

Legs, Good: Standing on foot. Good. Standing, eyes shut, Good.
TREMORS, Hands, Slight
Facial Muscles, No
Tongue, Slight
General, No
REFLEXES, Patellar, 6 - Equal.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
Eyelids twitching
SENSIBILITY,
HEART, Good
LUNGS, Good
OPHTHALMOSCOPIC EXAM.,

EXAM. URINE,


4327

TAKEN,

HABITS, Dirty,	Clean, kept	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium, Record	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, Maternal uncle Insane
Father or Pat. Relations, father tubercular
Brothers or Sisters,

Personal and Medical History of Christ Simpson

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4327.
Residence, Nyloga. Minnesota.
Date Admission, 19th February 1896. —
Admitted by D.C.B. Eby Hour, 7.45
How Sent, H.L. Buck Sh'ff. Winona County
Sex, — Male —
Age, — 27 years —
Civil Condition, single
Children, none
Age Youngest Child, —
Occupation, Laborer
Degree Education, Common School
Profession Religion, Not a church member
Habits, not intemperate —
Nativity, Denmark. (Parents also born there)
Physicians Committing, (S. Tracy & (C.B. McGaughey
Correspondents, none given on papers

No. for Year, 155
Insane Relatives, none
Cause Exciting, not known
Cause Predisposing, not given
Form, Paranoia.
Accompanying Bodily Disorder, twitching of face & muscles of eye
Suicidal or Not, not
Date of this Attack, a month ago
Duration, — a month —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 27 —
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exd by D. Herzog, Feby 22/96 **MENTAL CHARACTERISTICS.**

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

MEMORY:
Past Events, Seems good
Recent Events, — Do —
Special Subjects,

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

REASONING POWER:
Ordinary Subjects, Good
Own Mental State, Does not appreciate Condition
Special Subjects,

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

DELUSIONS:
Systematized or Not, Systematized
Special Subjects, — of persecution
Transitory or Not, fixed

HALLUCINATIONS:
ILLUSIONS: of taste

CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, fairly voluble

GENERAL DESCRIPTIVE REMARKS:

Patient is undersized, smooth faced, but of very fair muscular development. He left Denmark 7 years ago, where he had been apprenticed to his elder brother, a carpenter. He had no liking for the trade & works in this country as a fireman in the flouring mills, making just a living. He went back to Denmark a year ago. At this time he had the idea that there was something the matter with his shoulder, but it seems all right. He has been wearing a corset ever since for this trouble. He believes that the servant girl has been administering poison in his coffee having been bribed to do so by a man boarding in the house. This man has been a mystery to him, as he works nights & sleeps days time. He claims this man to be a doctor who is secretly experimenting with him. He thinks that if this Doctor can cure his disease he can cure any disease —

Personal and Medical History of Christ Simpson

EXAMINATION ON ADMISSION, CONTINUED.

CHARACTERISTICS.

Good.

nity came on about one year
ery nervous but no insanity
sumption.

irly prompt X

has Conjunctivitis)

Good. Standing, eyes shut. Good.

Tongue, Right

General, No

Facial Muscles, No

REFLEXES, Patellar, 6 - equal

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,
Eyelids twitching

SENSIBILITY,

HEART, Good

LUNGS, Good

OPHTHALMOSCOPIC EXAM.,

EXAM. URINE,

TAKEN,

HABITS, Dirty,	Clean, kept	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, Maternal uncle Insane

Father or Pat. Relations, father tubercular

Brothers or Sisters,

Personal and Medical History of Christ Simpson

BERRY, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4327. No. for Year, 155

Residence, Norwegian Dominion

Date Admission, 19th Dec

Admitted by D. C. B. Et

How Sent, H. L. Buck

Sex, Male

Age, 27

Civil Condition, M

Children,

Age Youngest Child,

Occupation, Laborer

Degree Education, Common School

Profession Religion, not a church member

Habits, not intemperate -

Nativity, Denmark: (Parents also born there)

Physicians Committing, J. S. Tracy & P. B. McGaughey

Correspondents, none given in papers

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exd by D. Herzog. Febry 22/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Clear

Quick or Sluggish, Quick

MEMORY:

Past Events, Seems good

Recent Events, - do -

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Good

Own Mental State, Does not appreciate Condition

Special Subjects,

EMOTIONAL STATE:

~~Normal, Calm,~~

~~Indifferent,~~

Exalted,

Depressed, Slightly

DELUSIONS:

Systematized or Not, Systematized

Special Subjects, - of persecution

Transitory or Not, fixed

HALLUCINATIONS:

ILLUSIONS: of taste

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, fairly voluble

GENERAL DESCRIPTIVE REMARKS:

Patient is undersized, smooth faced, but of very fair muscular development. He left Denmark 7 years ago, where he had been apprenticed to his step mother, a carpenter. He had no liking for the trade & worked in this country as oiler in the flouring mills, making just a living. He went back to Denmark a year ago. At this time he had the idea that there was something the matter with his kidneys, but it seems all right. He has been wearing a corselet ever since for this trouble. He believes that the Servant Girl has been administering poison in his coffee having been kicked & dosed by a man boarding in the house. This man has been a mystery to him as he works nights & sleeps days there. He believes this man to be a doctor who is secretly experimenting on him. He thinks that if this Doctor can cure his disease he can cure any

Personal and Medical History of Christ Simpson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4½ WEIGHT, 123 ½ lbs. NUTRITION, Fairly good

WOUNDS OR ABNORMALITIES, Scars of an electric belt; wears a corselet.

TONGUE, Tremors, Slight, if any Coatings, Clean. Somewhat large & tooth marked Promptness Movement, Fairly prompt

PUPILS, Equality, Yes Size, Normal

Response Light, Normal Accommodation, Normal (has Conjunctivitis)

SIGHT, Says good

HEARING, - do -

COORDINATION, Arms, Good. Finger to nose, eyes shut, good.

Legs, Good; standing, on foot, good. standing, eyes shut, good.

TREMORS, Hands, Slight Tongue, Slight

Facial Muscles, No General, No

REFLEXES, Patellar, 6 - equal.

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

Eyelids twitching

SENSIBILITY,

HEART, Good

LUNGS, Good

EXAM. URINE,



4327

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

Regular kept

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Maternal uncle Insane

Father or Pat. Relations, father tubercular

Brothers or Sisters,

Personal and Medical History of *Christ Simpson*

1896

This patient was brought here by Deputy Sheriff A. W. Fuhrman with following history. Patient is in good physical condition. No consanguinity or heredity: This is 1st attack; symptoms manifested a month ago, by hallucinations. Disease seems to be increasing, but variable and with rational intervals, but these not at regular periods. Derangement now shown is that he believes an attempt is being made to poison him slowly. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. No peculiarities noted previously known. There is no history of intemperance in self or parents, nor of any severe disease &c. He has not been restrained or confined; nor under medical treatment. Cause of disease, not known. On personal Examination, there is observed a twitching of the face & muscles of the Eye.

Feb 19 On admission, was put on B³. (G.H.N. R/H. Complexion light: hair light: eyes blue: constitution of skin good: tongue coated: clean: behavior good). P 80 R 20 T 99.4.

" 20 Feb 20/96 Slept all night. Am. Pulse 80 R 20 T 98.4. Appetite fair: bowels moved: no cough: behavior good. Talks rationally. Pm " 84 " 20 " 98.8. No complaints. Feb 21/96 Slept 8 hours.

" 21 Am. P 76 R 20 T 98.6. Pm " 74 " 20 " 99. Ate well: bowels in good condition, appetite. Behavior good. Quiet & appears contented. Feb 22/96 Slept 9 hours, restless 2 hours, last night. Am. Pulse 72 R 20 T 98. Is restless & excited, today. Shows delusions. Says "somebody is trying to chloroform him". Feb 23/96. Slept quite well. Am. Pulse 80 R 20 T 98.6. Again became quite excited today. Says "he is not insane & should be discharged". Refused to have his eyes treated.

" 24 Feb 24/96. Was quiet today. Eats fairly well: bowels in good condition. Sleeps well. Am. P 72 Pm P 76.

" 25 Feb 25/96. Says "he was chloroformed during the night". Am. P. 78 Pm P 84. Quiet, today. Goes out on grounds, every day. Makes no complaints. Feby 26/96 - Has continued to rest & sleep well, each night. Pulse, taken twice daily, about normal. Appetite good: bowels seem in good order: behavior quiet: is dispirited & rather despondent - Holds delusions: Makes strange remarks: says "there are but 3 or 4 insane patients in ward." Talks but little. Thinks he is being poisoned". Says also "he has rich relatives & friends, in the Old Country". March 1/96. Slept well. Pulse today, 80.

Mar 1 March 2/96. No change noticed in patient, during last few days: Eyes have improved much.

" 2 Makes no complaints as to physical condition. March 3/96. Complained of feeling feverish this am.

" 3 remained in bed: no breakfast: P 100 R 22 T 102. Bowels moved. Transferred to T.W, at 10 Am. P 96 R 18 T 101.6. Complained of slight pains over entire body. Very quiet. Was given bath & put to bed. Ate a fair dinner. (Dr on light diet): Slept from 3.00 to 6 Pm. Ate a good supper. March 4/96. Restless 4 hours, & slept only 4 hours. Am. Ate a light breakfast.

" 4 Complains of severe headache. 2.15 Pm. Vomited some. 5.30 Pm. Seems somewhat delirious. Bowels have moved. Skin perspiring profusely. (See attached Nurse's record of P. R. & T &c)

Summary: Behavior quite good, first two days: became restless & excited on 3d day: from 4th to last day, was quiet & well behaved. Appetite good, throughout the 2 weeks: bowels quite regular: eyes were somewhat sore, when received, but improved daily. He felt quite well, up to 13th day: then, felt sick & feverish & moved to T.W. Does not talk much: quite rational on some points, but still thinks people are trying to chloroform him, during night. Has slept well. Fever abated on the 14th night yet he seems somewhat delirious: placed on light diet on 14th day. March/96. Has been sleeping quite well. Pulse is good: but face is bluish. Appear much better & says he feels so. Talks quite

Personal and Medical History of *Christ Simpson*

CASE RECORD.

Patient's Name *Christ Simpson* Name Disease ____ Name Physician *H.H.H.*

1896 Date.	Temp.	Pulse.	Resp.	Medicine and Food.	Giving Baths, Enemata, Action Bowels, Kidneys, Skin and Other Symptoms.
May 3 10.00 am	101.6	96	18	Light diet - milk toast included.	Received upon ward from B³. Complains of slight pains over entire body. Very quiet. Has
" " 12 m				Fair dinner.	given bath and put to bed.
" " 1 Pm.				Powders.	
" " 3.30 "				"	Slept from 3.00 to 6.00 pm.
" " 6 pm				Good Supper.	
" " 6.30 "				Powders	Night - Slept 4 hrs. R.4.
" " 8.00 "				"	
" 4 Am	104.4	108	22	Light breakfast.	Complains of severe headache.
" " 1 pm	104.7	98	22	11.00 am Capsule	11.30 Mouth washed - sol. listerine. followed
" " 5 "	101.8	92	21	" Glass Mellins food	with wine wash.
" " 5.45 "	100.5	90	20	1.00 pm. Capsule.	2.15 pm. Vomited eggnog. Mouth washed
" " 7.30 "	99.8	88	18	2 pm. Glass eggnog.	as before.
" " 12.00 pm	99.6	76	20	3 - Capsule.	5.30 pm. Derma somewhat delirious.
				5 " Glass milk.	11.30 pm. Bowels moved - Perspiring profusely.
					S. 4 hrs.

Recorded by ____ Nurse.

May 3 1901 / Feb 19 / May 31 / Feby 3 / May 3 / July 20/31 / Aug 1 / 1901 / July 31

Aug 1 1901 / May 31 / Jan 31/03

Wt 138[lbs]. Nov 1 123[lbs] May 31/02. No change of importance, during year: very irrational: talkative & silly. At times, very noisy. Works well on ward. Is cleanly: health good. (Dr. Chapple) Has worked some on ward. No particular change in any way. Talks a great deal - at times obscenely & excited - occasionally will strike a patient without any provocation.

Personal and Medical History of *Christ Simpson*

1896

This p[atient] ... story
Pat[ient] ... tions
ma[de] ... and
wi[th] ... he
beh[aved] ... ches,
mo[re] ... is
no[t] ... ined
on[e] ...),
thre[e]

Feb 19 On
- dit
" 20 Feb
" 21 beh
Au
" 22 - pa
in
" 23 try
qu
" 24 F
" 25 Re
" 29 an
mi
qu
ha
Mar 1 - h
" 2 Re
" 3 Th
p
10
W
" 4 Ar
Co
4
S
d

Somewhat so, when received, no improvement ... [illegible] ... sick & feverish & moved to I.W. Does not talk much: quite rational on some points, but still thinks people are trying to Chloroform him during night. Has slept well. Fever abated on the 14th night yet he seemed somewhat delirious: placed on light diet on 14th day. Mar 8/96. Has been sleeping quite well. Pulse is good: but face is blotchy. Appears muchbetter & says he feels so. Talks quite

Personal and Medical History of *Christ Simpson*

1896

Mar 8 am — rationally. very quiet: has been troubled with a sore nose & lip: vaseline applied. They are now better.
" 9 Wt 111 pds. Mar 9/96. Quiet & contented in bed. Talks rationally: Cold - sores much better. Sleeps quite well.
" 10 Mar 10/96 Sleeps sound in daytime. Well behaved: quiet & easy. Complains of sore throat, bright -
" 11 Mar 11/96. Throat very sore: says it gives him great pain: Spits some blood: 11th slight nose-bleed: also complains
" 15 of severe headache & appears quite sick: throat treated. Mar 14/96. Throat much better. Lies very quietly:
" 16 says he feels well. Talks quite rationally - Mar 16/96 Exceptionally bright this morning. Looking quite well.
" 17 10th Rm. Up & Dressed. Behavio good. While up. Has continued to sleep well. Mar 17/96 11th Am. Up and
" 18 Dressed. Seems to improve steadily. Mar 18/96 Sleeps quite well: up & Dressed, all day. Feels quite well.
" 19/20 Mar 19/96. Up & around: behavio good: Habits neat & tidy: talks quite rationally. Mar 20/96. Works around.
" 21/22 Mar 21/96 No noticeable Change (Sleeps on B3). Mar 26/96. Complained of tooth ache - was treated -
" 31 Mar 31/96. Improvement has kept up & he is quite strong, physically. Works around (See Nurses record file 19).
Apl 2/30 Apl 2/96. Wt 122 pds. Apl 30/96 Physical condition seems quite good: appetite good: bowels regular - (Sleeps on B3). Habits clean. Talks quite rationally, on most subjects. No noticeable delusions. Works around.

May/96 to Aug/97 Summary Nurses Notes by Dr. Phelps - Patient rather irrational on some subjects: Talks incoherently at times: Is neat & tidy & fairly well behaved. Does some work: Continued in about this same condition during latter part of '96. For a while seemed to be improving slightly mentally, altho still had some foolishness of mind. During November became restless again & even violent & was taken to ward for disturbed patients: Since then he has quieted down some but has not been trusted much. Wt June 97 125 lbs physical condition fairly good. Aug 31/97 Wt. 125#. Rather uncertain in behavior but usually quiet & well-behaved. Kept upon disturbed ward. Needs watching At times excitable. Jan 31/99 Still upon same ward. At times noisy & excited: but usually works around in a quiet way. Feb - July 31/99. (Dr. Warnock) Wt. 126#. Has various delusions & exalted ideas: Believes himself some great personage. Very talkative Works in dining room. Feb 8 Had pregnacious spell. July 31 Incoherent & excitable: refuses work & remains very much excited. No change physically.

Aug 1 1900 to July 31 — Jan 31/1900. (Dr. Chapple) No change during period. Physical condition good Works well in dining room on ward. Has several times had trouble with other patients.
Feby 1 to May 3 — Talks in an incoherent, silly manner. Is at times very nervous. Feby 1. Wt 121#. Bed Transferred to Annex. July 20. Vaccinated: result negative: July 31. No change to note. Physical
July 20/31 — Condition good. Works well around. Is very restless and noisy at times very excited & incoherent.
Aug 1 1901 to July 31 — Is a usual Pervert. Aug 1. Wt 118#. Feb 10. D.D.T. - Jany 31/1901. Works in ward dining-room Is fairly neat in appearance: has numerous delusions & becomes very noisy & demonstrative at times, talking to imaginary people". Behavior usually good. Febys Wt 115½# May 1 120# Aug/97 Wt 138(21). Nov 1 123#. Jany 31/02. No change of importance, during year: Very irrational: talkative & silly. at times, very noisy. Works well on ward. Is cleanly: Health good.
1901 to Jan. 31/03 — (Dr. Chapple) Has worked some on ward. No particular change in any way. Talks a great deal - at times obscenely & excited - occasionally will strike a patient without any provocation.

Personal and Medical History of Karl Gschnatt

EGELEY, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4328.
Residence, St Paul, Minnesota.
Date Admission, 21st February 1896
Admitted by Dr. C. B. Eby. Hour, 6.45 P.M.
How Sent, G. Wilbrich Jo. P. Ramsey County
Sex, Male
Age, - 62 -
Civil Condition, Single
Children, None
Age Youngest Child, —
Occupation, Locksmith
Degree Education, None
Profession Religion, Catholic
Habits, - Intemperate
Nativity, Hungary: (Parents also born there).
Physicians Committing, G. Stanton & C. Eugene Riggs
Correspondents, "none given in papers"

No. for Year, 156.
Insane Relatives, not known
Cause Exciting, - degenerate -
Cause Predisposing, previous attack
Form, Mania sub-acute
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, not: but has threatened his wife.
Date of this Attack, Last June
Duration, about 8 months
No. of Attack, 2nd (probably more).
No. of Admissions, — / 1st here (?) (Was in Bremia Hospital)
Age First Attack,
Time of Leaving, Apr. 26. 1900
Time in Hospital,
Result, Transferred to Hastings.

EXAMINATION ON ADMISSION.

Ex'd by Dr. Herzog. Feby 24/96 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Quick
MEMORY:
Past Events,
Recent Events, } Considerably impaired.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, alert
Correct or Illusive, illusive, at times
REASONING POWER:
Ordinary Subjects, poor
Own Mental State, poor
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Has slight ulcers in pubic region resembling old chancroids. He says "only a week old". Veins of belly swollen: slovenly in appearance: Quite exalted. Forehead low: evidently of low intelligence.

EMOTIONAL STATE:
Normal, Calm,
~~Indifferent,~~
Exalted, Yes
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects, none noted
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, slightly incoherent
Voluble or Reticent, voluble

Personal and Medical History of Karl Gschnatt

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6in WEIGHT, 133 lbs NUTRITION, Fair
WOUNDS OR ABNORMALITIES, Complains of pain in right Chest: says "was hurt in St Paul": can find no broken rib. Is somewhat at fault: puffy under eyelids.
TONGUE, Tremors, none Coatings, heavy buff yellow at base Promptness Movement, fairly prompt
PUPILS, Equality, yes Size, somewhat contracted
Response Light, sluggish Accommodation, sluggish
SIGHT, Impaired luminous pupil
HEARING, seems good
COORDINATION, Arms, good: finger to nose, eyes shut, good.
Legs, good: standing on foot, good: standing, eyes shut, good.
TREMORS, Hands, no Tongue, none
Facial Muscles, No General, No
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION, mobile & unintelligent
SENSIBILITY,
HEART, impulse forcible: arteries atheromatous: temporals full.
LUNGS, seem good

TAKEN,

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, } no history obtainable
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Karl Gschnatt

1896

This patient was brought here by Deputy Sheriff Kinney, with following history. Patient is in fair physical condition. As to consanguinity or heredity, nothing known. This is not the 1st attack: he had one, many years ago; duration about a year: was then sent to hospital at Vienna, Germany: was cured(?). First symptoms of this attack manifested last June; became progressive. Disease appears to be increasing: Derangement now shown in that his symptoms seem to be of a sexual character: is greatly incensed against his wife. He has threatened his wife: is not suicidal: propensity not active. There is a disposition to filthy and destructive habits: as to any previous peculiarities, not known. He is intemperate & there is also history of intemperance in parents. He has not been subject to any severe disease, nor had any head-injury. Has only been confined as above stated. Supposed cause of the disease is "Degenerate". Has had no medical treatment this time. —

Feb 24 On admission was put on B3 (G.H.N.R'pt. Complexion dark: hair dark: eyes blue: Condition of skin good; right ankle stiff: no scars &c noticed: is dirty: behavior
" 25 good:) — 9 PM. Given sleeping dose. Feb 25/96. Restless 5 hours & slept only 4 hours. Am. Pulse 96 R 22 T 98 98⅖. Eat well: bowels moved. He is quite foolish, boisterous & happy: singing & talking, all day.
" 26 Habits not neat: is dirty. Feb 26/96. Restless 3 hours, but slept 6 hours (had been given sleeping dose).
" 27 Was laughing & talking foolishly, a great deal, today. Feb 27/96. Restless & slept only 5 hours, last night
" 28 Is now quiet today, though acting silly & foolish, as before. Does walking daily. Feb 28/96. Slept 8 hours:
" 29 Patient still restless: talking, as before: makes no complaints. Feb 29/96. Slept 7 hours, last night.
Mar 1 Is restless & troublesome: demented: talk incoherently. Mar 1/96. Restless 3 hours, but slept 6 hours,
" 2 Goes on walking: no change in behavior: need considerable watching. Habits untidy. Mar 2/96. Restless
" 3 4 hours. Slept 5 hours. Transferred to B'. March 3/96. Eat well: Pulse &c. Bowels moved:
" 4 Is noisy & restless; continually walking about in hall: untidy about his clothing. Mar 4/96. Restless 5 hours & slept only 4 hours, last night: has sores & sores on abdomen: no change in behavior & habits.
" 5/6 Mar 5/96. Am. P 92. No change noticed. Mar 6/96. Slept 8 hours, restless 4 hours. Am. Pulse 86. —
" 7/8 no change in behavior. Mar 7/96. Slept 5 hours: restless 4 hours. Am. P 78. Mar 8/96 - Slept well:
" 9/30 otherwise, is about the same. Mar 9/96. Still no change in any way. March 30/96. Complains of not feeling well: had severe headache & was put to bed (27th). P 82 R 24 T 99⅘ PM. P 84 R 22 T 99.6
Bowels moved: Saw medicine. On 28th. P 80 R 20 T 99. ate a good breakfast: complains still, of throat being sore. Bowels moved freely: 4³⁰ PM P 92 R 22 T 99.6: On 29th. apparently the same.
P 88 R 20 T 99. Used gargle. 4³⁰ PM. P 92 R 30 T 98⅘. Said he felt much better. Up & dressed
April 1 today, (30th). April 1/96. Ht 146 ft 8. P 98. (Dr. Hunter. Demented: talkative & untidy).
" 30 Apl 30/96. Behavior fairly good, on ward; but, when out walking, will fill his pockets with anything he finds. Habits clean, but untidy. Does not work.

May 1/96 Summary Nurses Notes by Dr. Phelps. Appears somewhat old: Is also rather troublesome &
& mischievous in behavior: Wt. 150 lbs. May 2nd 96. Oct. 22 Taken to Infirmary for operation;
Aug 1/97 remained in bed until 27th & was again transferred to B'. Wound healing nicely. During early part of 97 remained to Annex. Gets along quietly. Works at times on farm.
Aug 31 97 Wt. 144 Oct 31 General health good. Is rather confused mentally: rather quiet & seemingly more demented & depressed. Talks to himself. Works on farm. Jan 31 99 Patient appears to be

Personal and Medical History of Karl Gschnatt

1899

Feb 1 to July 31 / 1899 to Feb 1 1900 — The same in every way during period. Feb 1 - July 31 99 (Dr. Wanous) Wt. 150 lbs. At times refuses to work on farm: Physical condition seems good. Talks to himself a great deal. Aug 1 - Feb 1 1900 (Dr. Chapple) Aug 1. Wt. 158 lbs. No change during period: Has been in good physical health & has worked most of time on farm, or in soap house. Behavior usually very good: is quite demented: Talks in a rambling, incoherent manner to himself. Habits slovenly.

Apl 26 — No change to note in general condition: has worked on farm & at soap-house. Health has been good — Was, today, transferred to Hastings Asylum —

Personal and Medical History of Lewis Olson #3

EGBERT, FIELD & CHARLES, DAVENPORT, IOWA

Whole No. 4329

Residence, St. Paul. Minn.

Date Admission, 24th February 1896

Admitted by D. C. B. Eby Hour, 6

How Sent, G. Willrich. Hoff. Rauss

Sex, Male

Age, 33 (about)

Civil Condition, single

Children,

Age Youngest Child,

Occupation, Wood-Chopper

Degree Education, Common School

Profession Religion, Yes: Lutheran

Habits, not intemperate -

Nativity, Norway: (parents also born there).

Physicians Committing, J. O. Hage and John C. Nelson

Correspondents, none given in papers

Age First Attack, (?)

Time of Leaving,

Time in Hospital,

Result,

Sigvart O Ruistad
Hvrdals P.O.
Kristiania
Norway
Brother of Lewis Olson #3

Mar 20/96

Peter Klarin
Brooking
Friend of Lewis Olson #3
So. Dak.

Mar 20/96

Exd by Dr. Herzog. Feby 24/96.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, fairly good

Recent Events, very poor

Special Subjects,

PERCEPTIVITY:

Alert or Dull, somewhat dull

Correct or Illusive, on ordinary subjects

REASONING POWER:

Ordinary Subjects, poor

Own Mental State, realizes that he is ill & confused

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, much

DELUSIONS:

Systematized or Not, unsystematized

Special Subjects, of persecution

Transitory or Not,

HALLUCINATIONS: of hearing

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, slightly incoherent

Voluble or Reticent, somewhat reticent

GENERAL DESCRIPTIVE REMARKS:

Patient has been a strong man as shown by his bronzed cheeks & hard hands. His home is in St Paul: he was passing through on his way from Stanley Wis. to Brookings S. Dak & his memory is very deficient as to what occurred then. He says "he lost his watch & money" & remembers nothing of what happened. He seems drunk in excess. He says "he heard someone in St Paul say they were going to hang him & was much frightened. He is nervous; cannot sit still: depressed & much confused.

Personal and Medical History of Lewis Olson #3

ON, CONTINUED.

RISTICS.

NUTRITION, Considerably impaired.

ie Promptness Movement, slow

slightly Contracted

mmodation, somewhat excessive

good.

, fairly good. Patient stupid, face staring, eyes shut, good.

TREMORS, Hands, no

Facial Muscles, no

Tongue, some

General, no

REFLEXES, Patellar, 9; equal

Other very slight ankle clonus

ARTICULATION,

Slurred,

Hesitating, Yes

FACIAL EXPRESSION,

Depressed

SENSIBILITY,

HEART, Sounds somewhat muffled

No murmurs.

LUNGS, seem good



4329

TAKEN,

EXAM. URINE,

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 Lewis Olson #3

HERSEY, FIELD & CHURCHES, DAVENPORT, IOWA

Whole No. 4379

Residence, St. Paul: Minnesota.

Date Admission, 24th February 1896.

Admitted by Dr. C. B. Eby Hour, 6 hrs PM.

How Sent, G. Wilrich. Supt. Ramsey County

Sex, Male

Age, 33 (about)

Civil Condition, single

Children,

Age Youngest Child,

Occupation, Wood-Chopper (farmer)

Degree Education, Common School

Profession Religion, Yes: Lutheran

Habits, Not intemperate.

Nativity, Norway: (Parents also born there)

Physicians Committing, L. O. Hage and John C. Nelson

Correspondents, None given in papers

No. for Year, 1st

Insane Relatives, None

Cause Exciting, not known

Cause Predisposing, not given

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not attempted, but propensity active

Date of this Attack, probably recent

Duration, probably short.

No. of Attack, 1st —

No. of Admissions, 1st —

Age First Attack, (?)

Time of Leaving,

Time in Hospital,

Result,

Ex'd by Dr. Hayes. Feby 24/96.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, fairly good

Recent Events, very poor

Special Subjects,

PERCEPTIVITY:

Alert or Dull, somewhat dull

Correct or Illusive, on ordinary subjects

REASONING POWER:

Ordinary Subjects, Poor

Own Mental State, realizes that he is ill & confused

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Much

DELUSIONS:

Systematized or Not, unsystematized

Special Subjects, "of persecution"

Transitory or Not,

HALLUCINATIONS: "of hearing"

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, slightly incoherent

Voluble or Reticent, somewhat reticent

GENERAL DESCRIPTIVE REMARKS:

Patient has been a working man as shown by his bronzed cheeks & hard hands. His home is now St Paul: he was passing through on his way from Stanley Wis to Brookings S. Dak & his memory is very deficient as to what occurred since. He says he lost his watch & money & remembers nothing of what happened. He seems drunk in excess. He says he heard someone in St Paul say they were going to hang him & was much frightened. He is nervous; cannot sit still: depressed & much confused.

Personal and Medical History of Lewis Olson #3

ON, CONTINUED.

RISTICS.

NUTRITION, Considerably impaired.

ic Promptness Movement, Slow

Slightly Contracted

modation, Somewhat excessive

ood.

ion - Staring; eyes shut, good.

TREMORS, Hands,

Facial Muscles, no

Tongue, Some

General, No

REFLEXES, Patellar, 9; equal

Other Very slight ankle clonus

EXAM. URINE,

ARTICULATION,

Slurred,

Hesitating, Yes

FACIAL EXPRESSION,

Depressed

SENSIBILITY,

HEART, Sounds somewhat muffled

No murmurs.

LUNGS, Seem good



4529

TAKEN,

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 Lewis Olson #3

BERRY, FOLLAS & CHAMBERS, DAVENPORT, IOWA

Whole No. 4329

Residence, St. Paul: Minnesota

Date Admission, 24th February 1896

Admitted by Dr. C. B. Ely Hour, 6 P.M.

How Sent, G. Willrich, Supt. Ramsey

Sex, Male

Age, 33 (about)

Civil Condition, single

Children,

Age Youngest Child,

Occupation, Wood-chopper (Norway)

Degree Education, Common School

Profession Religion, Yes: Lutheran

Habits, Not intemperate.

Nativity, Norway: (Parents also born there)

Physicians Committing, L. O. Hage and John C. Nelson

Correspondents, None given in papers

Age First Attack, (?)

Time of Leaving,

Time in Hospital,

Result,

Exly St. Hospg. Feby 24/96.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, fairly good

Recent Events, very poor

Special Subjects,

PERCEPTIVITY:

Alert or Dull, somewhat dull

Correct or Illusive, on ordinary subjects

REASONING POWER:

Ordinary Subjects, poor

Own Mental State, Says that he is ill & confused

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, much

DELUSIONS:

Systematized or Not, unsystematized

Special Subjects, of persecution

Transitory or Not,

HALLUCINATIONS: of hearing

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, slightly incoherent

Voluble or Reticent, somewhat reticent

GENERAL DESCRIPTIVE REMARKS:

Patient has been a speaking man as shown by his bronzed cheeks & hard hands. His home is near St Paul: he was passing through on his way from Stanley Wis. to Brookings S. Dak & his memory is very deficient as to what occurred thus. He says he lost his watch & money & remembers nothing of what happened. He says he is semi drunk in weeks. He says he heard someone in St Paul say they were going to hang him & was much frightened. He is nervous; cannot sit still: depressed & much confused.

Personal and Medical History of Lewis Olson #3

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 Ft 6 in WEIGHT, 134 lbs. NUTRITION, Considerably impaired.

WOUNDS OR ABNORMALITIES, Palate high: teeth irregular.

TONGUE, Tremors, fine & coarse Coatings, clean, but anaemic Promptness Movement, slow

PUPILS, Equality, yes Size, slightly Contracted

Response Light, somewhat excessive Accommodation, somewhat excessive

SIGHT, Good

HEARING, Good.

COORDINATION, Arms, Good: finger to nose, eyes shut, good.

Legs, Fairly good: standing erect, fair: standing, eyes shut, good.

TREMORS, Hands, no Tongue, some

Facial Muscles, no General, No

REFLEXES, Patellar, 0; equal EXAM. URINE,

Other Very slight ankle clonus

ARTICULATION,

Slurred,

Hesitating, Yes

FACIAL EXPRESSION,

Depressed

SENSIBILITY,

HEART, Sounds somewhat muffled

No murmurs.

LUNGS, Seem good



4329

TAKEN,

photographed 2.

OPHTHALMOSCOPIC EXAM.,

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

Record kept

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 Lewis Olson #3

This patient was brought here by Deputy Sheriff W. B. Miller, with following history. Patient is in pretty fair physical condition - There is no history of consanguinity or heredity. This is 1st attack. He was found insane, on street, with fear that he was to be hung. Derangement now shown in that he thinks he is about to be hung, for having a cancer on his mouth. Patient is not disposed to injure others: has not attempted suicide: but propensity now active. No filthy or destructive habits. No peculiarities as previously shown: There is no history of intemperance in self or parents, nor of any severe disease or a head-injury. He has not been restrained or confined, nor under medical treatment. Cause of disease not known.

Feb 24 On admission, was put on B3 (G. H. N. R'pt. Complexion light: hair light: eyes blue: condition of skin good: no mark, scar or bruises noticed: is clean: (a mole on abdomen, left side): behavior good: is very quiet). Was given Sleeping dose at 9 P.M. Feb 25/96: Slept 7 hours, last night. Takes regular diet: urinated & bowels moved: Is quite confused & apparently afraid: talks little & is rather Despondent Feb 26/96. Slept 8 hours, last night. Is on medicine 3 times, daily. Is still dull & confused: complains of sickness at stomach & of inclination to vomit. Bowels moved Feb 27/96. Slept 8 hours: behavior same as yesterday: still complains of sickness & stomach. Bowels moved. (Temp: has been about normal. today. Am. 96. 5:30 P.M. 96.) Moved to I.W.

" 25 " 26 " 27 " 28 Feb 28/96. Slept 6 hours, last night: Appetite poor: Takes milk: also receives extra diet: Is on medicine. Bowels have not moved, Complains of headache & face is flushed: Behavior good

" 29 Feb 29/96. Slept 7 hours. appetite fair: no movement of bowels: Says "he ought not eat". No persuasion is used. Is very quiet. March 1/96. Slept 7 hours. 9 Am. Bowels moved slightly

Mar 1 " 2 " 3 Condition seems unchanged, today. March 2/96. Slept 7 hours: Says "bowels moved, during the night". no change noticed. Ate fairly well, today. March 3/96. Slept 7 hours, last night. Appetite fair, today. 9:00 am. Given Shower-bath. 4 P.M. Massage. Restless all day: no movement of bowels, today.

" 4 March 4/96. out of bed frequently: slept only 1 hour. Is on medicine. Appetite seems to improve, some, but persuasion still used: bowels moved: Is very restless & out of bed frequently. ——

" 5 " 6 March 5/96. Restless & slept only 5 hours, last night. No noticeable change more than improvement in appetite. Is now fed. March 6/96. Slept 7 hours. Does not wish to eat, but, by persuasion, can be made to eat all on tray. Complains of pains in stomach: (given pills). 3:30 P.M. Massage. Wt 120 pds.

" 7 " 8 " 9 March 7/96. Slept 6 hours. Still seems in depressed state of mind: will not eat, unless persuasion is used. 3:30 P.M. Electricity applied, (by physician). March 8/96. Slept 8 hours: Condition seems unchanged appetite seems good, but will not eat, unless fed. March 9/96. Slept 7 hours: Condition about same, today. very quiet: will seldom talk. Still on medicine. Bowels have moved fairly regularly, past few days.

Summary: Behavior good, throughout the 3 weeks. Remained quietly in bed, as a rule. Appetite not very good, for first few days: complained of sick stomach. Appetite improved, but he would not eat, without persuasion: bowels fairly regular. Temperature has been about normal, throughout, but pulse has, at times, shown great variations: He has slept quite well. Has been very quiet & apparently despondent. Would seldom answer questions asked him. Mar 10/96 Slept 6 hours

" 10 " 13 " 14 " 15 Mar 13/96. Slept 6 to 7 hours, nightly. Very quiet & rather stupid: apparently frightened. Seems quite thin & irregular in the Diet. Will not eat unless forced to do so. Mar 14/96. Seems more despondent today, than at any other time. 3:30 P.M. Given Massage treatment & Water, Shower bath. Mar 15/96. very quiet: appetite

Personal and Medical History of Lewis Olson #3

seems good, but he will not eat unless fed. 6:00 P.M. Crying: says "he has to eat too much". Mar 16/96. Slept only 3 hours, last night. Very quiet, all day: appeared despondent. Mar 17/96. Quite restless, during night & slept only 2 hours. Appears a little brighter, this morning, but is very uneasy: out of bed frequently: seems continually

Mar 17 " 18 " 19 " 20 " 21 " 22 " 23 " 25 " 26 " 27 " 31 in a state of fear Mar 18/96. Much disturbed, last night & slept none — Very restless & uneasy today. Frequently gets out of bed & race up the hall. Will eat nothing voluntarily. Mar 19/96. Slept 4 hours: More quiet this Am. was given Shower-bath: has been quite easy, all day, but appeared very despondent. Mar 20/96. Slept none last night: Very uneasy this Am. 9 Am. weeping bitterly: says "he feels bad". Twice, during afternoon, jumped out of bed, (apparently excited) & ran up the hall. Mar 21/96. Quiet, during night: slept 8 hours. Remained quiet, all day, but became wild & excited, about 6 P.M. Refused to eat, but did so after Considerable persuasion was used. Mar 22/96. Slept 6 hours. Very quiet, all day. Still very despondent: Cried slightly, at times, during day. Mar 23/96. Slept 8 hours. Behavior unchanged, today — Mar 25/96. Seems brighter & more quiet, today. Eats voluntarily & quite heartily. Is given Shower baths. Mar 26/96. 1:30 P.M. out for a walk. Quiet, in afternoon. Mar 27/96. 1:30 P.M. Up, in chair Is very quiet. Mar 31/96. Has been sleeping about 7 hours, on each of past few nights. Behavior about the same, from day to day. Is given massage-treatment: also Shower-baths. Still quiet and appears very despondent, at times. Eats well: Bowels fairly regular. (See Nurses-record on file 75) —

Apl 1/2 " 7 " 10 " 14 " 17 " 21 " 25 Apl 2/96. Wt 138 pds. Apl 3/96. Appears despondent: lies quietly in bed: seldom talks. Sleeps fairly well. Was crying several times today. Will not eat voluntarily: has to be fed. 1:30 P.M. Up, dressed & out. Apl 7/96. No change noticed. Is up, dressed & out, each afternoon. Is given massage treatment. Apl 10/96. Says "he cannot eat". Thinks he is getting poisoned". Despondent: cries when spoken to. Apl 14/96. No change noticed: tries sometimes to be very obstinate: will not eat voluntarily, and has to be fed. Sleeps well, at night. Apl 17/96. Given electrical treatment. 8:30 P.M. Vomited. Apl 21/96. Rests well at night. Up & dressed out, a portion of each afternoon, but then returns to bed. Willing to drink, when shown tube. Apl 25/96. Appears some better; also somewhat brighter; otherwise no change noticed. Goes out, quite often. Is restless, at times.

Apl 29/ May 30 " 8/10 " 19 " 23/ 26 " 28/ June 2 " 3/14 " 27 " 30 Apl 29/96. Had a vomiting spell (3:30 am). Apl 30/96. No change (specially noticeable — (See Nurse's record on file as 75). May 7/96. Appears some brighter: still restless, at times. sitting up in bed. Has vomited several times: bowels are constipated. Is out up, dressed, and taken out, some days. May 8/96. Wt 119 lbs. May 10/96. Crying, a number of times, during day. will not eat voluntarily: has to be fed: requires frequent enemata for bowels. Still vomits, at times. May 19/96. Has been treated by salt-solution injections in hips. Is very quiet: despondent & crying, at times. May 23/96. Wt 116 lbs. Goes out occasionally: May 23/96. Still treated by injections. Still very quiet: though seems some brighter, at times. Eats voluntarily. May 26/96. Wt 115 lbs. May 28/96. Restless, most all day: could not get him to eat. Is up & out, some days: May 31/96. No change specially noticeable: despondent & crying at times. June 2/96. Patient in bed: very quiet: will not eat voluntarily: refuses to talk: Is taken out on grounds. When attempt was made to feed with tube, he drank some eggnog, today. June 3/96. Wt 107½ lbs. June 4/96. No change noticed. Seems to sleep well, nights. Is taken out daily. June 7/96. appears about same from day to day. out on grounds, often. June 30/96. Is becoming restless of late: otherwise, about same

See Folio 70

Personal and Medical History of Elling. E. Larson.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4333
Residence, Minneola, Goodhue County
Date Admission, 27th February 1895.
Admitted by Dr. Phelps Hour, 2 PM.
How Sent, Axel Haller, Jo P. Goodhue County
Sex, Male
Age, 29
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Laborer
Degree Education, Common School
Profession Religion, Lutheran
Habits, Probably not good: his father drank
Nativity, Wisconsin (Parents born in Norway).
Physicians Committing, M. Juell and J. O. Anderson
Correspondents, None given in papers
Elling Larson Hader Goodhue Co Minn.

No. for Year, 161
Insane Relatives, Yes: a niece
Cause Exciting, probably head-injury & masturbation
Cause Predisposing, Heredity
Form, Melancholia acuta
Accompanying Bodily Disorder, nervous depression
Suicidal or Not, Yes by hanging: propensity active.
Date of this Attack, Latter part of Dec. 1895
Duration, about 2 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 29
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Slightly confused by delusions.
Quick or Sluggish, Some slow.

MEMORY:
Past Events,
Recent Events, Seems fair.
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Rather dull.
Correct or Illusive,

REASONING POWER:
Ordinary Subjects, Dulled.
Own Mental State, Poor
Special Subjects,

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

DELUSIONS:
Systematized or Not, Rather systematized
Special Subjects, of persecution
Transitory or Not,

HALLUCINATIONS: None noted
ILLUSIONS:

CONVERSATION:
Coherent or Incoherent, Steady & coherent. Deluded
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Had tough time for 5 yrs. working on railroad. Came home couple of months ago because scared home. Some unknown persons after him. First idea of this was last Fall. Before this had thought had done things wrong. Had been laboring man. Wandered about Country for many years. Wants to be prayed for & said. Says has done wrong.

Personal and Medical History of Elling. E. Larson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft 2½ in. WEIGHT, 175 lbs. NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Some. Coatings, None. Promptness Movement, Fairly so.
PUPILS, Equality, Equal. Size, Normal.
Response Light, Respond. Accommodation,
SIGHT, Good
HEARING, Fair
COORDINATION, Arms, Fair. Gen. incoordination.
Legs,
TREMORS, Hands, Steady Tongue,
Facial Muscles, General, Yes.
REFLEXES, Patellar, 8-9 Eq.
Other
ARTICULATION, Fairly good.
Slurred,
Hesitating,
FACIAL EXPRESSION,
Melancholy only.
SENSIBILITY,
HEART, Normal. Beats strong & accentuated.
LUNGS, Normal.

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium, ✓	Poor,
SLEEP, Good, 3 hrs. 1st night.	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, 66)60 (v.m.) 71 F. ae. a. 39 Bi. a. 37 Fron. d. 17 Aut. p. d. 209 Bi. d. 15.3 Fac. L. 13.
HISTORICAL,
LENGTH OF INVASION, 1 yr. approx. ONSET GRADUAL OR SUDDEN, Gradual, very
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, dead. Was told mother was killed.
Father or Pat. Relations, Living
Brothers or Sisters, Had sisters daughter was in St. Peter. Sister had fits

Personal and Medical History of *Elling E. Larson*

1896

This patient was brought here by Deputy Sheriff P. J. Lundquist & attended by Oscar Hagquist, with following history. Patient is in fair physical condition - No history of Consanguinity, but some hereditary; a niece having been insane. This is the 1st attack; Symptoms manifested in latter part of December 1895: imagined people wanted to kill him. Disease appears to be increasing; variable, but no rational intervals. Derangement is now shown in fact he is afraid everybody wants to kill him. Is not disposed to injure others but has attempted suicide by hanging & propensity now active: no filthy or destructive habits. Before the accession of the disease he masturbated & after he was so. Has been troubled with nervous depression. His father drank. Patient had a wagon wheel run over his head, when 8 years old. He has not been restrained or confined. Don't know Cause of Disease. Has had no treatment. Appears depressed says people have been following him & shooting around him.

Feb 27 On admission was Sutton B3 (G.H.R. R.H. Complexion dark: hair dark. brown: eyes blue: condition of skin good: no mark, 4 inches long, back of left ear & a cut, 2 inches long, on top of head: bruises on left leg. Is dirty. Behavior quiet). Pulse 92. R 22. T◎ 100 6/5

" 28 Feb 28/96. Slept 2 hours, restless 6 hours, last night. (Cut on head dressed by Dr. H.) Am. Pulse 80 R 20 T◎ 100. PM. Pulse 84 R 20 T◎ 99.8 Bowels active: Is on regular diet: behavior

" 29 quiet: is melancholy: no pain or cough. Feb 29/96. Slept 5 hours, restless 4 hours, last night. 9 Am. P 96 R 22 T◎ 99.6 bowels still active. Transferred to I W at 11.00 am very quiet & depressed. Given bath & put to bed. Appetite fair: given extra diet. 7.30 Pm. Given a hot bath.

Mar 1 Mar 1/96. Slept only 4 hours, last night. Lies very quietly in bed. Bowels moved twice, today.

" 2 Mar 2/96. Slept 6 hours, last night. Urinates regularly. 1.30 Pm. Given a hot bath. 4 Pm. Complains of pain in chest. Patient believes he has committed an unpardonable sin: Alleges buggery

" 3 with Cattle 17 years ago. Mar 3/96. Slept 7 hours. Complains of pain in chest & head:

" 4 No change otherwise. Eats well. Bowels move. Mar 4/96. Slept well (9 hours). Eats well. says he feels weak, this morning. Out of bed frequently, during day. Talks very little.

" 5/6 Mar 5/96. Slept 6 hours: Eats well: bowels move: no change noticed. Mar 6/96. Slept 7 hours. Does not seem as well as usual, this morning: Complains of pains over entire body. Very

" 7 quiet. Wt, today, 176 5/8 lbs. Mar 7/96. Slept well: has slight headache: Is very quiet: 3.00 Pm. Elec-

" 8 - tricity applied by physician. Was very quiet, remainder of day. Mar 8/96. Slept well: very quiet: no complaints: appears melancholy: Pm. No change to night. Eats well: bowels move.

" 9 Mar 9/96. Slept 6 hours: Am. No change: Pm. Very quiet, all day. Wound on head almost entirely

" 10 healed. Mar 10/96. Slept 5 hours. Seems some brighter this morning. Pm. Well behaved, during

" 11 day: no complaints. Mar 11/96. Slept 7 hours. Is unusually bright, today: talks quite rationally.

" 12 Mar 12/96. Slept 7 hours. Very quiet & despondent, today. 10.00 Pm. up & dressed. Behavior good, while up. Summary: Behavior good, throughout. Was very quiet & would seldom talk, unless spoken to. Has seemed strong, physically, but complained of pain in Chest & head on 4th & 5th days; of weakness, on 6th day & which continued until 12th day, when he became bright and somewhat talkative. Remained so, until 14th Day, when he again became quiet & apparently despondent: Appetite has been good: Slept fairly well: bowels active, till 3rd day, when they moved by aid of physic: have moved irregularly since. Temp. a trifle above normal. When received

Personal and Medical History of *Elling E. Larson*

1896

was believed to be of a suicidal nature, but made no attempts at suicide, while on ward. Mar 13/96. Att 1768.

Mar 13 ate a good breakfast. Given Tablets 7.30 & 10.30. Urinates: bowels move. Is on regular & extra diet: Quiet

" 18 and well - behaved, this morning. 11.00 am. Transferred to B3. Mar 18/96. Patient is melancholy: frequently

" 31 talks of suicide: behavior fair. Talks quite rationally: no delusions noticed. March 31/96. Condition

Apl 2/96 does not seem to change any. April 2/96. Wt 184 lbs. PO. Apl 16/96. Remains in same condition,

" 30 apparently, day after day. Frequently tries to escape: is under continual surveillance, while out of doors. Tries to open doors in hall, every day. Says "I want to kill himself". Apl 30/96. Sleeps well: appetite fair: (is on regular diet): No change, of late, noticed. Is very quiet: melancholy: talks of suicide, frequently. Goes out on grounds, daily. Works in hall some.

May 96 to Aug 96 Summary Nurses Notes by Dr Phelps. Patient rather restless, surly & cranky. Has delusion ideas on account of which he seems rather irritable as he thinks people are bothering him. Usually is rather despondent & talks of suicide: Has tried to escape several times: Is obstinate & lazy. Continues same at end of period.

Aug 97 Wt. 195 lbs Is restless & uneasy; uncertain in talk; easily irritated & scolds but is not usually violent. Jan. 1 '99 Visited by friends. During period has maintained almost steadily the same irritable behavior with delusions of persecution & apparently violent intentions altho he rarely gets into trouble.

Feb 1 - July 31 '99. (Dr Various) Wt. 177 lbs. Believes he is much abused: Has delusions of persecution. says someone is eating his heart out. Has habit of decorating himself with various articles. Complains of being disturbed at night. Claims that Nurse Allen is his persecutor. Aug 1 - Jan 31 1900 (Dr Chapple) Wt. 192 lbs. No change of note during period. Physical condition has been very good: Is very much deluded & frequently talks in a threatening manner because "people are troubling him". Occasionally is pugnacious towards an ward: Habits tidy. Feby 1900. Wt 186 lbs Peg. July 1900. vaccinated: result good.

July 31. No change, in any way. Health very good. Eats & sleeps well: works in ward: bowels regular. Has delusions of persecution & hallucinations. Speech very irrational & incoherent. Talks a good deal to himself & at times abusive to others. Thinks people are trying to kill him & injure him in various ways. Habits quite tidy. Stays in his own room, most of time. Aug 1. Wt 184 lbs - Nov 30. Nothing special to report. Jany 31 1901. Works in ward: health good: very irrational & incoherent: at times, becomes extremely noisy: has numerous "delusions of persecution" - occasionally threatening to nurses & others: habits tidy. Feby 1900 186 lbs. May 1900 189 lbs. Aug 1. 1900 196 lbs. Nov 1 1900 Wt 185 lbs - Nov 30. Visited by friends. Jany 31/01 - No change noticeable during year. has been in excellent health: usually, very well - behaved: stays in room, most of time: works well on ward: very irrational, when addressed: cursing & scolding about those who torment him.

Jan 31 '02 - Jan 31 '03 (Dr. Chapple) Has worked some on ward, but is surly & morbid and usually says he is not well. Says something is the matter with his head - usually quiet; but at times becomes abusive and threatening.

Personal and Medical History of Herbert A. Kinney.

HERBERT, PICKAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4336.

Residence, Minnesota

Date Admission, 29th February 1896

Admitted by D. C. B. Ely Hour, 5th P.M.

How Sent, Wm B. Chadwick Jo P. Steele County

Sex, Male

Age, 25 years

Civil Condition, single

Children,

Age Youngest Child,

Occupation, Laborer

Degree Education, Common School

Profession Religion, none

Habits, not intemperate

Nativity, Canada: (parents born in Vermont).

Physicians Committing, C. E. Bigelow and W. C. Eustis

Correspondents, J. W. Kinney is brother: lives at Austin Minn: with whom correspondence may be had.

No. for Year, 164.

Insane Relatives, none

Cause Exciting, masturbation

Cause Predisposing,

Form, Pubescent Insanity

Accompanying Bodily Disorder, none mentioned

Suicidal or Not, Not

Date of this Attack, several weeks ago

Duration, several weeks

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 24 (past)

Time of Leaving, June 5-7. 1898

Time in Hospital, 2 yr. 3 m. 29 d.

Result, Discharged Nov. 9. '98 Unimproved.

EXAMINATION ON ADMISSION.

Exd by D. Herzog, March 3/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, fairly clear

Quick or Sluggish, very slightly sluggish

MEMORY:

Past Events, good

Recent Events, seems good

Special Subjects, evidently is particular to be accurate -

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, good

Own Mental State, seems good

Special Subjects,

EMOTIONAL STATE:

~~Normal~~, Calm,

~~Indifferent~~,

~~Exalted~~,

Depressed, very slightly, introverted thus normal.

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not, none noted

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, fairly coherent

Voluble or Reticent, quite voluble.

GENERAL DESCRIPTIVE REMARKS:

Patient is anxious to show himself sane & is careful in his conversation & manner. He speaks with an Eastern accent and is rather slow & deliberate. He has a habit of repeating last words of phrase, then going on to the next. He tells of his actions since leaving home, of where he has worked & how long, with minutiae. He denies all personal & indecent proposals & says anyone so conducting themselves must be "wrong". He complains of pain in left testicle which he attributes to a gonorrhoea which he had not discharged for nearly 4 years. Has slight varicocele. Admits masturbation denies excessive practice -

Personal and Medical History of Herbert A. Kinney

EXAMINATION ON ADMISSION, CONTINUED.

H.A.Kinney.

Feb.10th,'96.--- Brother states case is of six or seven years standing; at certain intervals he made some trouble in his way of talking around his uncle's house and the uncle did not want to trust him there.

impaired: partly academic

HEARING,

COORDINATION, Arms, good: finger & nose, eyes shut, good.

Legs, good: standing on foot, good: standing, eyes shut, good.

TREMORS, Hands, No Tongue, slight

Facial Muscles, No General, No

REFLEXES, Patellar, 9 = equal EXAM. URINE,

Other abdominal reflex equal: Cremasteric normal: very slight ankle clonus

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION, always quite intelligent: eyes somewhat shifty - slightly worried. -



SENSIBILITY,

HEART, Sounds are good, but slightly softened -

LUNGS, Seem good on a casual examination -

TAKEN,

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,

mother & father both living: says all family healthy -

Personal and Medical History of Herbert A. Kinney.

HERBERT, PICARD & CHAMBERS, DAVENPORT, IOWA

Whole No. 4336.
Residence,
Date Admission, 29th
Admitted by D. C. B.
How Sent, Mrs B. Cha
Sex,
Age,
Civil Condition,
Children,
Age Youngest Child,
Occupation, Laborer
Degree Education, Common School
Profession Religion, none
Habits, not intemperate
Nativity, Canada: (parents born in Vermont).
Physicians Committing, E. E. Bigelow and W. C. Eustis
Correspondents, J. W. Kinney is brother: lives at Austin Minn: with whom correspondence may be had.

No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 24 (past)
Time of Leaving, June 27. 1898
Time in Hospital, 2 yr. 3 m. 29 d.
Result, Discharged Nov. 9. '98 Unimproved.

EXAMINATION ON ADMISSION.

Exd by D. Herzog, March 3/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, fairly clear
Quick or Sluggish, very slightly sluggish
MEMORY:
Past Events, good
Recent Events, seems good } evidently is particular to be accurate -
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, Correct
REASONING POWER:
Ordinary Subjects, good
Own Mental State, seems good
Special Subjects,

EMOTIONAL STATE:
~~Normal~~, Calm,
~~Indifferent~~,
~~Exalted~~,
Depressed, very slightly, but more than usual.
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, } none noted
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, fairly coherent
Voluble or Reticent, quite voluble.

GENERAL DESCRIPTIVE REMARKS:
Patient is anxious to show himself sane & is careful in his conversation & manner. He speaks with an Eastern accent and is rather slow & deliberate. He has a habit of repeating last words of a phrase, then going on to the next. He tells of his actions since leaving home, of where he has worked & how long, with minuteness. He denies aspermia & indecent proposals & says anyone so proposing themselves must be "wrong". He complains of pain in left testicle which he attributes to a gonorrhoea which he had for nearly 4 years. Has slight varicocele. Admits masturbation denies excessive practice -

Personal and Medical History of Herbert A. Kinney

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 10½ WEIGHT, 172 lbs. (usual 170-175) NUTRITION, somewhat impaired: ? acne vulgaris
WOUNDS OR ABNORMALITIES, very slight ptosis: acne vulgaris. —
TONGUE, Tremors, slight Coatings, light grayish white Promptness Movement, prompt
PUPILS, Equality, left slightly larger Size, right about normal
Response Light, somewhat sluggish in both eyes; left slightly more so } Accommodation, Do — Do
SIGHT, good —
HEARING, good —
COORDINATION, Arms, good: finger to nose, eyes shut, good.
Legs, good: standing upon foot, good: standing, eyes shut, good.
TREMORS, Hands, No Tongue, slight
Facial Muscles, No General, No
REFLEXES, Patellar, 9 = equal EXAM. URINE,
Other abdominal reflexes exaggerated: cremasteric normal: very slight ankle clonus
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION, appears quite intelligent: eyes somewhat shifty — slightly worried. —
SENSIBILITY,
HEART, Sounds are good, but slightly softened —
LUNGS, seem good on a casual examination -


4336

TAKEN,

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 & father both living: says all family healthy —
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Herbert A. Kinney.

1896

This patient was brought here by Sheriff J. Z. Barnard, with following history. Patient is in good physical condition. There is no history of consanguinity or heredity. This is Patient's has not been in hospital before. First symptoms of this attack were manifested several weeks ago, by loss of memory, low spirits, improper conduct towards women. The disease seems increasing; variable with rational intervals, but these not at regular periods. Derangement now shown as the subject of sexual relation with women. Patient is not disposed to injure others, nor suicidal: 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 a head-injury. He has not been restrained or confined. Supposed cause of disease is masturbation. He has had no treatment. Nothing further specially noted. Except the general appearance. Comments on cases of masturbation; and that he lately indulged in improper conduct towards girls & women, publicly.

Oct 29 / Mar 1 — On admission, was put on B3 (G.H.N. Rpt. Complexion light: hair light, eyes blue: condition of skin not good: no marks scars or bruises noticed. Is clean: behavior good). Mar 1/96. Disturbed and slept none, last night. Ate. Bowels moved. He talks rationally: no delusions or hallucinations noticed. He is afraid of other patients. Pulse & temp. about normal. Mar 2/96. Slept 8 hours, last night. Behavior good: talks hesitatingly: repeating much of what he says: ate regular diet & eats well.

" 2 — Mar 3/96. Slept 6 hours. Appears slightly confused: says he dont like to associate with the patients.

" 3 — Mar 4/96. Slept well (8 hours), last night. Behavior good: talks quite well: no delusions or hallucinations noticeable. Mar 5/96. Slept 8 hours. Behavior as before. Talks rationally, though a little unsteady. Mar 6/96. Bowels regular. Pulse about normal. Complains of being slightly lame in right foot, having run a nail into it, before he came here. Mar 7/96. Sleeps well: goes out walking daily. Is quiet & well-behaved. Mar 8/96. Is on regular diet: Eats well.

" 4 — " 5 — " 6 — " 7 — " 8 — " 13 — Bowels regular. Walks a little lame on right leg. Mar 13/96. Pain lacerated, patient has been resting & sleeping well at night. Has been up & about, daily: clean tidy & well behaved of good personal habits. Makes no complaints. Talks rationally: no delusions or hallucinations noticed: apparently, mental faculties are in good condition, though he talks & laughs to himself occasionally, but is quite reticent when asked as to his reason for doing so. Mar 14/96. Moves to C3

Summary: Patient has been quiet and well-behaved, during past two weeks. Has eaten & slept well: bowels in good condition. Talks well & rationally, when conversing, though in a drawling and hesitating manner. Talks & laughs occasionally, when he is alone & thinks none will notice him. Is apparently somewhat foolish. Habits neat & clean. Has a peculiar manner of carriage: throws his chest out & shoulders back, but in a manner to bring his stomach quite forward, making a rather curved appearance. Mar 17/96. No special change noticed. Mar 30/96. Is troubled with his stomach: Complains of its feeling sore. Does not eat very much: has had pains in abdomen & testicles & was compelled to be in bed, nearly all the time, for several days. He is quiet and orderly. Talks & laughs to himself, a great deal & is quite simple. Memory good: no delusions noted. April 1/96. Wt 166 pds. P 84. Apl 6/96. Is feeling better, the last few days. Does not complain of pains. Appetite improving (Is on extra diet). Apl 10/96. Appetite is regular: at one meal, he will eat heartily, then perhaps go two meals without eating anything. Makes no complaints. Apl 30/96. No change specially noticed. Is lazy & indolent. No improvement noted, mentally.

Apl 1/96 — " 30

Personal and Medical History of H. A. Kinney.

May 1/96 & Aug/97 — Summary Nurses Notes by Dr Phelps. During May '96 patient was thought to be improving somewhat in mental state: however, was simple & silly in manner during June & July. Appeared fairly well tho talked to himself some. Latter part of '96 grew somewhat worse mentally: rather less able to talk in an intelligent way & careless about his appearance. During '97 this has grown upon him & he is demented in appearance & in behavior: later appeared much more silly than formerly.

Aug 29/97 — Wt. 170#. Is beginning to be very untidy: Will not keep buttons on & clothing is torn & disordered. Dec. 2 Wt. 171#. No better in behavior: June 29 Went home with brother. Has gained a good deal in appearance of late but still shows considerable dementia.

Discharged.

4349 — James Reynolds — From Folio 100

Aug 1/97 — Patient lying quietly in bed on Infirmary: Temperature at times above Normal. Sept 1 Wt. 116#. Temp. occasionally up to about 100-101. Oct 1 Wt. 114# Lies quietly in bed. Of late will at times answer some questions. Nov. 1 Wt. 125 Rather stupid & inactive but quiet & well-behaved. Has appearance of very thorough dementia. Dec. 1 Wt. 127# 18 Up on ward. Jan 16/98 Again in bed. Always dull, stupid & inactive. Jan 6 Wt. 138# Feb 1st 119# Apr 1 115# Still lying quietly in bed. June 1st Wt. 128# Oct 1 Still in bed. No change. Jan 4/99

Jan 14/99 — Recently has been having some rise of temperature. Died today at 11:20 AM. Visited on 13th by brother. Visited by priest on 11th. Up to last few days little change in his condition. Failed toward last quite rapidly.

Died.

Personal and Medical History of Charles Panzer

EGBERT, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4337.
Residence, Steele County, Minnesota
Date Admission, 2nd March 1896.
Admitted by Dr. Phelps Hour, 6 35 P.M.
How Sent, Wm. B. Chadwick, Jo P. Steele County
Sex, Male
Age, 40 years.
Civil Condition, Divorced man
Children, one boy
Age Youngest Child,
Occupation, Laborer
Degree Education, Common School
Profession Religion, Yes: Lutheran
Habits, not stated: uses tobacco —
Nativity, Germany: (parents also born there).
Physicians Committing, E. E. Bigelow and W. C. Eustis
Correspondents, None given in papers

No. for Year, 165.
Insane Relatives, None
Cause Exciting, "Delusions"
Cause Predisposing, not given
Form, Paranoia
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, — not — but will injure others.
Date of this Attack, about 1st November 1895
Duration, about 4 months
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 40.
Time of Leaving,
Time in Hospital,
Result,

"Original Examination" filed with Commitment papers

EXAMINATION ON ADMISSION.

Exd by D. Herzog, March 4/96.

MENTAL CHARACTERISTICS.

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

MEMORY:
Past Events, } seems good
Recent Events, }
Special Subjects,

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

REASONING POWER:
Ordinary Subjects, good
Own Mental State, good.
Special Subjects,

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

DELUSIONS:
Systematized or Not, } see note
Special Subjects, }
Transitory or Not, }

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, fairly voluble.

GENERAL DESCRIPTIVE REMARKS:

Patient creates a favorable impression. His reasoning powers, even in regard to his alleged delusions is good. He is stated in "papers" to have been eccentric & probably was. Came to this County in 1873. In 1876 bought the S½ of SW¼ Sec 11. Somerset Township (the disputed property) for $700. In 1880, gave contract to his father (of which he kept a duplicate but has since lost it) whereby his

Personal and Medical History of Charles Panzer

Charles Panzer.

Feb.10th'96.---Letter from Judge of Probate and from Thomas Schmidt confirm the idea that this idea of Panzre's by which he claims to own his father's farm has just come up during his last stay at home; That the deed was made out in regular style, and recorded, and that therein it is shown that Carl never said anything otherwise until recently; that the father and four or five brothers are all said to be "queer"; That they know of no further delusive ideas except this one; that he was going to seemingly keep the farm in spite of all evidence to the contrary in consequence of which patient was committed here. No previous attack, and no consumption known in the family.

patient & his father - patient shortly afterwards went again to the far-West, where he remained until last December. He found the brother claiming the property via deed from the father. Patient has attempted to get an abstract of title, without success. Has consulted lawyers: was deterred from action by high fees. On advice, attempted to move some furniture in, on Saturday last. Has no idea of persecution: makes no threats: says "he want the matter decided & if the court decides against him he is willing to let it drop". -

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, mother dead: about 60: Cause unknown:
Father or Pat. Relations, father living: 70: healthy.
Brothers or Sisters, 4 brothers living, healthy: 2 sisters living, healthy: one brother dead: accident.

Personal and Medical History of Charles Panzer

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4337. No. for Year, 165.

Residence, Steele C

Date Admission, 2nd Ma

Admitted by D. Pfe

How Sent, Wm. B. Cha

Sex, Ma

Age, 40

Civil Condition, M

Children,

Age Youngest Child,

Occupation,

Degree Education, Co

Profession Religion, Yes:

Habits, not stated;

Nativity, Germany;

Physicians Committing, E. S. Bigelow and W. C. Curtis

Correspondents, None given in papers

(Original Examination filed with Commitment papers)

EXAMINATION ON ADMISSION.

Dr. by D. Herzog, March 4 96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, — Clear —

Quick or Sluggish, Quick

MEMORY:

Past Events, } Seems good

Recent Events, }

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, correct

REASONING POWER:

Ordinary Subjects, good

Own Mental State, good.

Special Subjects,

EMOTIONAL STATE:

Normal, Calm, Yes

~~Indifferent~~,

~~Exalted~~,

~~Depressed~~,

DELUSIONS:

Systematized or Not, } see note

Special Subjects, }

Transitory or Not, }

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, fairly voluble

GENERAL DESCRIPTIVE REMARKS:

Patient creates a favorable impression. His reasoning powers, even in regard to his alleged delusions is good. He is stated, in "papers" to have been eccentric & probably was. Came to this County in 1873. In 1876, bought the S½ of SW¼ Sec 11. Somerset Township (the disputed property) for $700. In 1880, gave contract to his father (of which he keeps a duplicate but has since lost it) whereby his

Personal and Medical History of Charles Panzer

EXAMINATION ON ADMISSION CONTINUED.

his father was to have the use of the property, rent free, for as long as he could manage it. His father paid him $60 for the stock & implements &c. Good.

Here is where the difficulty Commences. His brother claims that, at this time, the farm was deeded to the father. Patient worked on shares for 2 years; then bought ½ a farm with his wife's brother. In 1885 his wife left him & he sold his share. Since then he has worked at various things, usually going harvesting & Dakota until 1889, when he went to Oregon. He stays in the far West until '93 when he returned. The brother was then living on the disputed property, but did not claim it. Patient states that they had Conversation in the Probate Court concerning it, where the brother admitted that there was a contract between patient & his father. Patient shortly afterwards went again to the far West, where he remained until last December. He found the brother claiming the property on a deed from the father. Patient has attempted to get an abstract of title, without success. Has consulted Lawyers: was deterred from action by high fees. On advice, attempts to move some furniture in, on Saturday last. Has no idea of persecution: makes no threats. Says he wants the matter decided & if the Court decides against him he is willing to let it drop". —

Good.

Prompt

Exaggeration.

Good.

M. URINE,

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, mother dead: about 60: Cause unknown:

Father or Pat. Relations, father living: 70: healthy.

Brothers or Sisters, 4 brothers living, healthy: 2 sisters living, healthy: one brother dead: accident.

Pro.

Habits,

Nativity,

Physicians Comm.

Correspondents,

"Original Examination" filed with Commitment papers
Dr. Ely D. Herzog, March 4th

ADMISSION.

TERISTICS.

MENTAL ACTIVITY:

Clear or Confused, — clear

Quick or Sluggish, Quick

MEMORY:

Past Events, } seems good

Recent Events, }

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, correct

REASONING POWER:

Ordinary Subjects, good

Own Mental State, good.

Special Subjects,

EMOTIONAL STATE:

Normal, Calm, Yes

~~Indifferent~~,

~~Exalted~~,

~~Depressed~~,

DELUSIONS:

Systematized or Not, } see note

Special Subjects, }

Transitory or Not, }

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, fairly voluble.

GENERAL DESCRIPTIVE REMARKS:

Patient creates a favorable impression. His reasoning powers, even in regard to his alleged delusions is good. He is stated, in papers to have been eccentric & probably was. Came to this County in 1873. In 1876, bought the 5½ of SW¼ Sec 11, Somerset Township (the disputed property) for $700. In 1880, gave contract to his father (of which he kept a duplicate but has since lost it) whereby his

Personal and Medical History of Charles Sanzer

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 10in WEIGHT, not taken NUTRITION, Good.

WOUNDS OR ABNORMALITIES, see "G. H. N. Report" — Pannus of left eye.

TONGUE, Tremors, Quite marked Coatings, Yellowish over dorsum quite heavy Promptness Movement, Prompt

PUPILS, Equality, Equal Size, Slightly contracted.

Response Light, slightly exaggeration Accommodation, slightly exaggeration.

SIGHT, Good: —

HEARING, Good —

COORDINATION, Arms, Good: finger to nose, eyes shut, good.

Legs, Good: standing at foot, good: Standing, eyes shut, good.

TREMORS, Hands, Some. Tongue, quite marked —

Facial Muscles, Slight twitching General, —

REFLEXES, Patellar, 7 - 8: Equal

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

Good -

SENSIBILITY,

HEART, somewhat rapid: impulse forcible: sounds good: slightly forcible

LUNGS, seem good

EXAM. URINE,



TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Report kept	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, mother dead: about 60: Cause unknown:

Father or Pat. Relations, father living: 70: healthy.

Brothers or Sisters, 4 brothers living, healthy: 2 sisters living, healthy: one brother dead: accident.

Personal and Medical History of *Charles Panzer*

1896

This patient was brought here by Sheriff Barnard + attended by Mr. Jorson, with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is 1st attack, symptoms manifested at his brother's (reclaimed that he owned the brother's farm, about the 1st of November 1895. Disease seems increasing; variable with rational intervals, but these at irregular periods. Derangement is now shown in that he think that he owns farm, when there are no grounds for thinking so. Patient is disposed to injure others, but is not suicidal, nor of filthy or destructive habits. Previously, he was eccentric; his wife left him 8 years ago, for which he got a divorce. He uses Tobacco. Has not been subject to any severe disease or head injury. Has not been restrained or confined. Supposed cause of the disease is "Delusions". He has had no medical treatment. He now believes that he still owns a farm, that he deeded, in 1888, to his father. No further particulars given. —

Mar 1 — On admission, was put on B3 (G.S.W.R.P.P.). Complexion dark: hair black: eyes brown. — Condition of skin good: no marks, scars or bruises noticed: is clean: behavior is good). —

- 3 — Mar 3/96. Slept 7 hours, last night. Is on regular diet: bowels move: behavior good: talks rationally + well.
- 4 — no delusions noticed. Mar 4/96. Slept 7 hours: appetite good: bowels seem regular: makes no complaints
- 5/6 — out walking, daily. Mar 5/96. Behaves well: appears, and talks rationally. Mar 6/96. Sleeps well
- 7 — nightly. Appetite good: bowels regular. Quiet: out walking, daily. Mar 7/96. Is about as usual.
- 9 — Transferred to C3 East. Mar 9/96. Sleeps well: eats well: bowels regular. Is quiet + well behaved
- 10 — neat + clean: makes no complaints. Physical condition very good. Mar 10/96. Visited by brother,
- 16 — today: was quiet + orderly. Mar 16/96. Has been sleeping 8 hours, nightly, since last noted. Has been up + about, daily. Quiet + well-behaved. Talks rationally: no delusions or hallucinations noticeable. Makes no complaints. Can see nothing wrong with patient. Takes exercise. Works on ward, daily.
- 30 — (see attached Nurse's record). Mar 30/96. Attendant notes as follows: "Can discover nothing wrong with patient: no delusions, other than the one connected with the sale of some lands. Patient claims he still owns the lands + that he never sold them; but, as near as can be ascertained, the lands have been sold and by him. But, whether it is a delusion on his part or that he was swindled + does not know it, I am unable to state. He talks rationally." Is a good worker: goes out walking. Appetite good: no complaints. Apl 1/96. Wt 198 lbs. Sept Apl 30/96. Is very quiet: Talks rationally: no delusions noticeable. Works on ward. Neat tidy + clean in appearance. Never refers to his property, unless questioned.

Apl 1/96 to May 30/96

May 1/96 to Aug 1/96 — Summary Nurses Notes by Dr. Phelps. Quite uniformly the same ever since admission: On talking to him about going home he becomes irritable + talks with slight incoherence: Never asks to go home, never complains, always appears sullen + morose: Never talks to anyone: Most of answers are irrational in form: Noted at times as talking to himself. Wt. 196½ lbs. at end of period.

Aug 2/96 — Wt. 195lbs. Always rather dull + quiet. At times somewhat nervous. Appears sullen + irritable. Is disinclined to talk at all. Acts as if he had hallucinations but will not tell of them. Feb 1/99. Noted as talking to some imaginary being.

Apr 1900 — Visited by friends. Jan 31/99 Wt 202lbs. Still stubborn + quiet + seems to have hallucinations

Personal and Medical History of *Charles Panzer*

1899

Feb 1 to July 31/99 (Dr Warnock) Wt. 201. Has hallucinations + is apparently set in his ideas. May 4. Delusions seems fixed: is exclusive in manner. Aug 1/99 - July 31/1900. (Dr Warnock)

Aug 1 to July 31 1900. Wt. 196lbs. Patient rather sullen + cross. Does not associate with other patients. At times laughs + mutters to himself. Apr 29 Refused to work. Thinks he was wrongfully committed here. July 1. Wt. 196. July 20 Refused to be vaccinated but finally submitted: result successful. Aug 30 Patient is stubborn: generally scolds: talks to himself and goes through motions with head + hands. Oct 30. Oct 30 "Thinks he was wrongfully sent here". Refuses to wear new suit: says "that he is charged with electricity". Nov 22. Visited by friend: refused to acknowledge him. Jany 24/1901

Nov 22 1901 Jan 24 Visited by friend. Panzer thought he was deceiving him. Jany 31. Condition about same. —

Feby Wt 199lbs. Mar 96. Mar 31. Is stubborn, lazy + sulky. Still holds "delusions of persecution".

Mar 31 At times, is abusive - Mayb. "Thinks his clothing is charged with electricity" —

May 22 Visited by friend - May 22. Transferred to B3 - July 31 - No change noticeable —

July 31 Still holds to his "delusions of persecution". Augt 1. Wt 196". Jany 31/02. Patient quiet.

1901 Jany 31 Usually well-behaved; although has a sullen, saidy irritated appearance. Is quite stubborn — has spoken of "Clothing as charged with electricity".

Jan 31 04 (Dr. Phelps) Seems to have been no change in patient during whole period. Is sullen in manner. Generally quiet - makes no requests; no activity of any kind; answers rationally and looks intelligent.

Personal and Medical History of August Peterson #2

EBERT, FISCAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4338.

Residence, 986 Euclid Av. St Paul

Date Admission, 2nd March 1896.

Admitted by Dr Phelps Hour, 6th

How Sent, G. Wilbrich, Jap & Kaus...

Sex, Male.

Age, 28.

Civil Condition, Single

Children, None

Age Youngest Child, —

Occupation, Dry Goods Clerk

Degree Education, Common school Education

Profession Religion, Not a church member

Habits, not intemperate.

Nativity, Sweden: (Parents also born there).

Physicians Committing, Eugene Hubbell & F. A. Cause Margin

Correspondents, None seen in papers

August Peterson (admitted Mch 7)
Mrs. Anna Hennig
918 Fremont St.
St Paul, Minn

Age First Attack, — 23 —

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. by R. M. Phelps 10/16/96

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 young. On coming here had mild maniacal confusion. Later got quite rational but not entirely well. Then got "off" again became maniacal silly & confused. Lately has been in state of stuporous melancholia. For past 2 days has been talking some. The cyclical tendency seems evident.

Personal and Medical History of August Peterson #2

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 10in WEIGHT, not taken NUTRITION, Rather poor nourishment. Skin. not very good condition

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Reddish & sore looking Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, N. Accommodation,

SIGHT, Normal.

HEARING,

COORDINATION, Arms, — In bed but no impairment has been noted in his stay here.

Legs,

TREMORS, Hands, None of note. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,



TAKEN,

SENSIBILITY,

Arteries - Normal.

HEART, Normal.

LUNGS, Normal

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, L.(K.)59 (V.m.)67½ N.se.a.37 Bin.a.34½ Ant.p.d.19.5 Fram.d.15 Bin.d.13 Fac.L.11.5

HISTORICAL, Typhoid fever when a boy. — Drinks much drinking

LENGTH OF INVASION, Some months & years. ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Living

Father or Pat. Relations, " Healthy

Brothers or Sisters,

Personal and Medical History of August Peterson #2

EGBERT, FIDLAR & CHARGERS, DAVENPORT, IOWA

Whole No. 4338.
Residence, 986 Euclid Ave St Paul.
Date Admission, 2nd March 1896.
Admitted by R. Phelps Hour, 6 P.M.
How Sent, J. Wilbrich, Jail Ramsey County
Sex, Male.
Age, 23.
Civil Condition, Single
Children, None
Age Youngest Child, —
Occupation, Dry Goods Clerk
Degree Education, Common school education
Profession Religion, not a church member
Habits, not intemperate.
Nativity, Sweden: (Parents also born there).
Physicians Committing, Eugene Hubbell & J. Mann Magnus
Correspondents, None given in papers

No. for Year, 166.
Insane Relatives, None
Cause Exciting, Unknown
Cause Predisposing, not given
Form, Puberal Insanity
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, — not — but will injure others
Date of this Attack, 26th Febry 1896.
Duration, about 5 Days.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 23 —
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by R. M. Phelps 10/16/96

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 young. On coming here had mild maniacal confusion. Later got quite rational but not entirely well. Then got "off" again became maniacal silly & confused. Lately has been in state of stupour melancholia. For past 2 days has been talking some. The cyclical tendency seems evident.

Personal and Medical History of August Peterson #2

ADMISSION, CONTINUED.

HARACTERISTICS.

Taken NUTRITION, Rather poor now.
Skin. Not very good condition
ch & eye losing Promptness Movement,
Size, Normal.
Accommodation,

o impairment has been noted in his stay here.

TREMORS, Hands, None of note. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION, Good.
Slurred,
Hesitating,
FACIAL EXPRESSION,



SENSIBILITY,
Arteries - Normal.
HEART, Normal.
LUNGS, Normal

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, L.(L.)59 (r.w.)67½ N. o.c.a. 37 Bm.a. 34½ Ant.p.d. 19.5 Trans.d. 15 Bm.d. 13 Fac. L. 11.5
HISTORICAL, Typhoid fever when a boy. — Drinks much drinking
LENGTH OF INVASION, Some months & years. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Drinks
Mother or Mat. Relations, Living
Father or Pat. Relations, " Healthy
Brothers or Sisters,

Personal and Medical History of August Peterson #2

1896

This patient was received here at the hands of Deputy Sheriff M.H. Goss, with following history of case. There is no history of consanguinity nor heredity. This is 1st attack; has not been in hospital before: symptoms manifested Feby 26th 1896. Disease seems increasing. Not variable: no rational intervals. Derangement now shown by an exalted state of feeling. Delirious; provoking; violent. Patient is disposed to injure others, but not suicidal. Propensity not active. No filthy or destructive habits. Previously, he manifested impressions of some semi-religious character. There is no history of intemperance in self or parents. Has had no severe disease &c & head injury: has been only confined since March 1st. Supposed cause of the disease, unknown. Has had no medical treatment.

Mar 2 On admission was put on B2 (G.N.N.Rpt. Complexion light: hair light: eyes blue: condition of skin good: no marks, scars or bruises noticed: is clean: behavior good, but he is very talkative). Mar 3/96. Slept fairly well, last night. 8 Am. Pulse 100 R 20 Te 98.2. Has delusions of having superhuman curative power. Tried to elope, today: was caught and brought back. Transferred to I.W. at 5.30 PM: was in an excited condition. Was put to bed.

" 4 Ate a good supper: 9 PM. Was given hot bath (Mouth washed daily with Sol. Listerine). Mar 4/96. Slept 8 hours, last night. Is quiet this morning: is on liquid diet: was given hunyadi water: bowels moved.

" 5 Stelay, in an apparently unconscious condition, from 10.30 Am to 2 PM. Appeared excited during P.M. Mar 5/96. Slept 7 hours: very quiet this morning. Acts stupid. Takes Eggnogs freely. Bowels moved twice: Given shower-bath, this morning: a hot tub-bath in PM. also one in

" 6 Evening. Was quite talkative this PM. Has delusions: (see attached letter). Mar 6/96. Slept 8 hours. Quiet & well-behaved, this morning. Talks more rationally than yesterday. Has behaved well during the day. (Wt 144½ lbs.). Mar 7/96. Slept 9 hours. Ate well today: (eggnogs & light diet)

" 7 Urinates regularly: bowels moved: he seems much improved, this morning. Converses rationally - at

" 8 3.30 PM was up, in chair: behaved fairly well. Mar 8/96. Slept 9 hours. Eats well: is on regular & ward diet: (no meat): seems greatly improved: talks rationally on most subjects. —

" 9 Mar 9/96. Slept 8 hours. Is very bright this morning: behavior good. Up, in chair, all of

" 10 afternoon: out doors in chair, for 20 minutes. Mar 10/96. Slept 8 hours. Eats well: very quiet

" 11 and well-behaved, all day. Up & dressed, during afternoon. Mar 11/96. Slept 7 hours. Has slight cold in head, this morning. Quiet & well-behaved. 1.30 PM. Up & Dressed: Talks quite rationally -

" 12 Mar 12/96. Slept 8 hours. 10.00 Given shower bath. Up & dressed: appears to be doing nicely:

" 13 very obedient & quite rational. Mar 13/96. Slept 7 hours. 10.30 am. Up & dressed. Very quiet, all day.

" 14 Mar 14/96. Slept 7 hours. Babed in forenoon: up & dressed, in afternoon: quiet & well behaved, all day.

" 15 Appetite good: bowels move. Mar 15/96. Babed during forenoon: very quiet. 11.20 am. Up & dressed.

" 16/17 out for walk in afternoon. Mar 16/96. No change noted: out for walk in afternoon. Mar 17/96. Very quiet, this forenoon. PM. Up & dressed: quite talkative. Says "he is a business adviser & has some very important business matters to settle in St Paul & wishes to go there as soon as possible"

" 18 Mar 18/96. Up & dressed, for breakfast: seems about the same. Somewhat restless, during the day.

" 19 Mar 19/96. Has been sleeping about 9 hours, nightly, since last noted. Appetite good: bowels quite regular: still holds some delusive ideas. Behavior good: habits neat. Urinates regularly.

Summary: Was received in an excited condition; was subsequently transferred to I.W.

Personal and Medical History of August Peterson #2

1896

Apl 2/96 Was still very excited: put to bed: had a "spell" when he lay seemingly unconscious, for a few hours. Afterwards, became excited; but spent a quiet night: was stupid next day, but brightened up in PM. & was quite talkative. Was up & dressed, a part of each day. Out doors, in chair, on 7th day. Up & Dressed on 8th day & all afternoons following: out walking on 13th & 14th days. Has behaved well. Physical condition has seemed good, throughout. Appetite good: bowels regular. Temperature & pulse about normal

Mar 23/96 Various delusion that he possessed superhuman powers; conversation easily shows derangement of mind.

" 30/96 night. He possesses the power to perceive future events" Mar 31/96 Great what incoherently - Mar 29/96. Sleepwell, at

Apl 2/96 April 2 evening in an excited state of mind, all day - has various delusions; thinks he possesses

" 5 meals very excited, all day. (See nurse's record on file. 9/16).

" 11 in an excitable, some nights. Very excited & restless

" 17 last restant holding & watching. Refuses food & take p. taken. Apl 16/96. 8.30 PM. Has been trying some refuse all nourishment. Apl 11/96. Since

Apl 18/96 dition. Would open eyes long enough to

" 21/96 Has also been quite bright & has talked

" 24/96 but turned not open eyes, while under shock

" 25 nine enema to move them. Has been

" 30 s, has been brighter, but still has

Very he seems to realize all that is going on.

(See ines shower-baths. Refuses food quite often.

May 1/96 Stupid wets his bed. Apl 30/96. 2 PM. Up & out.

" 3 talk ne somewhat emaciated of late, has not

" 7 dition, all day. Out doors in afternoon

bed: May 7/96. Is given an occasional

hour-bath: goes out in afternoons, but requires close watching, as he will stroll away while at

Will not talk, but seems to realize. Everything that happens: requires enemata for bowels. —

" 8/9/13 May 8/96. Wt 138½ lbs. May 9/96. Tried to escape. May 13/96. Some days, seems brighter, but generally quiet & stupid: will not talk: penis somewhat swollen: is given shower-baths: goes out in

" 14 afternoons. May 14/96. Quite bright this morning: given shower bath. 2 PM. jumped out of bed & ran up

" 17 hall: slipped & fell & bruised knee: bathed freely this PM. May 17/96. Keeps quite bright, but will not talk at times: at others, very talkative, but talks quite irrationally. Still tries to escape. Seems improving physically. (Is treated by injecting salt-solution into left buttock). May 21/96. Condition shows

" 21 no special change. May 23/96. Still possesses the idea "that he has super-human powers".

" 23

carried to H8

Rochester 3/3-1896.

Mr. Axel Mystrom
1194 Minnehaha Street.
St Paul Minnesota.

Friend Mystrom,

I have been in the hospital long enough I think, and we have always been pretty good friends. I wished you would come down and bring me home I am getting very home sick. You know I have all my friends in St. Paul and I would be very glad to come back to St Paul again. I have nothing against Rochester as that concern.

Personal and Medical History of *August Peterson* #2

1896

This Patient was received here at the hands of Deputy Sheriff M.N. Goss, with following History of Case. There is no History of Consanguinity nor heredity. This is 1st attack; has not been in Hospital before: Symptoms manifested Feby 26th 1896. Disease seems increasing. Not variable: no rational intervals. Derangement now shown by an exalted state of Imagination; Delusions; Provoking; violence. Patient is disposed to injure others, but not suicidal. Propensity not active: No filthy or destructive habits. Previously, he manifested impressions of some semi-religious character. Has had no severe disease except March 1st. Supposed cause of the disease

Mar 2 On admission, was put on B3 (G.H.N.K. Condition of Skin good: no marks, scars or b

" 3 is very talkative). Mar 3/96. Slept fairly well. Has delusions of having superhuman curative brought back. Transferred to I.W. at 5.30 P.M.

" 4 Ate a good Supper: 7 P.M. Was given hot bath. (8 hours, last night. Quiet this morning. Is some Stelay, in an apparently unconscious Cond

" 5 during P.M. Mar 5/96. Slept 7 hours: very qu freely. Bowels moved twice. Given shower- ba

" 6 Evening. Was quite talkative this P.M. Has de 8 hours. Quiet & well-behaved, this morning. Talke

" 7 during the day. (Wt 144½ lbs.). Mar 7/96. Slept Urinates regularly: bowels moved: he seems muc

" 8 1.30 P.M. was up, in chair: behaved fairly well. regular & ordinary Diet: (no meat): seems greatly im

" 9 Mar 9/96. Slept 8 hours. Is very bright this

" 10 afternoon: out doors in Chair, for 10 minutes.

" 11 and well-behaved, all day. Up & dressed, during cold in head, this morning. Quiet & well-behav

" 12 Mar 12/96. Slept 8 hours. 10.00 Given Shower

" 13 very obedient & quite rational. Mar 13/96.

" 14 Mar 14/96. Slept 7 hours. Babed in forenoon: up & dressed, in afternoon.

" 15 appetite good: bowels moved. Mar 15/96. Babed during forenoon: very quiet. 11.30 A.M. Up & dressed.

" 16/17 out for walk in afternoon. Mar 16/96. No change noted: out for walk in afternoon. Mar 17/96. Very quiet, this forenoon. P.M. Up & dressed: quite talkative. Says "he is a business advisor & has some very important business matters to settle in St Paul & wishes to go there as soon as possible"

" 18 Mar 18/96. Up & dressed, for breakfast: seems about the same. Somewhat restless, during the day.

" 19 Mar 19/96. Has been sleeping about 7 hours, nightly, since last noted. Appetite good: bowels quite regular: still holds some delusive ideas. Behavior good: habits neat. Urinates regularly.

Summary: Was received in an excited condition; was subsequently transferred to I.W.

Rochester is all right as it is. But I dont like to stay here any longer. I know that you do not think me crazy and I am not crazy. You have always been an investigator of natural law, and exact truths. I will let you know what I am at the right time if it is proper for me to do so. All I know I must do that which is right. If I have to go anywhere I must goat the right time. All I will say about my self is that I am beyond Astrologer and medium in my power. I do not say what power this is. If it were proper for me to tell you I would. I must do that which is right. Sometimes some people think that I am doing wrong down here, But I am not. Some of my peculiar actions are liable to do more good to the world and to humanity than you have any Idea of. If I were to disobey certain things and certain movements which I have to do the whole universe is liable to be destroyed. I do not say that it is so. But a truth is a truth what ever it may me I never had any Idea before that right time was as

Personal and Medical History of *August Peterson* #2

1896

Mar 1 Was still very excited: put to bed: had a "spell" when he lay seemingly unconscious, for a few hours. Afterwards, became excited; but spent a quiet night: was stupid next day, but brightened up in P.M. & was quite talkative. Was up & dressed, a part of each day. Out doors, in chair, on 7th day. Up & Dressed on 8th day & all afternoons following: out walking on 13th & 14th days. Has behaved well. Physical condition has seemed good, throughout. Appetite good: bowels regular. Temperature & pulse about normal. Up to 4th day, talked very irrationally & labored under the delusion that he possessed superhuman powers.

" 2 subjects: yet conversation easily shows derangement persists. still believes he possesses the power to perceive future events" day: talks somewhat incoherently. Mar 2/96. Sleepy well, at

" 3 Mar 3/96. Seeming in an excited state of mind, all day- incoherent: has various delusions: thinks he possesses

" 4 Has been very excited, all day (extra record on file. 16). lowly: very restless, some nights. Very excited & irrational required constant holding & watching. Refuses food & have Temp. taken. Apl 5/96. 8.30 P.M. Has been lying 30 am: refused all nourishment. Apl 11/96. Since stupid condition. Would open eyes long enough to in some days. Has also been quite bright & has talked

" 5 bath, today, but turned not open eyes, while under shower. Bowels require enema to move them. Has been baths. At times, has been brighter, but still has es closed, tho' he seems to realize all that is going on. Also receives shower-baths. Refuses food quite often. Habits dirty: wets his bed. Apl 17/96. 2 P.M. Up out

" 6 day. Has become somewhat emaciated of late. Has out & stupid condition, all day. Out doors in afternoon

" 7 quite well, at night. Is given frequent hip-baths.

" 8 talk: is some brighter, at times. Habits are dirty. Lies very quietly in bed: will not talk: appears ted. May 3/96. A little brighter but will not

" 9 en returned to bed: May 7/96. Is given an occasional uris, close watching, as he will shut away, while at

" 8/9/13 will not talk: but seems to realize. Everything that happens: requires enemata for bowels. — May 8/96. Wt 138½ lbs. May 9/96. Tried to escape. May 13/96. Some days, seems brighter, but generally

" 14 quiet & stupid: will not talk: seems somewhat swollen: is given shower-baths: goes out in afternoons. May 14/96. Quite bright this morning: given shower bath. 2 P.M. Jumped out of bed & ran up

" 17 hall: slipped & fell & bruised knee: talked freely this P.M. May 17/96. Keeps quite bright, but will not talk at times: at others, very talkative, but talks quite irrationally. Still tries to escape. Seems suffering physically. (Is treated by injecting salt-solution into left buttock). May 21/96. Condition shows

" 21 no special change. May 23/96. Still possesses the idea "that he has super-human powers".

" 23

Carried to #8

Personal and Medical History of August Peterson #2

1896

This patient was received here at the hands of Deputy Sheriff M.M. Goss, with following history of case. There is no history of Consanguinity nor heredity. This is 1st attack; he has not been in Hospital before: Symptoms manifested Feby 26th 1896. Disease seems increasing. Not variable: no rational interval. Derangement now shown by an exalted state of being deliverous; provoking: violent. Patient is disposed to injure others, but not suicidal. Propensity not active. No filthy or destructive habits. Previously, he manifested impressions of some semi-religious character. There is no history of intemperance in self or parents: Has had no severe disease or head injury: has been only confined since March 1st. Supposed cause of the disease unknown. Has had no medical treatment.

Mar 2 On admission, was ... light: Eyes blue: condition of Skin good: ... avior good, but he is very talkative). Mar ... 2 to 98.2

" 3 Has delusions of having ... was caught and brought back. Transferred ... Was put to bed.

" 4 Ate a good Supper: 7 PM ... ium). Mar 4/96. Slept 8 hours, last night. Quiet ... water: urinates moved. Stelay, in an apparently ... appeared excited

" 5 during P.M. Mar 5/96. ... Takes Eggnogs freely. Bowels moved ... in PM. also ate in

" 6 Evening. Was quite talkative ... Mar 6/96 Slept 8 hours. Quiet & well behaved ... Has behaved well during the day. (Wt 1145) ... (3 eggnogs & light diet)

" 7 Urinates regularly: bowels ... es rationally - at

" 8 30 PM was up, in chair: ... well: Is an regular & this diet: (none ... subjects. —

" 9 Mar 9/96. Slept 8 hours. ... in chair, all of

" 10 afternoon: out doors in Cha ... ell: Very quiet

" 11 and well-behaved, all day ... hours. Has slight

cold in head, this morning. ... quite rationally.

" 12 Mar 12/96. Slept 8 hours. ... be dressing nicely:

" 13 very obedient & quite ra ... sed. Very quiet, all day.

" 14 Mar 14/96. Slept 7 hours. Bab ... well behaved, all day.

" 15 Appetite good: bowels move ... Up & dressed.

" 16/17 out for walk in afternoon. ... Mar 17/96. Very quiet, this forenoon. PM. Up & dressed: quite talkative. Says he is a business advisor & has some very important business matters to settle in St Paul & wishes to go there as soon as possible"

" 18 Mar 18/96. Up & dressed, for breakfast: seems about the same. Somewhat restless, during the day.

" 19 Mar 19/96. Has been sleeping about 7 hours, nightly, since last noted. Appetite good: bowels quite regular: still holds some delusive ideas. Behavior good: habits neat. Urinates regularly.

Summary: Was received in an excited condition; was subsequently transferred to T.W.

Important as it is. Sheriff is liable to be a good many changes in St Paul since I became what am. I do not know. But the people of St Paul will see for themselves. I will say one thing I know which is liable to surprise you. All the former actions of people and words that were spoken had to be spoken. All crimes and murderers which have been committed had to be done. And all people that are crazy had to be crazy.

Personal and Medical History of August Peterson #2

1896

Was still very excited: fist to bed: had a "spell" when he lay seemingly unconscious, for a few hours. Afterwards, became excited; but slept a quiet night: was stupid next day, but brightened up in PM. & was quite talkative. Was up & dressed, a part of each day. Out doors, in chair, on 7th day. Up & dressed on 8th day & all afternoon following: out walking on 13th & 14th days. Has behaved well. Physical condition has seemed good, throughout. Appetite good: bowels regular. Temperature & pulse about normal. Up to 4th day, talked very irrationally & labored under the delusion that he possessed superhuman powers. But after 4th day, talked quite rationally on most subjects: yet conversation easily shows derangement yet.

Mar 22/96. No change noticed. He sleeps well: "Still believes he possesses the power to perceive future events" somewhat incoherently - Mar 23/96. Sleeps well, at ... seemingly in an excited state of mind, all day - ... has various delusions: Thinks he possesses ... very excited, all day. (see Nurse's record on file. 96) ... restless, some nights. Very excited & irrational ... constant holding & watching. Refuses food ... temp. taken. Apl 1/96. 8:30 PM. Has been lying ... refused all nourishment. Apl 11/96. Since ... condition. Would open eyes long enough to ... up, has also been quite bright & has talked ... but turned not open eyes, while under them ... require enema to move them. Has been ... times, has been brighter, but still has ... tho' he seems to realize all that is going on. ... receives shower-baths. Refuses food quite often ... ity: lets his bed. Apl 17/96. 2 PM. Up out. ... became somewhat emaciated of late, has not ... Condition, all day. Out doors in afternoon ... well, at night. Is given frequent shower-baths. ... some brighter, at times. Habits are dirty ... quietly in bed: will not talk: appears ... May 3/96. A little brighter but will not ... now & bed: May 7/96. Is given an occasional ... watching, as he will start away while out ... ens: requires enemata for bowels. —

May 8/9/13 ... Up: ... & escape. May 13/96. Some days, seems brighter, but generally quiet & stupid: will not talk: penis somewhat swollen: is given shower-baths: goes out in

" 14 afternoons: May 14/96. Quite bright this morning: given shower bath. 2 PM. Jumped out of bed & ran up

" 17 hall: slipped & fell & bruised knee: talked freely this PM. May 17/96. Keeps quite bright, but will not talk at times: at other, very talkative, but talks quite irrationally. Still tries to escape. Seems improving physically. (Is treated by injecting salt-solution into left buttock). May 21/96. Condition shows

" 21 no special change. May 23/96. Still possesses the idea that he has super-human powers.

" 23

Carried to #8

Mr Nystrom should you come down to Rochester after me. Be sure to come down at the right time always remember that you are to do that which is right at the right at the proper place, do just what you ought to do dont care for all the policeman in the United States, they cannot hurt you or arrest you as long as you do what is right. Never get nervous or excited, if you get excited or nervous it will not be the same way as other people.

Personal and Medical History of *August Peterson* #2

1896

This Patient was received here at the hands of Deputy Sheriff M.N. Goss, with following history of case. There is no history of Consanguinity nor heredity. This is 1st attack; he has not been in Hospital before: symptoms manifested Feby 26th 1896. Disease seems increasing. Not variable: no rational intervals. Derangement now shown by an exalted state of brain; delirious; provoking; violent. Patient is disposed to injure others, but not suicidal. Propensity not active: No filthy or destructive habits. Previously, he manifested impressions of some semi-religious character. There is no history of intemperance in parents: Has had no severe disease or head injury: has been only confined since March 1st. Supposed causes of the disease, unknown. Has had no medical treatment

Mar 2 On admission was put on B3 (G.N. [illegible]
" 3 condition of Skin good: no marks or cuts (is very talkative). Mar 3/96. Slept fairly
Has delusions of having superhuman cura
brought back. Transferred to T.W. at 5:30
" 4 Ate a good Supper: 7 PM. Was given hot bath
8 hours, last night. Is quiet this morning:
Stelay, in an apparently unconscious
during P.M. Mar 5/96. Slept 7 hours: very
" 5 freely. Bowels moved twice: Given shower-
Evening. Was quite talkative this PM. Has
showers. Quiet & well-behaved, this morning. Talk
" 6 morning the day. (Wt 148½ lbs). Mar 7/96. Ate
Urinates regularly: bowels move: he seems mu
" 7 1:30 PM. was up, in chair: behaved fairly well
" 8 regular & ward Diet: (no meat): seems greatly
Mar 9/96. Slept 8 hours. Is very bright th
" 9 afternoon: out doors in Chair, for 20 minutes
" 10 and well-behaved, all day. Up & dressed, during
" 11 cold in head, this morning. Quiet & well-beha
" 12 Mar 12/96. Slept 8 hours. 10:00 Given Shower
" 13 very obedient & quite rational. Mar 13/96
" 14 Mar 14/96. Slept 7 hours. Babed in forenoon: up
" 15 Appetite good: bowels move. Mar 15/96. Babed,
" 16/17 out for walk in afternoon. Mar 16/96. No chang
quiet, this forenoon. PM. Up & dressed: quite
Some very important business matters to settle in St Paul & wishes to go there as soon as possible"
" 18 Mar 18/96. Up & dressed for breakfast: seems about the same. Somewhat restless, during the day
" 19 Mar 19/96. Has been sleeping about 7 hours, nightly, since last noted. Appetite good: bowels
Quite regular: still holds some delusive ideas. Behavior good: habits neat. Urinates regularly.

Summary: Was received in an excited Condition; was subsequently transferred to TW.

Personal and Medical History of *August Peterson* #3

1896

Was still very excited: fed at 6:00: had a "spell" when he lay seemingly unconscious, for a few hours. Afterwards, became excited; but slept a quiet night: was stupid next day, but brightened up in P.M. & was quite talkative. Was up & dressed, a part of each day. Out doors, in chair, on 7th day. Up & Dressed on 8th day & all afternoon following: out walking on 13th & 14th days. Has behaved well. Physical condition has seemed good, throughout. Appetite good: bowels regular: Temperature & pulse about normal. Up to 4th day, talked very irrationally & labored under the delusion that he possessed superhuman powers: but after 4th day, talked quite rationally on most subjects: yet conversation easily shows derangement yet.

Mar 7/96. No change noticed. He sleeps well: still believes he possesses the power to perceive future events" today: talks somewhat incoherently. Mar 8/96. Sleeps well, at
Mar 3/96. Seemingly in an excited state yet, all day-
incoherent: has various delusions: thinks he possesses
bed. Has been very excited, all day (extra record on file. 96).
poorly: very restless, some nights. Very excited & irrational
requires constant holding & watching. Refuses some
to have Temp. taken. Apl 5/96. 8:30 PM. Has been crying
10:30 am: refused all nourishment. Apl 11/96. Since
the stupid condition. Would open eyes long enough to
on some days, has also been quite bright & has talked
bath, today, but turned not open eyes, while under shower
: Bowels require enema to move them. Has been
baths at times, has been brighter, but still has
eyes closed, tho' he seems to realize all that is going on
on. Also receives shower-baths. Refuses food quite often.
Habits dirty: wets his bed. After 5/96. 2:00 PM. Up & out
today. Has become somewhat emaciated of late, has not
lost stupid Condition, all day. Out doors in afternoon
is quite well, at night. Is given frequent hose-baths.
& talk: is some brighter, at times. Habits are dirty.
Lies very quietly in bed: will not talk: appears
ated. May 3/96. A little brighter but will not
then returned to bed: May 7/96. Is given an occasional
es close watching, as he will skoot away, while at
what happens: requires enemata for bowels. —
escape. May 13/96. Some days, seems brighter, but generally
quiet & stupid: will not talk: penis somewhat swollen: is given shower-baths: goes out in
" 14 afternoons: May 14/96. Quite bright this morning: given shower bath. 2:00 PM. Jumped out of bed & ran up
" 17 hall: slipped & fell & bruised knee: talked freely this PM. May 17/96. Keeps quite bright, but will not
talk at times: at other, very talkative, but talks quite irrationally. Still tries to escape. Seems im-
proving physically. (Is treated by injecting salt-solution into left buttock). May 21/96. Condition shows
" 21 no special change. May 23/96. Still possesses the idea "that he has super-human powers.
" 23

carried to #8

May

Some people think you
are hurt and suffer yet
you do not feel any
pain in one sense of
the word. The pain you
are liable to have is different
from other people it really
does not hurt.
If you feel like coming
down after me why come
if you feel like coming
alone come alone, if you
feel like hiring an extra
hire an extra car and
let every one come with
you who wants to,
It would be proper for
you to pay your fare
You would have to pay.
Yet if you come at the
right time you could
hire an extra car.
and take two or three
hundred people with you
And no one would have to
pay their fares. Should
the conductor try to force
the people to pay if he
were improper for them
to pay they would not
pay and you may.
You would probaly have to
do some funny things
to the conductor. But
never do any thing improper.
Do not think about the
future remember that you
are to do what right from
minute to minute and
never try to force any one
to do any thing if it is
improper. Get I have Know
You for along time, and
Know you are a brave man.

Personal and Medical History of August Peterson #2

1896

This patient was received here at the hands of Deputy Sheriff M.R. Goss, with following history of case. There is no history of consanguinity nor heredity. This is 1st attack; has not been in hospital before: symptoms manifested Feby 26th 1896. Disease seems increasing. Not variable: no rational interval. Derangement now shown by an exalted state of mind; delirious; provoking violence. Patient is disposed to injure others, but not suicidal. Propensity not active. No filthy or destructive habits. Previously, he manifested impressions of some semi-religious character. There is no history of intemperance in self or parents: [illegible] seen only confined since March 1st. Sup[illegible] no medical treatment.

Mar 2 On admission [illegible] hair light: eyes blue: condition of skin [illegible] behavior good, but he

" 3 is very talkative [illegible] 90 R 20 To 98.2. Has delusions of hav[illegible] day: was caught and brought back. Tran[illegible] tion. Was put to bed.

" 4 Ate a good Supper: [illegible] Listerine). Mar 4/96. Slept 8 hours, last night. [illegible] yadi water: bowels moved. Stelay, in an appar[illegible] Pm. Appeared excited during P.m. Mar[illegible] cited. Takes Eggnogs freely. Bowels mov[illegible] talk in Pm. also ate in

" 6 Evening. Was quite [illegible] tte). Mar 6/96 Slept 8 hours. Quiet & well- [illegible] ay. Has behaved well

" 7 during the day. (W[illegible] (eggnogs & light diet) Urinates regularly: bo[illegible] nurses rationally - at

" 8 30 PM. was up, in ch[illegible] Eats well: sleeps regular & when diet: [illegible] quiet subjects. —

" 9 Mar 9/96. Slept 8 h[illegible] Up, in chair, all of

" 10 afternoon: out doors [illegible] Eats well: very quiet

" 11 and well-behaved, a[illegible] pt 7 hours. Has slight cold in head this mor[illegible] Talk, quite rationally -

" 12 Mar 12/96. Slept 8[illegible] ms to be doing nicely:

" 13 very obedient & qui[illegible] -dressed. Very quiet all day.

" 14 Mar 14/96. Slept 7 ho[illegible] iet & well behaved all day.

" 15 Appetite good: bowel[illegible] 20 am. Up & dressed.

" 16/17 out for walk in afternoon. Mar 16/96. No change noted: out for walk in afternoon. Mar 17/96. Very quiet this forenoon. Pm. Up & dressed: quite talkative. Says "he is a business adviser & has some very important business matter to settle in St Paul & wishes to go there as soon as possible"

" 18 Mar 18/96. Up & dressed for breakfast: seems about the same. Somewhat restless, during the day.

" 19 Mar 19/96. Has been sleeping about 7 hours, nightly, since last noted. Appetite good: bowels quite regular: still holds some delusive ideas. Behavior good: habits neat. Urinates regularly.

Summary: Was received in an excited condition; was subsequently transferred to IW.

I would be very pleased to have you come if you should come, that is what I think I know. But I do not know what I will think or do the next minute. I never look ahead unless you must. Remember you are what you are, you are no more. You know what you know. And do the right thing at the right time.

Your Friend
August Peterson
Rochester
Minn.

Personal and Medical History of August Peterson #2

1896

Mar 2 Was still very excited: fought bed: had a "spell" when he lay seemingly unconscious, for a few hours. Afterwards, became excited; but spent a quiet night: was stupid next day, but brightened up in Pm. & was quite talkative. Was up & dressed, a part of each day. Out doors, in chair, on 7th day. Up & dressed on 8th day & all afternoons following: out walking on 13th & 14th days. Has behaved well. Physical condition has seemed good, throughout. Appetite good: bowels regular. Temperature & pulse about normal. Up to 4th day, talked very irrationally & labored under the delusion that he possessed superhuman powers. But after 4th day, talked quite rationally on most subjects: yet conversation easily shows derangement persists.

" 22 Mar 22/96. No change noticed. He sleeps well: "still believes he possesses the power to perceive future events" & various other powers. Mar 23/96. Very talkative, today: talks somewhat incoherently - Mar 24/96. Sleeps well, at

" 30 night. Talks more rationally, each day - Mar 30/96. Seemingly in an excited state of mind, all day -

" 31 Mar 31/96. Mind decidedly deranged: speech incoherent: has various delusions: thinks he possesses great powers". 11 am. Given bath & put to bed. Has been very excited, all day (nurse's record on file. 96). Apr 2/14 April 2/96. Wt 142½ pds. Aps 1/96. Sleeps poorly: very restless, some nights. Very excited & very irrational most of the time, 1st day. Desires to fight: has required constant holding & watching. Refuses some

" 5 meals: at times, has to be forced to eat. Refuses to have Temp. taken. Aps 4/96. 8:30 PM. Has been lying

" 11 in an apparently stupid condition since 10:30 am: refused all nourishment. Aps 10/96. Since last note, have been, off and on, in this same stupid condition. Would open eyes long enough to take nourishment. Appeared brighter at night. On some days, has also been quite bright & has talked some, but irrationally - Was given Shower-bath, today. Intermed not open eyes, while under them.

" 17 Aps 17/96. Has been urinating irregularly: Bowels require enema to move them. Has been wetting his bed. He has been given Shower-baths. At times, has been brighter, but still has these "Spells" when he is stupid & lies with eyes closed, tho' he seems to realize all that is going on.

" 18 Aps 18/96. Given electrical treatment 3rd Pm. Also receives Shower-baths. Refuses food quite often.

" 25/26 Aps 25/96 Condition does not seem to change. Habits dirty: wets his bed. Aps 26/96. 2 PM. Up out.

" 27 Aps 27/96. Appears brighter yesterday & today. Has become somewhat emaciated of late. Was out

" 25 doors in afternoon. Aps 25/96. In a somewhat stupid condition, all day. Out doors in afternoon.

" 30 Aps 30/96. No special change noticed. Sleeps quite well, at night. Is given frequent Shower-baths.

May 2 Very quiet & seemingly stupid. Will not talk: is some brighter, at times. Habits are dirty. (See Nurse's records on file as 96). May 2/96. Lies very quietly in bed: will not talk: appears

" 3 stupid: seems weak & is somewhat emaciated. May 3/96. A little brighter but will not

" 7 talk: out in Pm. Seemed very stupid, when returned to bed: May 7/96. Is given an occasional hot-bath: goes out in afternoons, but requires close watching, as he will start away while out. Will not talk, but seems to realize. Everything that happens: requires enemata for bowels. —

" 8/9/13 May 8/96. Wt 138½ lbs. May 9/96. Tried to escape. May 13/96. Some days, seems brighter, but generally quiet & stupid: will not talk: penis somewhat swollen: is given Shower-baths: goes out in

" 14 afternoons. May 14/96. Quite bright this morning: given Shower bath. 2 PM. Jumped out of bed & ran up

" 17 hall: slipped & fell & bruised knee: talked freely this Am. May 17/96. Keeps quite bright, but will not talk at times: at others, very talkative, but talks quite irrationally. Still tries to escape. Seems improving physically. (Is treated by injecting salt-solution into left buttock). May 21/96. Condition shows

" 23 no special change. May 23/96. Still possesses the idea "that he has super-human powers".

Carried to #8

Personal and Medical History of George L. Pierce

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4371

Residence, St. Paul, Minn

Date Admission, 3rd March 1896. —

Admitted by D. Herzog — Hour, 6.15 P.M.

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

Sex, — Male —

Age, — 56 years —

Civil Condition, Single

Children,

Age Youngest Child,

Occupation, Carpenter

Degree Education, Slight: primary education

Profession Religion, not a church-member

Habits, — Not known —

Nativity, Pennsylvania: (Parents also born there).

Physicians Committing, V. J. Hawkins 2nd J. A. Quinn

Correspondents, None given in papers

D.H. June 3/96. James Allen 173 South Wabasha St. Paul (Guardian)

No. for Year, 169

Insane Relatives, None known of

Cause Exciting, "Recluse" —

Cause Predisposing, not given

Form, Paranoia

Accompanying Bodily Disorder, None known

Suicidal or Not, — Not —

Date of this Attack, Ten Days since

Duration, — Ten days —

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, —

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps. 3/4/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Fairly clear in form.

Quick or Sluggish, Quick

MEMORY:

Past Events,

Recent Events, } Says he thinks it is good -

Special Subjects, } He repeats things as if accurate.

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Somewhat irritable - Talk is unreliable - Some confusion of ideas.

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,

QUEER IDEAS.

George L. Pierce "Hasn't a Full Row of Buttons."

George L. Pierce, sixty-three years old, appeared yesterday afternoon in the probate court under an information of insanity filed against him by a milkman residing in the suburbs of St. Paul. He was employed by this milkman until he became so "queer" that the milkman became frightened.

In the probate court yesterday afternoon Mr. Pierce said he was imbued with a superior intellect, on which account he was being pursued and persecuted by every one. He said that he was always looking for people with superior intellects, and that he could discover them by looking through his hand. He looked at Judge Willrich in that manner, and asked him if he thought God has an intellect greater than that of Robert Ingersoll. Judge Willrich said he certainly thought so.

"Ah, let me shake your hand," Mr. Pierce said, walking up to the judge's bench. "I am now no longer in the world. I have found a man with a superior intellect, and I feel much easier." He turned to the physician who was examining him and put the same question to him. The physician answered as Judge Willrich did, and again Mr. Pierce wanted to shake hands.

He then became quite talkative, and imparted the knowledge, confidentially, of course, that his actions were guided by a voice. Whatever the voice told him to do he did. That was the reason the milkman became frightened. He was afraid the voice would tell Pierce to kill some one, and he was not going to take any chances. Pierce exhibited a little spelling book. All the leaves were torn out, and Pierce said they had mysteriously gone away.

"But one has recently returned," he added joyfully. "It came back all alone, and I am sure all the others will come back one at a time." Pierce was just as reluctant to leave the court room as he had been to enter it. He had to be carried away, for he stoutly announced that he had not walked in and he was not going to walk out. Judge Willrich sent him to the Rochester asylum.

Personal and Medical History of George L. Pierce

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ WEIGHT, 123 lbs NUTRITION, Somewhat poor.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Some tremors Coatings, None of note Promptness Movement, Fairly.

PUPILS, Equality, Equal Size, Normal -

Response Light, Respond. Accommodation,

SIGHT, Many Spectacles.

HEARING, Fair.

COORDINATION, Arms, } Fair.
Legs, }

TREMORS, Hands, Some - not very notable - Tongue,

Facial Muscles, General,

REFLEXES, Patellar, ?- 8 Equal. EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION, Fair.

SENSIBILITY,

HEART, Exaggerated - Palpitating - Murmur on subclavian artery - Sounds some blurred - No Radial atheroma

LUNGS, Sounds good

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, B.(L.) 58 (r.w.) 67 Fac.a 38 Bi.a. 32 Front.d 15 Ant.p.d. 20.4 Bi.d. 142

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Died 82

Father or Pat. Relations, Dead

Brothers or Sisters, 1 or children - 2 insane 1 at. Peter - 1 died at Utica. "Had a previous attack 12-15 yrs. ago" "Don't think I was."

Personal and Medical History of George L. Pierce

GIBBEY, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4341.
Residence, St. Paul, Minn
Date Admission, 3rd March 1896. —
Admitted by Dr. Herzog — Hour, 6 P.M.
How Sent, G. Willrich, Jof P. Ramsey County.
Sex, — Male —
Age, — 56 years —
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Carpenter
Degree Education, Slight: primary education
Profession Religion, not a church-member
Habits, — not known —
Nativity, Pennsylvania: (Parents also born there).
Physicians Committing, V. J. Hawkins and J. A. Quinn
Correspondents, none given in papers

D.H. June 3/96. James Allen 173 South Wabasha St Paul (Guardian)

No. for Year, 169.
Insane Relatives, none kn
Cause Exciting, Rel
Cause Predisposing, not
Form, Paranoia
Accompanying Bodily Disorder, Non
Suicidal or Not, — No
Date of this Attack, Jan de
Duration, — L
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 56 —
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by P.M. Phelps. 3/4/96.

MENTAL ACTIVITY:
Clear or Confused, Fairly clear in some.
Quick or Sluggish, Quick
MEMORY:
Past Events,
Recent Events, Says he thinks it is good -
Special Subjects, He repeats things as if accurate.
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Somewhat irritable - Talk is unreliable - Some confusion of ideas.

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,

...iums collected by the
...ligible. No uncertain
policy.
LIFE INSURANCE.
...is the most progressive Life
...ON DOLLARS. It has over
...olicies last year. About Ten
...rce Bldg., St. Paul, Minn.
IDENT,
...a family of 7 persons.
...illustrated publication, free.
...rd where all who desire insur-

Personal and Medical History of George L. Pierce

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ WEIGHT, 123 lbs NUTRITION, Somewhat poor.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Some tremors Coatings, None of note Promptness Movement, Fairly.
PUPILS, Equality, Equal Size, Normal -
Response Light, Respond. Accommodation,
SIGHT, Wears Spectacles.
HEARING, Fair.
COORDINATION, Arms, } Fair.
Legs, }
TREMORS, Hands, Some - not very notable - Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 7-8 Equal. EXAM. URINE,
Other
ARTICULATION, Good.
Slurred,
Hesitating,
FACIAL EXPRESSION,
Fair.
SENSIBILITY,
HEART, Exaggerated - Palpitating - Murmur on Sublavian artery - Sounds some blurred - No Radial atheroma
LUNGS, Sounds good

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, G(E) 58 (r.m) 57 Fac.a. 38 Bi.a. 32 Fronto.d 15 Ant.p.d. 20.4 Bi.d. 142
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Hereditly.
Mother or Mat. Relations, Died 8 yrs
Father or Pat. Relations, Dead
Brothers or Sisters, 1 yr children - 2 insane 1 at Potsdam - 1 died at Utica "Had a previous attack 12-15 yrs. ago" "Don't think I was."

Personal and Medical History of George L. Pierce

This patient was brought here by Deputy-Sheriff F.W. Kenney, attended by Ed. Clark with following history. Patient is in fair physical condition. As to consanguinity not known: no insanity in family. Patient has been insane about ten days since, Derangement re Patient is not de no peculiarities no acts of any severe medical treatmen he is found to be mic

G.S.Pierce.

Mar.13th'96.---D W.McLeod writes that patient's symptoms commenced 10 days before commitment, as far as he knows, and he has not noticed in eleven years knowledge of him any other symptoms of insanity; seemingly had heard of none. Patient was temperate, industrious, economical and well liked. He has a nephew, Wm. Pierce, at Great Falls, Montama.

Mar 3 Dr admission, was put on B³ (25Y.11.Kft. complexion light: hair gray: eyes blue, condition of skin good: has hernia at left side of abdomen: is clean: behavior good). Mar 4/96. Slept 7 hours last night: is on regular diet. bowels moved: behavior good: he seems feeble-minded & simple: restless;
" 5 marches up & down hall, whistling & singing. Mar 5/96. Slept 5 hours. Complains of lungs feeling
" 6 bad this am. Is restless & more noisy, today. Mar 6/96. Slept 5 hours. Eat well: bowels regular.
" 7 Is noisy & troublesome; (apparently assumed). Requires continual attendance. Mar 7/96. Slept only 4 hours, last night. Gave him hot bath (temp. 105°) for 5 minutes: was some quieter after
" 8 bath. Patient is quite aggravating, at times. Eat well. Mar 8/96. Slept only 1 hour: was noisy, a great deal of the night. Troublesome & noisy, during day. Is cont walking daily.
" 9 Mar 9/96. Restless & slept only 3 hours. Is more quiet, today, than usual. Makes no complaints.
" 10 Mar 10/96 Slept only 3 hours, last night. Behavior quiet, today. Talks to himself & laughs.
" 11 Mar 11/96. Sleeping but 2 hours, last night. Behavior quiet. Talks considerable, though very
" 12 quietly. Mar 12/96 Rested poorly, sleeping only 2 hours, last night. No delusions or hallucinations
" 13 noticeable Mar 13/96. Slept only 3 hours, last night. Quite restless, today. Talks a great deal, in a
" 14 rather foolish manner. Appetite good: bowels regular. Mar 14/96. Slept but 2 hours, last
" 15 night. Behavior good of late. No especial change in patient, for last 2 or 3 days. Mar 15/96. Slept
" 16 only 3 hours, last night. very restless, today. March 16/96. Slept only 2 hours, last night. No change in
" 17 behavior, today. Mar 17/96. Slept only 3 hours: patient seems doing better, every day. —

Summary: Patient was very troublesome, for several days, after admission: noisy & very restless, both night & day: talking rather incoherently; laughing & whistling Patriotic tunes, Continually. Physically, is in very Good condition, considering his age. Does walking, daily. No delusions & hallucinations noticed. He has been much better, of late: more quiet: talks
" 30 less & more sensibly than before. Works some & appears steadily improving. Mar 31/96. From last note, for some time, was restless at night & sleeping poorly. Is now sleeping 7 to 8 hours, nightly. Otherwise condition remains as above generally described. Apl 2/96. Wt 137 lbs. Pulse 88.
Apl 2 " 10 (has gained some in flesh): Apl 10/96. Quite noisy, a great deal of the time: singing & whistling. Promenades the hall a great deal. Talks incoherently. Has delusions of a "Spiritual" character.
" 30 April 30/96. Has improved considerably, of late. Is more quiet & rational. Works on ward and in dining room.
May 1/96 to Aug 1/97 Summary Nurses Notes by Dr. Phelps Wt. May 1/96 138 lbs. Is becoming very restless & noisy June 4 transferred from B¹ to B³ but is still quite restless

Personal and Medical History of George L Pierce

and troublesome: July 29 Transferred to C on account of his behavior. Since that he has been unreliable in behavior, rather abusive & noisy in talk: at times threatening altho usually is not violent. July/97 transferred to Annex. Aug. 31/97 Wt. 148# Oct. 31/97 Health good: behavior noisy & contrary. Is more or less demented. Apr. 30/98 At annex: Very noisy, talks in a rambling, incoherent way. Dec. 1 Patient has been on Infirmary for 4 or 5 months, simply on account of ease in caring for him there; he has not been sick. Jan 30/99 No change of any special importance in behavior, is perhaps a little more quiet of late.

Feb 1 — July 31/99. Wt. 147#. Stubborn, abusive noisy & vulgar. Always irritable when physicians are on ward. July 2. Attempted to strike one of the other patients.

Aug 1 1900 to Jan 31 — Jan 31 1900 (Dr Schapple) Wt. 147#. No change during period: Physical condition fairly good - Sits all day in one place: Talks to himself almost constantly. Is very abusive when spoken to: very incoherent & has numerous delusions. Does no work, & takes no exercise: quite tidy in habits. Febry/1900. Wt 156#. Pst. May 6. Transferred to N.E. July 10. Was vaccinated: results negative - July 31. No change. Physical condition apparently quite good: Eats & sleeps well: never goes out for exercise. very stubborn: constantly haranguing in a very irrational manner. very obscene & abusive, especially to physicians. Has numerous delusions: habits quite tidy. Does no work. Wt 154# ± Clothes. Sept 10. Transferred to D. Jany 31/1901. No apparent change in any way: no illness: no exercise. Febry Wt 155#: May. 155# Aug 1. 155# Nov 1. 157# — Jany 31/02. No change: always very noisy, during day: very profane & obscene, in language: at times, singing loudly: always sits at same bench: never goes out doors: is extremely stubborn: health fairly good.

Aug 1/03 to Jan 31/03 Weight 154#.

Has had no visitors during year; has been in pretty good health; usually obscene & abusive in language; never goes out of doors & does not move about ward except to meals. Has been quite neat.

Personal and Medical History of George L. Pierce

This patient was brought here by Deputy-Sheriff F.W. Kinney, attended by Ed. Clark with following history. Patient is in fair physical condition. As to consanguinity not known: no insane relatives so far as known. This is 1st attack: symptoms manifested ten days since, by religious fervor, hallucinations: disease seems increasing; continuous; Derangement now shown by his thinking the world is opposed to him; all men are his enemies. Patient is not disposed to injure others, nor suicidal, nor of filthy or destructive habits. Has no peculiarities had been observed. As to any history of intemperance, not known. nor as to any severe disease &c, or head-injury. He has not been returned a convict, nor under medical treatment. Supposed cause of the disease is "Recluse". On personal Examination he is found to be incoherent & given to incessant talk: whistling & a dictatory manner. —

Mar 3 On admission, was put on B³ (G.S.N.R.P.F.) Complexion light: hair gray: eyes blue, condition of skin good. Has hernia at left side of abdomen. is clean: behavior good). Mar 4/96. Slept 7 hours last
" 4 night: is on regular diet: bowels moved: behavior good. Seems feeble-minded & simple: restless;
" 5 marches up & down hall, whistling & singing. Mar 5/96. Slept 5 hours. Complains of lungs feeling
" 6 bad this am. Is restless & more noisy today. Mar 6/96. Slept 5 hours. Eats well: bowels regular.
" 7 Is noisy & troublesome; (apparently assumed). Requires continual attendance. Mar 7/96. Slept only 4 hours, last night. Gave him hot bath (temp. 105°) for 8 minutes: was some quieter after
" 8 bath. Patient is quite aggravating, at times. Eats well. Mar 8/96. Slept only 1 hour: was noisy, a great deal of the night. Troublesome & noisy, during day. Goes out walking daily.
" 9 Mar 9/96. Restless & slept only 3 hours. Is more quiet, today, than usual. Makes no complaints.
" 10 Mar 10/96 Slept only 3 hours, last night. Behavior quiet, today. Talks to himself & laughs.
" 11 Mar 11/96. Sleeping but 2 hours, last night. Behavior quiet. Talks considerable, though very
" 12 quietly. Mar 12/96 Rested poorly, sleeping only 2 hours, last night. No delusions or hallucinations
" 13 noticeable Mar 13/96. Slept only 3 hours, last night. Quite restless, today. Talks a great deal in a
" 14 rather foolish manner. Appetite good: bowels regular. Mar 14/96. Slept but 2 hours, last
" 15 night. Behavior good of late. No especial Change in patient, for last two or three days. Mar 15/96. Slept
" 16 only 3 hours, last night. very restless, today. March 16/96. Slept only 2 hours, last night. No change in
" 17 behavior, today. Mar 17/96. Slept only 3 hours: Patient seems doing better, every day. —

Summary: Patient was very troublesome, for several days, after admission: noisy & very restless, both night & day: talking rather incoherently: laughing & whistling Patriotic tunes, Continually. Physically, is in very good condition, considering his age. Does walking, daily. No delusions or hallucinations noticed. He has been much better, of late: more quiet: talks
" 30 less & more sensibly than before. Works some & appears steadily improving. Mar 30/96. Same last note, for some time, was restless at night & sleeping poorly. Is now sleeping 7 to 8 hours, nights.
Apl 2 Otherwise condition remains as above generally described. Apl 2/96. Wt 137 lbs. Pulse 88.
" 10 (has gained some in flesh): Apl 10/96. Quite noisy, a great deal of the time: singing & whistling.
" 30 Promenades the hall a great deal. Talks incoherently. Has delusions of a "Spiritual" Character.
April 30/96. Has improved considerably, of late. Is more quiet & rational. Works on ward and in Dining room.
May 1/96 to Aug 1/97 Summary Nurses Notes by Dr. Phelps Wt. May 1/96 138 lbs. Is becoming very restless & noisy June 4 Transferred from B³ to B³ but is still quite restless

Personal and Medical History of George L. Pierce

and troublesome: July 29 Transferred to C' on account of his behavior: Disease that he has been unreliable in behavior, rather abusive & noisy at times threatening attks usually is not violent.

Aug 1 1900 to Jan 31 1901 Jan 31/1900 (Dibbapple) Wt. 147#. No change during period: Physical condition fairly good - Sits all day in one place: Talks to himself almost constantly. Is very abusive when spoken to: very incoherent & has numerous delusions. does no work & takes no exercise: quite tidy in habits. Febry/1900. Wt 156#. Pst. May 6. Transferred to D.E. July 29. Was
Feb 1 vaccinated: results negative - July 31. No change. Physical condition apparently quite good: Eats & sleeps
July 29/31 well: never goes out for exercise. Very stubborn: constantly haranguing in a very irrational manner. Very obscene & abusive especially to physicians. Has numerous delusions: habits quite tidy. Does no work.
Aug 1 1900 Wt 154½ lbs Sept 10. Transferred to D.E. Jany 31/1901. No apparent change in any way: no illness:
Jany 31 1901 no medicine. Febry Wt 155#: May 1. 155# July 1. 155# Nov 1. 157# — Jany 31/01. No change:
Feby 01 always very noisy, during day: very profane & obscene in language: at times, singing loudly: always sits at same bench: never goes out doors: is extremely stubborn: health fairly good.
Aug 1/03 Weight 154#.
Jan. 31/03 Has had no visitors during year; has been in pretty good health; usually obscence & abusive in language; never goes out of doors & does not move about ward except to meals. Has been quite neat.

Mar 15th/96.—D.W. Cleland writes that patient's symptoms commenced 10 days before commitment, as far as he knows, and he has not noticed in eleven years knowledge of him any other symptoms of insanity; seemingly had been of none. Patient was temperate, industrious, economical and well liked. He has a nephew, Wm. Pierce, at Great Falls, Montana.

D.E. Pierce.

D.I. 3/1/97 Health good: behavior At annex: Very Patient has been of ease in caring uge of any special uet of late. ble when physicians ats.

Personal and Medical History of August Meyer.

EBBERT, FICKE & CHAMBERS, DAVENPORT, IOWA

Whole No. 4342.
Residence, St Paul. Minnesota.
Date Admission, 4th March 1896.
Admitted by Dr. Herzog Hour, 6 45 P.M.
How Sent, G Wilrich, Jail. Ramsey County.
Sex, Male.
Age, 29.
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Hostler
Degree Education, limited: can read & write.
Profession Religion, not known.
Habits, Unknown.
Nativity, Hungary: (Parents also born there).
Physicians Committing, Arthur Sweeney and J Hage
Correspondents, Father's name Joseph Meyer lives in Hungary.

No. for Year, 170.
Insane Relatives, unknown
Cause Exciting, not stated.
Cause Predisposing, not stated
Form, Paranoia.
Accompanying Bodily Disorder, unknown
Suicidal or Not, not attempted.
Date of this Attack, probably recent
Duration, probably
No. of Attack, unk
No. of Admissions, 1
Age First Attack, (?)
Time of Leaving,
Time in Hospital,
Result,

HAVE QUEER MINDS.

Insane Hospitals Are Being Rapidly Filled.

August Meyer was committed to the insane asylum yesterday by Judge Willrich. Meyer is twenty-nine years of age, and is a Hungarian. He is a hostler and was arrested about a week ago for following a girl. He talks incoherently.

(See note below)

EXAMINATION ON ADMISSION.

Exd by Dr. Herzog March 5/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Seems clear
Quick or Sluggish, somewhat sluggish
MEMORY:
Past Events, } Seems fair
Recent Events, }
Special Subjects,
PERCEPTIVITY:
Alert or Dull, fairly alert
Correct or Illusive, Seems correct
REASONING POWER:
Ordinary Subjects, Seems fair
Own Mental State, — do —
Special Subjects,

EMOTIONAL STATE:
~~Normal, Calm,~~
~~Indifferent,~~
~~Exalted,~~
Depressed, Yes
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, } unknown
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
~~Coherent or~~ Incoherent, I suppose so
Voluble or ~~Reticent~~, fairly.

GENERAL DESCRIPTIVE REMARKS:

Patient is fairly well-behaved, but considerably depressed. He is a Croat from Hungary, and no one in the House can speak his language. He speaks no English, but understands a little. He understands German fairly well, but his efforts to speak are a failure. Patient Karl Schnatt claims to understand him & says that, at times, he is rational & at other times incoherent. Schnatt is himself so irresponsible as to make his statements of not much avail. Patient says his address is 166 — 7th St. St Paul and that he drove a team for one George Schneider whose address he does not know. He cannot give the address of any friends —

note

Personal and Medical History of August Meyer

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 11½ WEIGHT, 176 lbs NUTRITION, Good
WOUNDS OR ABNORMALITIES, bruise over left eye: (see G.H. note left).
TONGUE, Tremors, Some Coatings, quite clean Promptness Movement, prompt
PUPILS, Equality, Yes Size, normal
Response Light, somewhat excessive Accommodation, somewhat excessive
SIGHT, Seems good
HEARING, somewhat impaired.
COORDINATION, Arms, Good: finger to nose, eyes shut, good.
Legs, Good: standing on feet, good: standing, eyes shut, good.
TREMORS, Hands, Some Tongue, Some
Facial Muscles, no General, Yes
REFLEXES, Patellar, 4- equal.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
Good
SENSIBILITY,
HEART, rapid: impulse forcible sounds good.
LUNGS,
Seem good

EXAM. URINE,


4342

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, Record kept	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 August Meyer.

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4342.
Residence, St. Paul. Minnesota.
Date Admission, 4th March 1896.
Admitted by Dr. Herzog Hour, 6th P.M.
How Sent, G. Wilrick, Jail. Ramsey County.
Sex, - Male -
Age, - 29 -
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Hostler
Degree Education, limited: can read write.
Profession Religion, not known
Habits, - Unknown -
Nativity, Hungary: (Parents also born there).
Physicians Committing, Arthur Sweeney and J. Hage
Correspondents, Father's name, Joseph Meyer lives in Hungary -

No. for Year, 170.
Insane Relatives, unknown
Cause Exciting, not stated -
Cause Predisposing, not stated
Form, Paranoia.
Accompanying Bodily Disorder, unknown
Suicidal or Not, not attempted.
Date of this Attack, probably recent
Duration, probably Short.
No. of Attack, unknown
No. of Admissions, 1st.
Age First Attack, (?)
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Ex'd by Dr. Herzog March 5/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Seems clear
Quick or Sluggish, somewhat sluggish
MEMORY:
Past Events, } Seems fair
Recent Events, }
Special Subjects,
PERCEPTIVITY:
Alert or Dull, fairly alert
Correct or Illusive, Seems correct
REASONING POWER:
Ordinary Subjects, Seems fair
Own Mental State, — do —
Special Subjects,

EMOTIONAL STATE:
~~Normal, Calm,~~
~~Indifferent,~~
~~Exalted,~~
Depressed, Yes
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, } unknown
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
~~Coherent or~~ Incoherent, Supposedly
Voluble or ~~Reticent~~, fairly.

GENERAL DESCRIPTIVE REMARKS:

Patient is fairly well-behaved, but considerably depressed. He is a Croat from Hungary, and no one in the House can speak his language. He speaks no English, but understands a little. He understands German fairly well but his efforts to speak are a failure. Patient Karl Gschwatt claims to be educated man & says that, at times, he is rational & at others quite incoherent. Gschwatt is himself so irresponsible as to make his statements of not much avail. Patient says his address is 166 - 7th St. St. Paul

note { and that he drove a team for one George Schneider whose address he does not know. He cannot give the address of any friends -

A STENOGRAPHER OF EXPERIENCE DESires a position; willing to work for moderate salary. Address E. H. M., 537 Minnehaha ave.
A YOUNG COLORED LADIES WOULD like a position to clean up gentlemen's rooms in the morning. Please address K. R., 501 Wabasha.
WASHING WANTED TO TAKE HOME-delivered; good work and cheap. South street Box

Personal and Medical History of August Meyer

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 11½ WEIGHT, 176 lbs NUTRITION, Good
WOUNDS OR ABNORMALITIES, bruise over left eye: (see G.H. Nkept).
TONGUE, Tremors, Some Coatings, quite clean Promptness Movement, prompt
PUPILS, Equality, Yes Size, normal
Response Light, somewhat Excessive Accommodation, somewhat Excessive
Seems good
somewhat impaired.
INCOORDINATION, Arms, Good: finger to nose, eyes shut, good.
Legs, Good: standing on feet, good: standing, eyes shut, good.
TREMORS, Hands, Some Tongue, None
Facial Muscles, no General, Yes
REFLEXES, Patellar, 4 - quick.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION, Good.
SENSIBILITY,
HEART, rapid: impulse forcible. sounds good.
LUNGS, Seem good

EXAM. URINE,


M 3 6 V

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, Record Kept	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 *August Meyer*

1896

This patient was brought here by Deputy Sheriff M. N. Goss, with following history. Patient is in fair physical condition. History is not very full. As to consanguinity or heredity, unknown. Number of attack unknown. He was found on the street, clapping his hands, jumping and talking to himself. State of disease unknown: apparently, no rational intervals: he talks incoherently & answer to most questions. Derangement now shown by incoherent talk, answers questions in an irrelevant manner: has created a disturbance on the street, by following a girl, and acting wildly. Patient is not disposed to injure others: has not attempted suicide: if propensity active, unknown: as to habits, unknown. If any peculiarities previously shown, if any intemperance in self or parents, if subject to any disease or a head injury, nothing seems to be known. If he has been restrained or confined, unknown. Cause of disease not stated. He has had no medical relief. Patient was arrested, a week ago, for disturbing the peace, by following a girl, gesticulating wildly & jumping. He has since talked very incoherently, wandering off from the subject & unable to tell much about himself. He is apparently insane and needs the care of an hospital. —

Mar 4 On admission, was put on B½ (G.H.N.R'ft. Complexion dark: hair black: eyes blue. Gait & skin good: scars on left wrist: is clean. behavior good: very quiet. Can't talk English.).

" 5 Mar 5/96. Was given bath last Evening. Slept fairly well: tho somewhat restless. Is acting rather discouraged: seems depressed: crying at times. Is on regular diet. Eats well: bowels move.

" 6 Mar 6/96. Slept 2 hours: restless 7 hours, last night. 9 Am. Temp. 100⅖ (had been working when this was taken). No change noticeable in behavior. Mar 10/96. Has been sleeping well, since last

" 10 noted. Appetite good: bowels regular: behaves well: works on ward. Mar 11/96. Seems more contented

" 11 than at first. Neat & tidy in dress: a good worker on ward. Mar 19/96. Sleeps well (8 hours) nightly.

" 19 Behavior same as usual. Jumps about daily: makes no complaints: Habits clean & tidy.

Summary: Appetite has been good: bowels regular: behavior good. Patient cannot converse in the English Language, and only one patient here (see Remarks on Examination) seems to understand what he says. No delusions or hallucinations noticed. He seems to be hard of hearing. Works on ward. Mar 30/96. No change specially noticed. Behavior good. Habits neat and

" 30 clean: Talks now, but seems to understand when spoken to. Works on ward. Bowels regular.

Apl 1 Apl 1/96. Wt 175 lbs. P 80. Apl 4/96. Actions are very queer: while out walking, waving his handkerchief & imitating Patient James Cooley "shooting". Quiet & well behaved on ward.

" 30 Apl 30/96. Has been somewhat stubborn of late & wants to have his own way: at times, when out, acts very silly. Habits are clean: of late, works but little on ward.

May 96 to Aug 1 97 Summary Nurses Notes by Dr. Phelps. Wt. Aug. 1/96 171 lbs. Physical condition good: Always quiet: rather melancholy in manner: mumbles to himself: Cannot speak English - speaks only Hungarian: No special change to end of period

Aug 1 97 Wt. 107 lbs. Oct 31 97 Uneasy & restless in behavior: Walks floor: Seems to be under influence of delusions. Jan 31 99 Has maintained about the same behavior during all the time: Is somewhat violent at times. Tries to elope

Feb 1 – July 31 99 (Dr Warnock) Wt. 159 lbs. Inclined to be ugly & pugnacious: Has delusions: Is incoherent in speech. Aug 1 – Jan 31 1900 (Dr Chapple) Wt. 165. No important change dur-

Personal and Medical History of *August Meyer*

1900

ing period. Physical health has been good, is considerably demented & talks incoherently & unintelligibly, but is tidy in habits & joins in games &c on ward. Is rather restless & inclined to be troublesome at times. Feby 1 1900. Wt 160 lbs

July 19 Vaccinated: result negative. July 31. No change; health good: is usually well-behaved, but restless, and at times, strikes others without provocation: habits tidy: talks a great deal in an unintelligible manner — seems to have delusions. Works on ward. Augs. 16 — Jan 11 1901. Transferred to Annex.

Aug 1 1900 Jany 31 Health good: habits fairly cleanly but is becoming more slovenly of late: talks to himself a good deal; cannot be understood: works on ward: is very restless & irritable; will strike patients without provocation. Feby Wt 167 lbs. April 17. Transferred to C. (for throwing dishes, at table).

Feby Mayo 1900 Jany 31 To D. July. To C. (for violence). Aug 16. To B. Nov. Wt 177½ lbs — Jan 31 1901. No change of importance: In good health: works quite well, on ward: occasionally troublesome and mischievous: habits tidy: very rational.

Jan. 31/01 (Dr Chapple) Has been in good physical health; rather erratic in behavior, at times strikes without provocation; talks in an unintelligible manner; Does some work on ward and will work outside.

Personal and Medical History of Julius W. Herrninger

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4314

Residence, St Paul: Minnesota.

Date Admission, 5th March 1896.

Admitted by Dr. Herzog Hour, 6.45 PM.

How Sent, G. Willrich, Jopt. Ramsey County

Sex, — Male —

Age, — 19 years —

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Mechanic

Degree Education, fairly educated

Profession Religion, Yes: St. Paul's Lutheran.

Habits, not intemperate

Nativity, U.S. St. Paul, Minn. (Parents born in Germany)

Physicians Committing, A. W. Dunning & J. Ohage

Correspondents, none given in papers —

Theo Henninger. 390 Thurman St. St. Paul, Minn.

No. for Year, 175.

Insane Relatives, none

Cause Exciting, Masturbation

Cause Predisposing, not stated

Form, Pubescent Insanity.

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, — not —

Date of this Attack, One year ago

Duration, one year

No. of Attack, 1st —

No. of Admissions, 1st —

Age First Attack, — 18 —

Time of Leaving, Apr. 7th. 1897.

Time in Hospital, 1 yr. 1 mo. 3 da.

Result, Discharged Aug. 11. 1897. Improved.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by R.M. Phelps 3/6/96.

MENTAL ACTIVITY:

Clear or Confused, Erratic.

Quick or Sluggish, Quick

MEMORY:

Past Events,

Recent Events, } Thinks Generally good —

Special Subjects,

PERCEPTIVITY:

Alert or Dull, } Not very correct.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State, } Weak.

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Did not talked about sending him to Dacon City - said Karl Lambrecht had been there - Got an idea someone was tying to poison him it was last year sometime - Recollects poorly - refers us to other people - Shows a feebleness of mind by his answers.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, About being poisoned

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Julius W. Henninger

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

Julius Henninger.

Feb. 10th, 1896.---The father writes that first symptoms were noted April 22nd, '95, coming on suddenly and lasting two weeks. His mother was insane six years after he was born going to St. Peter for seven months; she recovered and has been well ever since though somewhat nervous: No consumption in family: Patient has been rather nervous for past few years and tends to go to extremes.

COORDINATION, Arms, Good.

Legs, "

TREMORS, Hands, None Tongue, —

Facial Muscles, — General, —

REFLEXES, Patellar, Normal 5 EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,

Slightly silly & evasive.

SENSIBILITY,

HEART, Normal.

LUNGS, Normal.



TAKEN,

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 (fm) 64½ N.-oc.a. 36 Bm.a. 31½ Fram.d. 15.2 Ant.-p.d. 19.2 Bin.d. 14 L.-L. 12.6

HISTORICAL,

LENGTH OF INVASION, Probably gradual. ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Can't tell about heredity.

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Julius W. Henninger

HERBERT, FIOLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4347 — No. for Year, 175

Residence, St Pa[illegible]

Date Admission, 5th [illegible]

Admitted by Dr. He[illegible]

How Sent, G. Wilbric[illegible]

Sex, — M

Age, — 1[illegible]

Civil Condition,

Children,

Age Youngest Child,

Occupation, Mechanic — No. of Admissions, 1st

Degree Education, fairly educated — Age First Attack, — 18

Profession Religion, Yes: St. Paul's Lutheran — Time of Leaving, Apr. 7th. 1897.

Habits, not intemperate — Time in Hospital, 1 yr. 1 mo. 3 da.

Nativity, U.S. St Paul, Minn. (Parents born in Germany) — Result, Discharged Aug 11. 1897. Improved.

Physicians Committing, A. W. Dunning & J. Okage

Correspondents, None given in papers —
Theo Henninger. 390 Sherman St. St. Paul, Minn

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by R.M. Phelps 3/6/91.

MENTAL ACTIVITY:

Clear or Confused, Erratic.

Quick or Sluggish, Quick

MEMORY:

Past Events, / Recent Events, / Special Subjects, } Thinks generally good —

PERCEPTIVITY:

Alert or Dull, / Correct or Illusive, } Not very correct.

REASONING POWER:

Ordinary Subjects, / Own Mental State, / Special Subjects, } Weak.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, About being poisoned

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Dr. Not talked about sending him to Dakota City - said Carl Laubrecht had been there - Got an idea someone was trying to poison him. Was last year sometime - Recollects poorly - refers us to other people - Shows a feebleness of mind by his answers.

Personal and Medical History of Julius W. Henninger

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6½ in. — WEIGHT, 136 lbs. — NUTRITION, Fair.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, None. — Coatings, Broad flabby — Promptness Movement, Prompt.

PUPILS, Equality, Equal. — Size, Normal.

Response Light, Respond. — Accommodation,

SIGHT, Near sighted

HEARING, Fair.

COORDINATION, Arms, Good.

Legs,

TREMORS, Hands, None — Tongue, —

Facial Muscles, — — General, —

REFLEXES, Patellar, Normal 5 — EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,

Slightly silly & evasive.

SENSIBILITY,

HEART, Normal.

LUNGS, Normal.



TAKEN,

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 (fm) 54½ N. oc. a 36 Bim. a. 31½ Fram. d. 15.2 Ant.-p. d. 19.2 Bin. d. 14 L. L. 12.6

HISTORICAL,

LENGTH OF INVASION, Probably gradual — ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Can't tell about heredity.

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Julius. W. Henninger.

1896

This patient was brought here by Deputy Sheriff M. N. Goss, with following history. Patient is in good physical condition. There is no history of consanguinity or heredity. This is the 1st attack: symptoms manifested one year ago. The disease seems increasing: not variable; no rational intervals. Derangement now shown by inaction: hallucinations in regard to sexuality. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. There is no history of any peculiarities previously shown, nor of any intemperance in self or parents, nor of any severe disease or head-injury. He has not been restrained or confined. Supposed cause of the disease is masturbation. He has had tonic treatment, without effect.

Mar 5 On admission, was put on B3. (G.H.N.R.P.) Complexion dark: hair dark-brown: eyes blue: condition of skin good: no marks scars or bruises noticed: is clean: behavior good). Mar 6/96. Slept only 5 hours last night: was somewhat restless. No pain or cough: behavior good: is quiet. Passes urine quite frequently: bowels seem regular: Eats well: has "delusions of poisoning". Mar 7/96. Slept 6 hours: is simple & foolish: laughs frequently at nothing in particular: Goes out walking daily. Eats well.
" 8 Mar 8/96. Behaves well & is quiet: says "he is going to have an operation performed upon him,
" 9 but does not know for what purpose". Mar 9/96. Much disturbed & restless, sleeping only 3 hours.
" 10 last night. Is quite restless today: walking up & down hall a great deal. Mar 10/96. Pulse about normal: says "he does not get lonesome, but would like to be more by himself, with
" 11 something to amuse himself with". Mar 11/96. Slept 6 hours, last night. Was very noisy
" 12 this Am.; "raving, crying & pulling his hair": spell lasted about 1 hour. Mar 12/96. Was
" 13 quiet, than heretofore, today: eating considerable. Mar 13/96. Slept 6 hours. Quite restless, today
" 14 apparently quite homesick. Is on regular & extra diet: out walking daily. Mar 14/96. Slept
" 15 6 hours, last night. Am. P 80: PM. P 88. Mar 15/96. Slept 8 hours. More restless than usual, today.
" 16 Quite excited, at times. Talks of being poisoned or killed frequently". Mar 16/96. Slept 7 hours.
Talks incoherently: laughs & sings, a great deal: quite noisy, at times. Breath quite foul.
" 17/18 Mar 17/96. Slept 6 hours: today, restless & noisy, as usual. Goes walking, daily. Mar 18/96. Slept
only 3 hours, last night: very restless 6 hours: noisy & at times very excited during day: Gave him
" 19 hot-bath (105°), continued for 5 minutes. Mar 19/96. Slept 5 hours: restless 24 hours: behavior
is restless & noisy: appears to be doing worse, every day. Summary: Patient was fairly
quiet & well-behaved, for several Days, after admission, but has become restless & noisy, and, at
times, very excited, of late. Physically, is in good condition, apparently: Skin good: in good
flesh: muscles large & well formed. Patient has delusions. "Calls everyone his father or
his sweetheart" & similar names. Has incoherency of speech. Sings a great deal & quite
" 27 well: laughs & talks to himself. Mar 27/96. Restless at night, but sleeps fairly well. (Urinates
" 28 in bed during the night). Mar 28/96. Sleep poorly now: appetite good: bowels constipated: Masturbates, during
" 25 night; also passes urine in bed: very noisy, at times: also destructive. Mar 25/96. Became quite violent,
this Am. Attacked Mr Schwartz: had to be held for some time. Is growing much more troublesome of late.
" 28 Mar 28/96. very troublesome, all day today. Transferred to TW. at 6 30 PM. Appeared somewhat excited:
" 29 given bath & put to bed. Mar 29/96. Slept only 5 hours, last night. Very restless all day: talked very ir-
" 30/ rationally. Makes no complaints. Mar 30/96. No change noticed. Mar 31/96. Very restless & quite
Apl 1/97 troublesome, during night & forenoon. No change noticed, today. Apl 1/96. Quite talkative, this morning;

Personal and Medical History of Julius. W. Henninger.

Apl 1 talks incoherently. 11 30 Am. Very troublesome & quite profane. Quiet in PM & Sept 10 to 3 30 PM.
" 2 6 45 PM. Transferred to B3. Apl 2/96. Wt 148 pds. Still restless, noisy & troublesome. Incoherent.
" 15 Is on medicine. Apl 15/96. Has been sleeping well, of late: Has also improved much. Talks some
rationally. Works on ward & in dining-room. Quiet & well-behaved. Bowels in good condition.
" 18 Apl 18/96. Has a very offensive breath: Has been on medicine (powders). Is, at times, also quite restless.
" 30 Apl 30/96. Has improved considerable, of late. Talks fairly rationally: no delusions or hallucinations
noticeable. Is restless, at times, when patient becomes irritated, because of confinement.
Sleeps well. Works on ward & in dining-room. Habits neat & clean.
May 1/96 to Apr 7/97 Summary Nurses Notes by Dr. Phelps May 1/96 wt. 148 lbs. Works quite well: is rather
well-behaved. June 10 Went to work in laundry did not work there very
long: Appetite poor: became somewhat depressed. Extra diet given. Placed upon
Infirmary: Rather stubborn & melancholy while there: no prominent physical
ailment. During September & October up & about again: Had to be urged to
eat: rather depressed & careless in behavior. Had to be fed at times
Nov. 9 Escaped from window: was found later on grounds: During December
improved rather more rapidly. January improved still more.
Apr 7 went home. Had become fairly well recovered altho there was
still a slight childishness noted in manner

Discharged.

Personal and Medical History of Emil Johnson

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4348.
Residence, South Stillwater, Minn.
Date Admission, 7th March 1896.
Admitted by Dr. Herzog Hour, 6 45 P.M.
How Sent, E. G. Butts. Sup't. Washington County.
Sex, Male.
Age, 22.
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Laborer (lumbering)
Degree Education, Common School
Profession Religion, not a church member
Habits, Not intemperate
Nativity, Sweden (Parents also born there)
Physicians Committing, W. H. Pratt and J. C. Clark
Correspondents, None given in papers

No. for Year, 176.
Insane Relatives, None so far as known
Cause Exciting, probably irritation from injured eye
Cause Predisposing, not given
Form, Pubescent insanity.
Accompanying Bodily Disorder, injury & left eye.
Suicidal or Not, Not.
Date of this Attack, about one week ago
Duration, about 1 week
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 22.
Time of Leaving, July 3. 1897
Time in Hospital, 1 yr. 3 mo. 26 da.
Result, Discharged Jan. 3. 1898 Recovered.

EXAMINATION ON ADMISSION.

Exam by R.M. Phelps. 3/16/96.

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: Is a young man who apparently is somewhat feeble & defective. Is rather unwilling to talk freely besides being unfamiliar with the language - Answers are straight as far as they go

Personal and Medical History of Emil Johnson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 Ft 10½ WEIGHT, 158 lbs NUTRITION,
WOUNDS OR ABNORMALITIES, Eye destroyed
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Rt. Eye only. Size, dilated some.
Response Light, Accommodation,
SIGHT, Left eye destroyed
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, None of note. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 6 - Equal EXAM. URINE,
Other
ARTICULATION, Good
Slurred,
Hesitating,
FACIAL EXPRESSION, not especially abnormal - possibly feeble.
SENSIBILITY,
HEART, Normal - palpitates on listening.
LUNGS,



TAKEN,

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, Brother in Stillwater.

Personal and Medical History of Emil Johnson

1896

This patient was brought here by Deputy Sheriff G.W. Smith with following history. Patient is in fair physical condition. No history of consanguinity or heredity, so far as is known. This is 1st attack; symptoms manifested about one week ago: walks the floor: talks to himself: refuses to answer questions. The disease seems increasing, but variables with rational intervals: but these not at regular periods. Derangement now seems to be manifested on religious subjects, chiefly. Patient is not disposed to injure others nor suicidal nor of filthy or destructive habits. No peculiarities had been previously shown. There is no history of intemperance in self or parents. Has had no serious disease &c except an injury to left eye, received when a child. He has not been restrained or confined, nor under medical treatment. Cause of the disease unknown, unless due to irritation from injured eye. Physical condition is fair, aside from eye. Patient refuses to answer any questions.

Mar 7 On admission, was put on B^3 (G.H.N.R'pt. Complexion dark: hair brown: eyes gray: condition of teeth good: is blind in left eye. Some scars on right arm, 1 inch long: is clean: behavior good: would not talk). Mar 8/96. Slept 8 hours, last night. Patient dull & apparently afraid: seems quite weak: bowels active. Talks some: cannot speak or understand English, apparently. Took 2 quarts milk & eg.
" 9 March 9/96. Slept 6 hours, last night. Still dull & stupid: ate a little cold food. Is quite restless, today
" 10 walking up & down hall much. Remained in hall, all day. Mar 10/96. Slept 7 hours, last night. — Transferred to IW. at 11 Am. Appears quiet: was given bath & put to bed. Has vomitated: ate fairly today. Has been restless & somewhat destructive, during P.M. 7^{30} P.m. Cold shower. Mar 11/96. Slept 6 hours, last night. Very quiet & stupid, this morning. Urinates regularly — given enema: bowels moved.
" 12 4^{30} P.m. Massage. Mar 12/96. Slept 6 hours. Behavior unchanged: will not talk but "answers, with a smile." Has eaten well today. Mar 13/96. Slept 7 hours. No noticeable change, today.
" 14 Mar 14/96. Slept only 5 hours, last night. Talked a little today: 3^{30} P.m. Massage. Eat well: bowels move. March 15/96. Slept 6 hours. Seems much brighter this morning, very restless,
" 16 during afternoon: out of bed frequently. 3^{30} P.m. Somewhat pugnacious. Mar 16/96. Restless & slept only 3 hours, last night. Lies quietly, this morning: no improvement noticed: has
" 17 been seen masturbating, occasionally, of late. Mar 17/96. Slept 7 hours: behavior does not
" 18 differ from Yesterday's. Eats well: bowels move. Mar 18/96. Slept 7 hours: 4^{30} P.m. Massage.
" 19 Mar 19/96. Restless & slept only 4 hours, last night. Very restless this Am. Seems some brighter.
" 20/21 Mar 20/96. Slept 7 hours. No change generally noticeable. March 21/96. Slept 6 hours, last night. Appetite good: bowels run regular: he has been restless, but quite well-behaved, all day. Says "he wishes to get up." Summary. Received on B^3: very quiet & stupid: remained so until 3rd day when was transferred to I.W. & put to bed: somewhat destructive in P.M. very quiet & stupid all night. Remained so until 7th day, when he brightens up some & talked a little. Very restless in morning of 8th day, but seemed brighter: somewhat pugnacious in P.M. very quiet & apparently stupid, on 9th day seemed to remain so until 14th day. Physical appearance has not been very good. Has somewhat emaciated, when received & has not appeared to gain any flesh. Appetite, after 3rd day, was good but bowels were irregular. Averaged 6 hours sleep, nightly. Temp. a trifle above normal, throughout. Received
" 23 Massage treatment on 4th - 7th & 11th - Days. March 23/96. No marked Change. Tho' he appears
" 24 some brighter. Mar 24/96. Somewhat destructive, this morning: tearing bedding. 11^{30} Am. Patient was

Personal and Medical History of Emil Johnson

1896

Transferred to B^3. Mar 30/96. Patient is very restless & quite noisy. Behavior not good. Very troublesome, striking other patients & causing much disturbance. Mentally, no change noticeable.
Apl 2/96 Apl 2/96. Abt 156 pds. Pulse 88. Apl 9/96. Noisy, restless, mischievous & troublesome; requiring
" 11 continued attendance. Apl 11/96. Transferred to B^1 at 11^{00} Am. Very talkative & restless.
" 13 Apl 13/96. No change in conduct or behavior: is noisy & restless; very stubborn & hard to make
" 17 them mind. Apl 17/96. Dr. H notes: "Has quite transformed since admission: was then melancholiac, with tendency towards stupor: is now maniacal: good appetite: restless & uneasy, fingers & talks: exalted." Apl 30/96. Behavior very restless & mischievous, both on hall & when out
" 30 with the crowd. If allowed, will keep constantly on the move: picks up chunks of dirt & sand & throws them at other patients. Habits clean. Works but little.
May 1/96 to July 3/97 Summary Nurses Notes by Dr. Phelps. May 1/96 Wt. 165. Behavior somewhat noisy & mischievous at this time. In June noted as imposing a good deal: worked in dining room. Latter part of June had a spell of obstinate behavior: Refused to eat & was fed with tube on June 29. In July improved somewhat altho still somewhat stubborn. Sept. improved quite a good deal: Talked quite rationally, ate well: was up & about. Worked along quietly on ward during early part of '97 & was finally sent home July 3/97 Having been behaving well in every way: Fairly well improved.

Discharged.

Personal and Medical History of James Reynolds.

ROBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4349.
Residence, Rice Co. Minnesota.
Date Admission, 9th March 1896.
Admitted by Dr. Phelps Hour, 6.45 P.M.
How Sent, R. A. Mott, Sheff. Rice County —
Sex, — Male —
Age, — 58 —
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farmer
Degree Education, none
Profession Religion, not a church member
Habits, not intemperate
Nativity, Otsego Co. N.Y. Father born in Ireland; Mother in N.Y.
Physicians Committing, Roscoe N. Jackson and W. A. Lang
Correspondents, none given in papers

No. for Year, 177.
Insane Relatives, none
Cause Exciting, unknown
Cause Predisposing, previous attacks
Form, Dementia terminal
Accompanying Bodily Disorder, Epilepsy (?) When Young
Suicidal or Not, not
Date of this Attack, some years ago —
Duration, — Some Year —
No. of Attack, not 1st.
No. of Admissions, 1st here (was at St. Peter).
Age First Attack, (?)
Time of Leaving, 14 Jany 1899.
Time in Hospital, 2 yrs 10 mo 5 da
Result, Died Valvular heart disease

EXAMINATION ON ADMISSION.

Exam by Dr. Phelps. about March 12 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: Exam a case of stupous melancholia, not very profound - Additional elements are those of age & arterial sclerosis - Probably delusions & dementia. but wont talk except with difficulty. Complains of pain in stomach & difficulty in overcoming constipation.

Personal and Medical History of James Reynolds

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

Copy.

Webster, April 25, 1896.

Dr. Kilbourne,

Dear Sir:- I hope you will excuse me if I am troublesom in writing so offten. but I an ancious to here from my Brother James Reynolds pleas to let me know how how he is mentely. you must not expect to much of him as his intilict has never been strong he has or was always sick once a year when a child and had spasims and when when he became a man he had Brain fever twice I think that weeking his intilect he was always very quiet seemed to take no intrest in ey thing. I will send him some close if he is to remain eney length of time if you will let me know what he needs. did he have eney diseas when he was taken to the asilem I mean bodley disseas

Yous respectably

Mrs John Molloy

Webster, Minne.

HEIGHT, 5ft 6in
WEIGHT,
NUTRITION,
GENERAL ABNORMALITIES,
TONGUE, Tremor,
Coating,
Prominence Movement,
SPEECH, Equality, Articulation,
Size,
Response Light,
Accommodation,
HEARING,
COORDINATION, Arms,
Gait,
Legs,
TREMORS, Hands,
Tongue,
Facial Muscles,
REFLEXES, Patellar,
EXAM. URINE,
ARTICULATION, Are there any words which you cannot pronounce readily?
Stumbled, Halting & Talk, Thin
Hesitating, Answers slowly
FACIAL EXPRESSION,
Dull & melancholy.
SENSIBILITY,
HEART,
Some arterial Sclerosis.
LUNGS,
TAKEN,

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,

Whole No.

Residence,

Date Admission, 9

Admitted by Dr. O.

How Sent, R. A. Mott, Jr.

Sex, - Male -

Age, - 58 -

Civil Condition, single

Children,

Age Youngest Child,

Occupation, Farmer

Degree Education, none

Profession Religion, not a church member

Habits, not intemperate

Nativity, Otsego Co. N.Y. (father born in Ireland, mother in N.Y.)

Physicians Committing, Roscoe N. Jackson and W. A. Lang

Correspondents, none given in papers

(Potter).

499.

Time 3 mos 5 da

Result, ular heart disease

EXAMINATION ON ADMISSION.

Exam by Dr. Phelps. about Mch 12 '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: Presents a case of stupous melancholia, not very profound - Additional elements are those of age & arterial sclerosis - Probably delusions & dementia. but wont talk except with difficulty. Complains of pain in stomach & difficulty in overcoming constipation.

Personal and Medical History of James Reynolds

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in WEIGHT, 130 lbs. NUTRITION,

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Left eye destroyed Size,

Response Light, Accommodation,

SIGHT,

HEARING,

COORDINATION, Arms, } Sluggish - wont get up - probably good - except as to age

Legs, }

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal.

Other

ARTICULATION, Has trouble in

Slurred, starting to talk. Then

Hesitating, answers slowly -

FACIAL EXPRESSION,

Dull & melancholy -

SENSIBILITY,

HEART,

Some arterial Sclerosis.

LUNGS,

TAKEN,

EXAM. URINE,

Passed 7 pm 2 P.M.

Character Clear.

Color Yellow

Sp. Gr. 1007

Reaction Acid

Albumen None

Sugar None.

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 James Reynolds.

1896

This patient was brought here by Deputy Sheriffs W. A. Hibbard, with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is not the 1st attack: was always weak-minded: was at St Peter hospital, where he was confined for 2 years. He came from St Peter better, but not cured: has grown gradually worse since. The disease seems increasing; variable with rational periods. Has outbreaks about every 3 or 4 weeks. Derangement now shows in that he thinks he is being mutilated &c. Lets urine right & goes at various things. Patient is disposed to injure others, but not suicidal, nor of filthy or destructive habits. Patient has always been unreasonable & high tempered. There is no family history of intemperance. Think he had Epilepsy, when young. Cause of disease is unknown. Has had no treatment except being at St Peter. His wit bright: cannot answer questions correctly: there is

Mar 9 an appearance of dementia. On admission, was put on B³ (G.H.N. B'pt. Complexion fair: hair gray: eyes brown: condition of skin good: back & left hip scarred: Social: behavior

" 10 is good). Mar 10/96. Slept 8 hours, last night. Has regular diet: bowels move: Skin dull & unstipid. Talks a

" 11 little: is quite feeble & tremulous: no cough noticed: makes no complaints. Mar 11/96. Restless and slept

" 12 only 2 hours. Last night: toiled his bed: was transferred to B¹. 8³⁰ PM. Very quiet all day. Mar 12/96. Slept 5 hours, last night. Eats poorly: did not take any supper, but drank 1 pint of milk. Bowels have not moved.

" 13 Is very quiet: sitting in same place, most all the time: very feeble: not able to dress or undress himself. March 13/96. Slept only 1 hour, restless 5 hours last night: does not move around. Trembles as tho he is cold. Refused breakfast, but ate a light dinner & supper. Transferred to I.W. at 9³⁰ am. Was in a very

" 14 feeble condition. Given bath & put to bed. Chest after going to bed: was very quiet during afternoon: Was given Enema: no effect. Very quiet all day: is somewhat filthy. Mar 14/96. Slept 6 hours, last night.

" 15 11⁴⁵ am. Again given Enema. 12⁰⁰ Turpentine stupe, applied to abdomen, relieved pain. Was fed: ate well today. Mar 15/96. Restless & slept only 4 hours, last night: has been very quiet, all day.

" 16 appears rather helpless. Has to be fed: eats lightly: bowels moved copiously. 3²⁰ PM. Very filthy. Mar 16/96. Slept 8 hours, last night. Appears somewhat stupid, this morning. Wets his bed. Otherwise

" 17 condition has not changed. Mar 17/96. Restless & disturbed: slept none, last night. Is still quite helpless. Is fed & eats quite well. Seems some stronger, tonight, and ate supper without assistance.

" 18 Mar 18/96. Slept only 2 hours, last night. No change noticed, this morning. Does not require feeding.

" 19 Mar 19/96. Quite restless, during night & slept only 2 hours. Appears to be improving gradually. Will talk more than usual. 7 PM. Complained of severe pain in abdomen: Applied hot cloths until 8 PM:

" 20 was given Enema: bowels then moved freely. Mar 20/96. Very quiet during night: no complaints, but slept only 3 hours. Complains this morning, of severe pain in pit of stomach: has been

" 21 somewhat restless during the day. Eats quite well. Mar 21/96. Slept only 1 hour, last night. Can notice no change, today. Eats fairly well: still complains of pain in abdomen. Habits filthy.

" 22 Lies quietly. Mar 22/96. Slept only 3 hours. Condition remains about same, from day to day.

" 23 Mar 23/96. Slept only 4 hours, last night. Behavior unchanged: seems continually in pain. Is very much constipated. Abdomen hard & quite swollen. Has some difficulty in

" 24 passing urine. Habits still filthy. Mar 24/96. Was very restless & slept only 1 hour, last night.

Summary: Patient was received at B³ &. Weak & feeble: quiet & somewhat stupid. Moved to B¹ on second day & remained until 4th day: then moved to I.W. & put to bed. Habits filthy; appetite quite poor, up to

Personal and Medical History of James Reynolds

1896

Summary Cont'd 4th day, when an improvement noticed, and up to last day, was quite marked. Bowels active from first day - have to get them to move even by enema: had more or less pain in abdomen, up to last day. For first few days, he trembled so that it was impossible for him to feed himself. Nerves became steadier on 4th day & he was then able to feed himself: Is a child, when put to bed, but recovered from it in a short while: no cough noticed: has averaged about 3½ hours sleep nightly. Talks very little that it is hard to gain much of an idea as to his mental state: he seems to realize very little of what is going on (See Attached records).

Mar 25/96 Mar 25/96. Still has pain in abdomen: Given Enema: Lies very quietly: Habits filthy. Mar 25/96. appears

" 29 better, today: pain in abdomen is quite slight - very quiet all day - Mar 29/96. Rested tolerably straight and

" 30 Slept very poorly (1 or 2 hours), but is quiet & easy, by day. Mar 30/96. Up in chair, in afternoon.

" 31 Mar 31/96. Slept 2 hours, last night - Has been very quiet, all day - Up, in chair, during PM.

Apl 1 Apl 1/96. Rested during night: slept only 2 hours: (See nurses' record on file 9/17)

" 2/7 Apl 2/96. Wt 119 pds. Apl 7/96. Has been resting very poorly at night. Lies very quietly: Makes no complaints: says "he does not wish to get up", but is up in chair, this PM. Eats very well.

" 11 Habits still dirty. Bowels require Enema quite often. Apl 11/96 Was out doors, in chair, today.

" 14 Put to bed again at 11⁰⁰ PM. Apl 14/96 Can see no improvement of late. Says "he feels bad always". Habits very filthy at times. Lies very quietly: never talks unless spoken to. Eats quite heartily, but does not seem to relish what he eats. Has complained some of pain in abdomen. Groans some.

" 19/20 Apl 19/96. Still complains of severe pain in abdomen: rolls in bed & groans. Apl 20/96. Appears

" 21 much easier, today & says "he feels some better". Apl 21/96. Complains, today, of soreness over entire body: principally across abdomen: Says "he feels very disagreeable after eating". Does not seem to relish food. Apl 26/96. No change noticeable. Still Complains of these pains: also, of headache. Physical condition seems very poor. Able to stand up, but says "it hurts him to walk".

" 30 Apl 30/96. Is restless, at night, & sleeps very poorly. Is about the same, all the time. Always

May 7 complaining of pains. Is quite weak. (See nurses' record on file as 9/17) - May 7/96. Patient's condition does not seem to change, from day to day: he appears in very poor physical condition: is quite feeble: continues to complain of pain in abdomen: says "he has pain while bowels move". Lies very

" 8 quietly: (out in chair at 6th in PM). May 8/96. Wt 113½ lbs: Quite restless, today: Will not talk: rather

" 14 weak & somewhat helpless. May 14/96. No change to note. Still lies very quietly: Habits filthy:

" 21 is given Enemata for bowels, often. May 21/96. Habits still dirty & filthy: Remains the usual

" 31 Complaints. No apparent Change in Condition. May 31/96. Still given frequent Enemata: No

June 3 Change noticeable in his Condition. June 3/96. Wt 112½ lbs. Patient remains in bed: lies

" 14 very quiet: Talks some to himself: Habits dirty: Sleeps poorly: June 14/96. Lies steadily in bed:

" 30 Somewhat restless of late: Condition seems about same, from day to day: bowels very irregular.

June 30/96. Still in bed: at times, restless & out of bed often: bowels still very irregular: Condition does not seem to change any.

July 1/96 to Aug 1/97 Summary Nurses Notes by Dr. Phelps. Patient sick: Kept upon Infirmary during nearly all of his stay here & sick wards notes kept during all of the time: Physical condition during this time has seemingly been quite senile: Has been in bed steadily: always appears demented & stubborn: Does not talk: whispers answers to questions. Frequently holds head up off of pillow for hours at a time: Sleep usually normal while physical state is impaired, no prominent physical ailment noted & There has been no change during period.

See Folio 72

Personal and Medical History of Edward Littel

HERBERT, PIGLER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4350.

Residence, Faribault, Minn.

Date Admission, 11th March 1896 —

Admitted by D. Phelps Hour, 3:30 P.M.

How Sent, R. A. Matt. Jo. Co. Rice County

Sex, Male.

Age, 31 years

Civil Condition, not married

Children, ——

Age Youngest Child, ——

Occupation, Laborer

Degree Education, Common School.

Profession Religion, Yes, Catholic

Habits, no histories of Intemperance.

Nativity, Wisconsin (Father's, Germany; mother's, Bohemia)

Physicians Committing, Brevoort Matlocks & W. A. Lang

Correspondents, None given in papers

No. for Year, 178.

Insane Relatives, Yes; his mother.

Cause Exciting, Sunstroke (?)

Cause Predisposing, Heredity & previous attack

Form, Mania sub acute

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, not

Date of this Attack, Within a few days

Duration, — a few days —

No. of Attack, Not 1st (one 14 years ago)

No. of Admissions, 1st here: (in Oregon 92-93)

Age First Attack, about 17.

Time of Leaving, April 19th 96.

Time in Hospital, 1 mos. 8 da.

Result, Disc. Apr. 30 96. Rec.

EXAMINATION ON ADMISSION.

Ex'd by D. Herzog. Mar 12/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Slightly Confused

Quick or Sluggish, quick

MEMORY:

Past Events, Considerably impaired

Recent Events, Considerably impaired

Special Subjects, Considerably impaired

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Seems correct

REASONING POWER:

Ordinary Subjects, Fair, but not continued

Own Mental State, realizes Condition

Special Subjects,

EMOTIONAL STATE:

~~Normal~~, Calm,

~~Indifferent~~,

Exalted, Yes

~~Depressed~~,

DELUSIONS:

Systematized or Not, None brought out

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Incoherent slightly

Voluble or Reticent, reticent slightly

GENERAL DESCRIPTIVE REMARKS:

Says: was in Salem, Oregon, Asylum; does not remember for how long nor when. Wore a muff most of the time, while there. Is now restless & inclined to be irritable. Is inclined to resent examination. Expresses no definite delusions. Is in mild maniacal condition. Nutrition seems very good: Large & powerful man.

Personal and Medical History of Edward Littel

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 11 in WEIGHT, 175 lbs NUTRITION, Good

WOUNDS OR ABNORMALITIES, Superficial pigmented circular scar on right fore arm.

TONGUE, Tremors, Slight Coatings, Slight grayish Coat somewhat pale Promptness Movement, Prompt

PUPILS, Equality, Yes Size, Slightly dilated

Response Light, Excessive Accommodation, Excessive

SIGHT, Seems good

HEARING, — do —

COORDINATION, Arms, Good: finger to nose, eyes shut, good.

Legs, Good: standing on foot, good: standing, eyes shut, good.

TREMORS, Hands, no Tongue, slight —

Facial Muscles, no General, no

REFLEXES, Patellar, 7 — 8 —

Other

ARTICULATION,

Slurred,

Hesitating, Good

FACIAL EXPRESSION,

face mobile

SENSIBILITY,

HEART, somewhat irregular, tones slightly muffled: no murmurs.

LUNGS,

Seem Good

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,		Constipated,	Irregular,
APPETITE, Good,	Record kept	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 Edward Little

1896

This patient was brought here by Sheriff's Deputy G. Geigher, with following history. Patient is in fair physical condition. No history of consanguinity, but there is of heredity: his mother was insane. This, not 1st attack: one occurred 14 years ago, in Wisconsin: duration about 2 weeks. (supposed to be caused by sunstroke): was also sent to an hospital in Oregon '92 – 3: no permanent benefit. First symptoms of this attack manifested within a few days: has been subject to delusions: Disease seems to be stationary: constant: Derangement now shown largely as religious subject: Patient is not disposed to injure others, nor suicidal, nor of filthy or destructive habits. – No peculiarities had been previously shown. There is no history of intemperance in self or parents: No special injury, unless supposed sunstroke: has only been confined as above stated. Supposed cause of the disease is sunstroke(?): has had no regular treatment outside of hospital: he is now found to be subject to religious & general delusions.

Mar 11 On admission, was put on B3 (G.H.N.R.). Complexion light: hair black: eyes gray: condition of skin good: no marks scars or bruises noticed: is clean: behavior good). at about 5.30 PM, it was deemed desirable to move patient to C1. Patient appeared uneasy: refused supper: makes no complaints. Mar 12/96. Was given a "dose" at bed time, last night, and slept fairly well. Has eaten fairly well, today. No Cough, cold or complaint to note. Inclined to be violent, by spells. Few medicine 4 times a day. Mar 13/96. Eats & sleeps fairly well: bowels moved.

" 13 " 14 behavior quiet, all day: Complained of being nervous, this am. Is given extra diet. Mar 14/96. Behavior quiet. Inclined to be stupid, by spells. Bowels move: Is still on medicine, daily.

" 15 Mar 15/96. Slept fairly well: has, still, a stupid spell: is sluggish in movements: talks quite rational-

" 16 -ally. Bowels did not move, today: was given cathartic, at bed time. Mar 16/96. Bowels moved 5, during the day: talk rationally, though, at times, confused. Appetite very fair: Still on medicine.

" 17/18 Mar 17/96. Eats & sleeps fairly well: no complaints: medicine discontinued. Mar 18/96. Behaves

" 19 well: talks quite rationally: Complains some of constipation. Transferred to A' E. Mar 19/96. Plays

" 20 games: talks freely: appetite fair: no complaints. March 20/96. No change especially noticeable

" 21/22 March 21/96. Behavior good: talks freely: no delusions noticed. Mar 22/96. Walked away from the crowd:

" 23 said "he wanted to go to Church". Came back willingly: when spoken to. Mar 23/96. Eats and

" 24/25 sleeps well: is on regular diet. Mar 24/96. About as usual. Mar 25/96. Behavior good: Talks freely: no delusions noticed. Appetite good: bowels seem more regular. Still seems somewhat silly, & weak minded. Admits, however, that there was something wrong with him. Works on ward.

Summary: On admission, was put on B3: subsequently, appearing uneasy & being inclined to become violent, by spells, he was transferred to C1. After the first few days, he became quiet: stupid & sluggish in movements & manner. By 7th day he had made some improvement & was transferred to A'. Had been quiet & well-behaved; talked rationally, tho', at times, confused. While on A', he has behaved well: has talked freely: admitting there was something wrong with him" – no delusions were noticed: has played games &c: has made no complaints, of late.

" 26 Mar 26/96. Visited by a friend. Mar 31/96. Patient is somewhat peculiar in his ways, & manner.

Apl 1/96 Talks freely: no delusions or hallucinations noticed. Eats & sleeps well: works some on ward. Apl 6/96 Wt 173 lbs. B3

" 18 Apl 8/96. Somewhat quarrelsome, of late: talking to himself: has refused to help on ward: said "he wanted pay

" 19 for his work". Apl 19/96. Visited by father & taken home by him on trial.

Discharged

Personal and Medical History of John Baker. No. 4352

From Folio 108

July 1/96 to Sept 1/96 Summary Nurses Notes by Dr. Phelps. July 1/96 noted as being on Infirmary: Temperature during last few weeks slightly above normal at times but usually quite well. Improved rapidly: Has, however, many delusions: Latter part of march up & about ward. Says he is in a hotel at Albert Lea: Is at times noisy: During month of September patient was becoming quite weak & rather cross & abusive: Coughs some, put to bed during September: noted as having asthma & congestion with some oedema. Died Sept 24/96 cause heart weakness, dicemia & oedema & general circulatory impairment.

Died.

From Folio 116

John J. Flannigan 4354

Sept 24/97 Patient remained same until latter part of month, from which time he has improved rapidly: Talks rationally & in a good clear voice: Receives Electrical treatments abdominal galvanism – 3 times weekly: also on medicine 3 × day

Oct 1 to 5 Continues to improve: Is very nervous, starts if spoken to suddenly Wt. 150 lbs. Trans. to A'. Oct 31 Went home today with wife.

Discharged.

Personal and Medical History of John Baker

ESSERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4352.
Residence, Manchester, Minn
Date Admission, 12th March 1896.
Admitted by D. C. B. Eby Hour, 6 (45) P.M.
How Sent, Heman Blackmer, Supt Freeborn County
Sex, Male
Age, - 59 -
Civil Condition, Married
Children, - 5 -
Age Youngest Child,
Occupation, Farmer
Degree Education, - moderate.
Profession Religion, Yes; Catholic
Habits, - not known -
Nativity, Germany; (parents also born there)
Physicians Committing, H. H. Wilcox and J. P. Von Berg
Correspondents, Wm John Baker (mail & 2d).
Manchester, Minn

No. for Year, 180.
Insane Relatives, not known
Cause Exciting, probably chronic meningitis
Cause Predisposing, probably age & Insolence
Form, Mania senila.
Accompanying Bodily Disorder, Paralysis Bowels &c
Suicidal or Not, - not -
Date of this Attack, 3 to 4 weeks ago
Duration, 3 to 4 weeks -
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, - 59 -
Time of Leaving, Sept. 24 - 1896
Time in Hospital, 6 mo. 1 da.
Result, Died
Valvular Heart Disease

EXAMINATION ON ADMISSION.

Exam. by C. M. Phelps - 3/16/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Somewhat sluggish.
MEMORY:
Past Events,
Recent Events, } Seems fair.
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Very deaf. Can't get much information from him. Seems a sluggish, feeble man - rather old - with senile Brain Atrophy + atheroma

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 John Baker

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ WEIGHT, 166 lbs. NUTRITION, Somewhat impaired.
WOUNDS OR ABNORMALITIES, Two cuts on nose - Kicked by horse - Enlarged veins on leg.
TONGUE, Tremors, Tremulous - Coatings, Reddish - raw look Promptness Movement, Fairly.
PUPILS, Equality, Unequal - Right larger - Size, Somewhat dilated
Response Light, Yes. Accommodation,
SIGHT,
HEARING, Very deaf.
COORDINATION, Arms, Not markedly impaired
Legs,
TREMORS, Hands, Not very noticeable. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 2-3 EXAM. URINE,
Other
ARTICULATION,
Slurred, Slow but clear
Hesitating,
FACIAL EXPRESSION,
Somewhat dull.
SENSIBILITY,
Arteries - Some atheroma
HEART, Feeble
Sounds accentuated.
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, Fair.	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 John Baker.

1896

This patient was brought here by Deputy Sheriff W. C. Mitchell, attended by John Fluidt. with following history. Patient is in good physical condition. No history of Consanguinity, nor hereditty known of. This is 1st attack. First symptoms manifested three to four weeks ago; was abusive, sleepless & restless, and would require members of the family to do needless and unusual work, such as banking pig-pen, straight & painting same, next day: would require four horses or one buggy, where one or two were sufficient. The Disease seems increasing variable & with natural intervals: is worse at night. Derangement now shown in that he is unreasonable buying things not needed, and, as above stated, requiring four horses or buggy: wants to go to town every night: goes to his neighbors during the night. He is disposed to injure others, but not suicidal, nor of filthy & destructive habits. No speculation - this had been previously shown. As to any history of intemperance, not known. He had an injury of nose and sunstroke 15 years ago: has not been restrained or confined, except by watching - Cause of the Delirium is probably chronic meningitis; has been under sedative & hypnotic treatment. No further particulars given. ——

Mar 12 On admission, was put on B3 (G.S.H.N.R.P.P.). Complexion dark: hair gray: eyes blue: Condition of skin poor: no marks, scars or bruises noticed. Is clean. behaves good: seems quite deaf). —
" 13 Mar 13/96. Was very restless & slept poorly last night. Condition is such, that it was deemed desirable to move him to I.W. at 10¹⁰ Am. Appears feeble: is quite deaf: was restless during afternoon.
" 14 was given hunyadi water: bowels afterward moved. Has eaten quite well, to day. Mar 14/96. Was very restless & out of bed frequently, during the night. coughed some: bowels moved: slept only 3 hours. seems somewhat confused this morning. Asks for his clothes. Ate well: bowels moved: urinates regularly: has been very restless, all day: out of bed quite often. Mar 15/96. Again very restless & slept only 3 hours, last night 12³⁰ am. a bloody discharge from mouth noticed. Behavior fairly good
" 16 all day, though out of bed quite often. Says he feels very bad, to night. March 16/96. Slept only 2 hours last night. Is more quiet this morning: has slight pain in stomach, his bowels move twice
" 17 daily. Rested fairly well, today. Eats well. Mar 17/96. Restless during night. Slept only 2 hours. Is
" 18 quiet, this morning: behaved well, during day: bowels quite loose. Mar 18/96. Slept only 3 hours. last night. Causes no change, this morning. Complains of slight headache, this P.M. Mar 19/96. Again
" 19 restless, sleeping only 4 hours. last night. Quiet & well-behaved, to day. Talks very little, but
" 20 quite rationally: Mar 20/96. Slept only 4 hours: Eats well: bowels move: makes no complaints.
" 21 sleeps some in morning. Quiet, today. Mar 21/96. Slept 5 hours: Condition does not seem to change.
" 22/23 Mar 22/96 Slept 6 hours: Lies quietly: asks to get up. Mar 23/96. Slept 8 hours: Is very
" 24 quiet, this morning. 1³⁰ Pm. Upon chair, 2½ hours. Mar 24/96. Slept only 4 hours: no change noticed
" 25 this morning. Up, in chair, during afternoon. Mar 25/96. Slept 6 hours: Condition remains apparently the same, day after day. Upon chair, during afternoon. He has been eating well:
" 26 bowels move quite regularly. Mar 26/96 Slept 7 hours, last night. No change noticed, today. Up in rolling-Chair, in P.M. Summary: Patient received at B3 & transferred to I.W. in following morning. Was put to bed. He has been quiet & well-behaved, during the 2 weeks, with exception of times when he would become restless & get out of bed. Appetite has been good, from first day: bowels loose: patient is somewhat weak & feeble, although seems stronger than when received. Upon roller-chair in afternoons

Personal and Medical History of John Baker

1896

Mar 12 of 11th 12th 13th & 14th Days - At first day, Temp. dropped from 100½ to 97⅘: (he did not seem affected by the sudden drop): after 1st Day, Temp. was about normal. He averaged about 3½ hours sleep, nightly. Does not talk much but seems quite rational - Is quite deaf. Mar 27/96. No change noticed. Sleeps well. 1³⁰ Pm. Up, in Chair.
" 28 Mar 29/96. No change. Upon chair, in P.M. Mar 30/96. 10³⁰ Am. Up & dressed: returned to bed 4¹⁵ Pm. ——
" 30 Mar 30/96. Quite restless during night & slept only 3 hours. 7³⁰ Am. Up & dressed: very uneasy & troublesome
" 31 moved to "Green Bay" Mar 31/96. Very restless, all night & slept none. Restless & quite troublesome, all day: appears confused 7³⁰ Pm. Transferred to B3. Apl 2/96. During the whole, patient has been sleeping
Apl 2 quite well, this month (about 6 hours, on the average) nightly. Apl 30/96. Patient is quite restless
30 generally. Very noisy, at times. Is hard of hearing & has an idea that everyone else is also deaf & that he must shout to make them hear. Asks to go home, very frequently; says "we have no right to keep him shut up here", & becoming very indignant over his confinement. Appetite good. Bowels in good Condition: habits fairly neat & clean. Complains, often, of headache & lies down
May 1/10 frequently, during the day. May 1/96. Wt 158 lbs. P78. May 10/96. Seems to have improved much, of late. Quiet during day & contented: lies down, much of day, while in doors. Eats & sleeps well:
" 16/14 bowels in good condition, generally. May 15/96 On medicine, 3 times a day. May 2/96. Refused to get up, this Am: became very excited: was taken up & dressed: very troublesome, all day, requiring Continual attendance of 2 nurses. Refused nourishment: also medicine. P100 R22 T99⅘.
8³⁰ Pm. Transferred to Infirmary Ward: was in an Exalted Condition: very noisy, and quite
" 22 unmanageable. Put in restraint sheet at 9 Pm. May 22/96. Slept none, last night. Has been fairly quiet, since taken out of restraint: has some cough & expectorates Contains blood.
" 25 May 25/96. Fairly well-behaved, of late. 3³⁰ Pm. Became noisy & pugnacious: was put in restraint sheet.
" 26/29 May 26/96. Very quiet this morning: taken out of restraint at 8³⁰ Am. May 27/96 No change noted.
" 31 May 31/96. Has Continued to sleep poorly: very troublesome at times, by day: requiring to be
June 2 tied very irrationally. Complains some of headache. June 1/96. Patient in bed. very restless & somewhat noisy: will not stay in bed. Thinks he owns the place & should have
" 7 the right to do as he pleases". June 7/96. Very quiet & well-behaved, of late: asks for his clothes,
" 8 says "he feels strong enough to get up": talks irrationally. June 8/96. Wt 144½ lbs: (has lost flesh)
" 10/13 June 10/96. No change noticed. Transferred to B3. (6³⁰ Pm). June 13/96 On medicine, 3 times
" 16 a day. appetite fair: he complains of constipation. Goes out in grounds, every day. June 15/96. Patient is quite troublesome: asking to have the door opened, "so he can go home". Thinks he is at a hotel & we
" 21 won't let him go, because he can't pay for his board. Is quite deaf. June 21/96. Complained
" 22 of a pain in left side: could not walk without help: says, bowels are Costive. June 22/96. Says left side, pains him very much, whenever he moves: & pain causes him to scream. Was
Transferred to I.W. at 10⁰⁰ Am. Given bath & put to bed. Is quite noisy. Complains of pain over heart. Heart is palpitating, intermittent: impulse forcible: murmur with 1st mitral sound.
" 23/25 June 23/96. Restless & somewhat noisy, during afternoon & night. Seemed in great pain. Slept none. June 24/96. He does not know when bowels moved last: was given enema. Is very restless: complains of pain,
" 26 all over body: pulse intermittent. Appears some better, today. June 26/96. Visited by nurse.
" 27 June 27/96. Discovered crabs on body: blue ointment applied: testicles swollen & somewhat inflamed:
" 28 bathed in alcohol. June 28/96 Appears some worse to day. Seems to suffer pain in region of heart: —
" 30 June 30/96. Seems to rest some easier. Testicles treated as before. (see attached sheet) —

See Folio 104

Personal and Medical History of Caspar Schneider

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4353.
Residence, Fairbault, Minn
Date Admission, 13th March 1896.
Admitted by Dr. Herzog — Hour, 3 45 PM
How Sent, R. A. Mott. Sh. Rice County.
Sex, Male
Age, — 66 —
Civil Condition, married
Children, 11
Age Youngest Child, ——
Occupation, at Turners-trade
Degree Education, Common School.
Profession Religion, not a church-member
Habits, "Indulges", occasionally.
Nativity, Germany: (Parents also born there).
Physicians Committing, D.M. Cook & M. L. Mayland
Correspondents, none given in papers

No. for Year, 181
Insane Relatives, None
Cause Exciting, not known: possibly anxiety.
Cause Predisposing, probably age
Form, Melancholia agitata.
Accompanying Bodily Disorder, Poor physical Condition. Partial loss of sight.
Suicidal or Not, Not
Date of this Attack, about two weeks ago
Duration, — about 2 weeks —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 66 —
Time of Leaving, Oct. 30, 1899
Time in Hospital, 3yr. 7m. 17d
Result, Died Chronic Interstitial Nephritis

EXAMINATION ON ADMISSION.

Ed. by Dr. Herzog March 14/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, somewhat confused.
Quick or Sluggish, Fairly quick —
MEMORY:
Past Events, Fairly Good
Recent Events, slight impairment, particularly during past 2 weeks.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, fairly alert
Correct or Illusive, Correct in the main
REASONING POWER:
Ordinary Subjects, slow
Own Mental State, realizes Condition
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Has had for some time past, Complicated hallucinations. Sees & hears persons talking at night. Ascertain, afterwards, that they are imaginary, but believes in them at the time. His account of them is quite unsatisfactory. He does not understand quite what they are doing. Has been sleepless. Denies trouble with relatives. —

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly.
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS: of sight and hearing —
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, quite coherent
Voluble or Reticent, fairly voluble

Personal and Medical History of Caspar Schneider

Willie Snyder
St Louis Borders,
East Grand Forks,
Minn.
Daughter of Caspar Schneider

...ON, CONTINUED.

...RISTICS.

NUTRITION, fair to good.

...was very feeble after
... coming on rather sud-
... days. He suddenly
...ng to think himself
...alked of suicide, was
troubled and ...

Daughter says there is no consumption in the family.

REFLEXES, Patellar, 6-7 = Equal
Other.
ARTICULATION,
Slurred,
Hesitating, Good
FACIAL EXPRESSION, somewhat
unintelligent appearance. Some acne Rosacea
SENSIBILITY,

HEART, Sounds weak: no murmurs
Arteries somewhat stiff.
LUNGS, Seem good. —

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, kept Constipated, Irregular,
APPETITE, Good, Record 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

BEBBET, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4353.
Residence, Faribault, Minn
Date Admission, 13th March 1896.
Admitted by Dr Herzog — Hour, 3 45 PM
How Sent, R. A. Mott. Jof P. Rice County.
Sex, Male
Age, — 66 —
Civil Condition, married
Children, 11
Age Youngest Child, ——
Occupation, at Turners-trade
Degree Education, Common School.
Profession Religion, not a church-member
Habits, Indulges, occasionally.
Nativity, Germany: (Parents also born there).
Physicians Committing, D.M. Cook and M. L. Mayland
Correspondents, none given in papers

No.
Insane Relat.
Cause Exciting,
Cause Predisposing,
Form, Melancholia
Accompanying Bodily Disorder, Poor health
Suicidal or Not, Not
Date of this Attack, about two weeks ago
Duration, — about 2 weeks —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 66 —
Time of Leaving, Oct. 30. 1899
Time in Hospital, 3yr. 7m. 17d
Result, Died Chronic Interstitial Nephritis

EXAMINATION ON ADMISSION.

Ed. by Dr Herzog March 14/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Somewhat Confused.
Quick or Sluggish, Fairly quick —

MEMORY:
Past Events, Fairly Good
Recent Events, Slight impairment, particularly
Special Subjects, during past 2 weeks.

PERCEPTIVITY:
Alert or Dull, Fairly alert
Correct or Illusive, Correct in the main

REASONING POWER:
Ordinary Subjects, Slow
Own Mental State, realizes Condition
Special Subjects,

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

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

HALLUCINATIONS: of sight and hearing —

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent, quite coherent
Voluble or Reticent, fairly voluble —

GENERAL DESCRIPTIVE REMARKS:
Has had for some time past, Complicated hallucinations. Sees & hears persons talking at night. Is certain, afterwards, that they are imaginary, but believes in them at the time. His account of them is quite unsatisfactory. He does not understand quite what they are doing. Has been sleepless. Denies trouble with relatives. —

Personal and Medical History of Caspar Schneider

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

Mr. Schneider.

Apr. 22nd. -- Was taken with La Grippe last February, was very feeble after it. First symptoms were noted the last of February, coming on rather suddenly; would for hours walk not speaking for several days. He suddenly claimed that the man told him he could speak, seeming to think himself controlled by some other man. Slept very little, talked of suicide, was troubled and walked about considerable.

Daughter says there is no consumption in the family.

REFLEXES, Patellar, 6-7 = Equal
Others,
ARTICULATION,
Slurred,
Hesitating, Good
FACIAL EXPRESSION, Somewhat contempt appearance. Some acne Rosacea
SENSIBILITY,
HEART, Sounds weak. Murmurs
Arteries somewhat stiff.
LUNGS, Seem good. —

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good, Record kept	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 [illegible]

Whole No. 4353.
Residence, Faribault, Minn
Date Admission, 13th Ma
Admitted by Dr Herzog
How Sent, R. A. Mott.
Sex, Male
Age, - 66 -
Civil Condition, marrie
Children, 11
Age Youngest Child, —
Occupation, at Iwo
Degree Education, Com
Profession Religion, not a c
Habits, Indulges occasionally.
Nativity, Germany: (Parents also born there).
Physicians Committing, Dr Cook & M. L. Mayland
Correspondents, none given in papers

Time in Hospital, 3yr. 7m. 17d
Result, Died Chronic Interstitial Nephritis

EXAMINATION ON ADMISSION.

Ed. by Dr Herzog, March 16th. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, somewhat confused.
Quick or Sluggish, Fairly quick —
MEMORY:
Past Events, Fairly good
Recent Events, Slight impairment, particularly during past 2 weeks.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly alert
Correct or Illusive, Correct in the main
REASONING POWER:
Ordinary Subjects, Slow
Own Mental State, realizes Condition
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly.
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS: of sight and hearing —
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, quite coherent
Voluble or Reticent, fairly voluble

GENERAL DESCRIPTIVE REMARKS:
Has had for some time past, Complicated hallucinations. Sees & hears persons talking at night. Is certain, afterwards, that they are imaginary, but believes in them at the time. His account of them is quite unsatisfactory. He does not understand quite what they are doing. Has been sleepless. Denies trouble with relatives. —

Personal and Medical History of Caspar Schneider

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6½ WEIGHT, 157½ lbs. NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES, see "G. A. N. Left": Double hernia, inguinal, not descending. —
TONGUE, Tremors, Quite marked Coatings, Clean Promptness Movement, Prompt
PUPILS, Equality, right slightly Contracted; left pupil is irregular & fixed adherents from accident. Size,
Response Light, right Good Accommodation, right Good
SIGHT, right eye impaired; left almost lost, from accident
HEARING, Fairly good
COORDINATION, Arms, slight impairment: finger to nose, eyes shut, uncertain
Legs, slight impairment: standing at foot, with difficulty: standing eyes shut, always sway.
TREMORS, Hands, None Tongue, quite marked
Facial Muscles, no General, no
REFLEXES, Patellar, 6-7 = Equal
Others
ARTICULATION,
Slurred,
Hesitating, Good
FACIAL EXPRESSION, somewhat unkempt appearance. Some acne Rosacea
SENSIBILITY,
HEART, Sound weak: Murmurs
Arteries somewhat stiff.
LUNGS, Seem good. —

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,	Record kept	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 *Caspar Schneider*

1896

This patient was brought here by Deputy Sheriff L. L. Hutchinson, with following history. Patient is in poor physical condition: As to consanguinity not stated: no insane relatives. This is 1st attack; first symptoms manifested about two weeks ago, by insomnia, with hallucinations. Disease seems about stationary: variable, with rational intervals; apt to occur in the daytime. Derangement now shown in that he has insomnia attended with hallucinations; seeing & hearing persons: one, a friend, trying to lead him right; the rest trying to lead him wrong. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in his habits. No peculiarities had been previously shown: he has "indulged" occasionally. Had a hurt, in 1859; (no influence on his present condition). He has not been restrained or confined: Dont know cause of disease; possibly, anxiety for the future, because of loss of sight (partial) & inability to work: no regular treatment: All of the above particulars are derived from him and his personal examination. —

Mar 13 On admission, was put on B3 (G. St. N. Hpt. Complexion light: hair gray: eyes blue: condition
" 14 of skin good: is blind in left eye: hernia, at both sides: is clean: behavior good). Mar 14/96. Slept
" 15 9 hours, last night. Bowels costive: gave him seidlitz powder, before breakfast: bowels, afterward, moved freely. Eats well. Talks well. Mar 15/96. Slept 7 hours, last night. Behavior good: is
" 16 quiet & rational: no delusions or hallucinations noticeable: goes walking, daily. Walks very well, considering his age. Mar 16/96. About the same. Habits are neat and clean.
" 17 March 17/96. Slept only 3 hours, last night: was restless 6 hours. Complains of dizziness & faintness,
" 18 today. Has some cough: expectoration slimy and rather dark in color. Mar 18/96. Slept only 1 hour, restless 8 hours, last night: coughing a great part of the night & raising phlegm. Eats poorly.
" 19 Mar 19/96. Slept 6 hours: Coughs & raises phlegm, day & night: complained of being exhausted
" 20 and weak & went to bed at 5 P.m. Pulse 80. R 20. Ja 1/99 – March 20/96. Slept 6 hours: Eats poorly: bowels seem regular. Behavior good: goes out walking daily & walks fairly well.
" 27 March 27/96. During this, the 2nd week, patient has, on the whole, been sleeping quite well, (5 & 8 hours) nightly – tho' he was very restless & slept only 2 hours, last night: some times, is up during night, frequently. During the early part of this week he was more dull, than usual, appeared confused: talked fairly rationally, at times. Is growing more despondent, though there are times when he will appear somewhat brighter. Complains of exhaustion, a good deal. Talks but little. no delusions or hallucinations noticed. appetite still keeps poor. Is on medicine. Summary. Patient has been very well-behaved, during last 2 weeks. Has been restless, at times, & not well contented. Physical condition run down. Complains of exhaustion and dizziness quite frequently. Talks rationally: no delusions noticed: has been growing more dull & despondent, of late, than at first. (see attached sheet)
" 31 March 31/96. Has been sleeping quite well, since last noted. Otherwise condition about the same.
Apl 7/1 April 2/96. Wt 152 lbs. Pulse 84. April 7/96. Seems to sleep quite well. Appetite fair: bowels not regular.
" 10 Takes medicine (capsules, 2 times, daily). Talks rationally: no delusions noticed. Is quiet and well-behaved. Appears to be failing physically. Apl 10/96. Arose & dressed, during the night:
" 11/30 had to be forced to retire again. Apl 11/96. Capsules discontinued. Apl 30/96. Eats fairly well, but still losing flesh, apparently. "Wants to get away from here", he says. Goes out on grounds, daily. Complains frequently of headache. —

Personal and Medical History of *Caspar Schneider*

May 1 Wt. 147 lbs: Patient upon extra diet: usually quiet & well-behaved: Has many delusions: During June was noted as becoming more weak: Complained that she could not go up & down stairs: Transferred to 4th. While there got along better: somewhat asthmatic in breathing, some circulatory impairment: Condition continues in this state up to date. July 31/97 Wt. 163# Oct 31/97 Has a good many delusions: Thinks he is visited by spirits & comparatively quiet & inactive. Jan 30/99 Patient still holds to very many delusions which seem to change from time to time. Jan 31/99 No change of importance noted during period
1897 Feb 4 – July 31/99. Wt. 179# Has many delusions & Physical health good – & incoherent in
Oct 3 1 speech. Oct 3 1/99. Wt 170#. Appetite good: bowels regular: habits tidy: works in dining-room: well-
" 20/21 behaved. Oct 20. Complains of not being well: legs swollen: appetite poor: pain in back. Oct 21
" 22/23 given salts. Oct 22. Some better today. Oct 23. Urinalysis made: trace of albumen. Oct 24. Feels
" 23/24 worse & was transferred to T.W.: put on medicine T.I.D. & milk diet. Oct 25. Patient is failing,
" 29/30 Respiration labored. Oct 29. very restless. Takes but little nourishment. Oct 30. Continues to fail rapidly and Died at 5th a.m.

Died

Personal and Medical History of John. J. Flanigan

BECKET, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4354.
Residence, Winona County, Minn.
Date Admission, 16th March 1896.
Admitted by L. Phelps Hour, 7.45 PM
How Sent, H. L. Buck. Jo P. Winona County.
Sex, Male.
Age, 39
Civil Condition, married
Children, Three
Age Youngest Child,
Occupation, Farmer
Degree Education, Common School
Profession Religion, Catholic
Habits, Formerly intemperate.
Nativity, Minnesota: (parents born in Ireland).
Physicians Committing, D. A. Stewart and W. T. English
Correspondents, Mrs Flanigan
Dakota, Minn

No. for Year, 182.
Insane Relatives, none
Cause Exciting, Meningitis, a year ago
Cause Predisposing, previous attack
Form, Melancholia acute stuporous
Accompanying Bodily Disorder, weakness re
Suicidal or Not, not
Date of this Attack, 2 months ago
Duration, — Two months —
No. of Attack, 2nd: (had one, 1 year ago)
No. of Admissions, 1st
Age First Attack, — 38 —
Time of Leaving, Oct. 31 '96.
Time in Hospital, 7 mo. 15 da.
Result, Discharged Jan. 5. 1897. Recovered.

EXAMINATION ON ADMISSION.

Eddy D. Herzog, March 17/96. **MENTAL CHARACTERISTICS.**

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

MEMORY:
Past Events, Seems Poor
Recent Events,
Special Subjects,

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

REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,

GENERAL DESCRIPTIVE REMARKS:
Will not speak: hardly seems to understand what is said to him. Extreme Physical depression. Condition quite serious.

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

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
Unknown

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Reticent

Personal and Medical History of John. J. Flanigan

MAY PLEAD INSANITY.

Minnesota Farmer Who Knocked Out a La Crosse Policeman.

La Crosse, Wis., Special, Feb. 8.—John Flanigan, the Minnesota farmer charged with committing an assault on Officer Joseph McGrath in the central police station, was placed on trial in the circuit court to-day. It was apparent from the outset that the case is to be hard fought. Both the state and the defense have a large array of witnesses, several of whom are experts on insanity. Dr. Stuart of the Rochester insane asylum will testify in behalf of the defense. His knowledge of Flannigan's mental aberration and the subsequent spasmodic attacks of insanity that he is alleged to have been subject to after being discharged from the asylum as cured is the principal support upon which the contention is based that Flannigan was insane when he struck McGrath. The court room was crowded with spectators to-day and much interest is being taken in the case.

FLANNIGAN Absolved

The Case Will Reach the Jury Probably To-day.

La Crosse, Wis., Feb. 12.—Dr. Gapin's testimony in the Flannigan case was the most important introduced yet, and would seem fatal to the defense's plea of insanity. Dr. Gapin thought that Flannigan's previous attacks of insanity in 1895 and 1896 were due to alcoholic ataxia instead of meningitis. This conclusion he drew from the evidence of his symptoms at the time. He though Flannigan was feigning hallucinations when in La Crosse the day he struck McGrath. The case will probably go to the jury late this afternoon.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 162½ lbs. NUTRITION, very much impaired.

MALITIES, per "G. H. N. Rpt."

Coatings, heavy dark brown: broken teeth. Promptness Movement, will not protrude.

Size, dilated

Accommodation, sluggish

Tongue,

General, can not stand

EXAM. URINE,



TAKEN,

17 Hesitating,
18 FACIAL EXPRESSION, Dull: downcast.
19 heavy headdown: constant twitchings of mouth
20 SENSIBILITY,
21
22 HEART, rapid, tumultuous, marked
23 Mitral Murmur
24 LUNGS,
25 Examination unsatisfactory.
26
27 OPHTHALMOSCOPIC EXAM.,
28 HABITS, Dirty, Clean, Careless,
29 BOWELS, Normal, Constipated, Irregular,
30 APPETITE, Good, Medium, Poor,
31 SLEEP, Good, Poor, Irregular,
32 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 John. T. Flanigan

EBBERT, FIELAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 43574.
Residence, Winona County, Minn.
Date Admission, 16th March 1896.
Admitted by L. Phelps, Hour, 7 45 P.M.
How Sent, H. L. Buck. Jo P. Winona County.
Sex, Male.
Age, 39
Civil Condition, married
Children, Three
Age Youngest Child,
Occupation, Farmer
Degree Education, Common School
Profession Religion, Catholic
Habits, Formerly intemperate.
Nativity, Minnesota: (Parents born in Ireland)
Physicians Committing, D.A. Stewart and W. T. English
Correspondents, Mrs Flanigan Dakota, Minn

No. for Year, 182.
Insane Relatives, No
Cause Exciting, Meningi
Cause Predisposing, previous
Form, Melancholia acut
Accompanying Bodily Disorder,
Suicidal or Not, no
Date of this Attack, 2 mo
Duration,
No. of Attack, 2nd: (had a
No. of Admissions, 1st
Age First Attack, — 38 —
Time of Leaving, Oct. 31 '96.
Time in Hospital, 7 mo. 15 da.
Result, Discharged Jan. 5. 1897
Recovered.

Choice farm loans and mortgages on improved properties in the cities of Duluth and Minneapolis. Apply
ST. PAUL TITLE & TRUST CO.
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I Must Sell My Kettle-Curlew and Boundary Camp Stock.
Best offer takes them. Good Reason for selling. Write at once for particulars.
OTTO MUNSON,
Bank of Commerce, Minneapolis, Minn.

...Ohio, have taken the ground ... the scheduled contest between ... ies, the champion pugilist of ... orld, and Ruhlin, a formid... val is to be a simon-pure p... ght; hence their petition for an ... unction. In this view the govern... nd his associates are upheld by th... any other experienced lawyers. ... The governor is making use of his ... full powers to prevent what he calls ... a "disgrace"; he has even secured ... the authorization of the state emer... gency board to spend as much as ...

EXAMINATION ON ADMISSION.

Exby Dr. Herzog, March 17/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Seems poor
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Will not speak: hardly seems to understand what is said to him. Extreme physical depression. Condition quite serious.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Much
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Unknown
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Reticent

Personal and Medical History of John. T. Flanigan

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 10in WEIGHT, 162½ lbs NUTRITION, Very much impaired.
WOUNDS OR ABNORMALITIES, see G.S.W. R. Eye.
TONGUE, Tremors, marked Coatings, heavy dark brown: tooth marks: Promptness Movement, will not protrude.
PUPILS, Equality, Yes Size, dilated
Response Light, sluggish Accommodation, sluggish
SIGHT, ?
HEARING, ?
COORDINATION, Arms, Much impaired. } usual tests not used;
Legs, Much impaired. } Can scarcely stand.
TREMORS, Hands, Yes Tongue, Yes
Facial Muscles, about mouth General, in standing
REFLEXES, Patellar, Exaggerated EXAM. URINE,
Other abdominal reflex exaggerated
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION, Dull: downcast.
hangs head down: Constant twitching of mouth
SENSIBILITY,
HEART, rapid, tremulous, marked Mitral Murmur
LUNGS, Examination unsatisfactory



TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,	Record lost	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 John T. Flanigan.

1896

This patient was brought here by Deputy Sheriff A. W. Fuhrman, with the following history. Patient is in poor physical condition. No history of Consanguinity or heredity. — This is not 1st attack: he had one, a year ago; duration 3 weeks: was not sent to hospital. First symptoms of this attack were manifested 2 months ago. Disease seems increasing: variable, no rational intervals. Derangement now shown by Dementia. Patient is disposed to injure others, but not suicidal, nor of filthy or destructive habits. No peculiarities had been previously shown: Patient was formerly intemperate: has been subject to disease: has required watching for 6 weeks. Supposed cause of the disease is Meningitis, a year ago. Has been under regular treatment by family physician. Patient is now in a demented condition. —

Mar 16 On admission, was put to I.W. (G.A.R. Ward. Complexion dark: hair black: eyes blue: Condition of skin good: has a hole or old wound at the side of right knee: is clean: behavior good: is rather weak). When received onward, seemed weak & was perspiring freely. Was given
" 17 bath & put to bed. Mar 17/96. Very restless & somewhat pugnacious, during night. out of bed frequently: slept none. Is very restless this morning: seems delerious: thinks he sees snakes held in bed: 8^00 am. Visited by relatives: 2^30 Pm. Given alcohol sponge bath. Very uneasy during afternoon: unmanageable at 8 Pm. was put in restraint: has taken fairly freely of
" 18 milk & eggnogs, today. Bowels do not move. Mar 18/96. Slept none, last night. Wet his bed. 7^45 am. Taken out of restraint. Was somewhat restless, at times, during day. 8^00 Pm. Catheterized.
16 oz. urine: S. G. 1020. Albumen: Some pus & mucus: ammoniacal odor. Is on diet of
" 19 eggnogs, milk & beef-tea. Takes freely of them. Mar 19/96. Very quiet during night. Quiet, this morning. 10^30 Sponge-bath. Slept some, today: There is noticed a distinct murmur, as of mitral regurgitation. Was very quiet, in afternoon. Is on diet of beef tea, eggnogs &c.
" 20 Mar 20/96. Quiet, all night: slept 7 hours. Very quiet, this morning: will not talk: 10^30 am. Catheterized:
13 oz. cloudy: alkaline: slightly ammoniacal urine. Sp gr. 1020: traces of albumen: 5^30 Pm. Wet bed.
" 21 Has been very quiet & apparently stupid, during day & night. Mar 21/96. Slept 7 hours. 5-20 am. Passed a large quantity of urine, in bed. Can see no change in condition. Bowels moved by aid of Enema.
" 22 Takes nourishment quite freely. Mar 22/96 6 Am. Bowels moved: has been very quiet, all day:
" 23 seemed stupid. Mar 23/96. Slept only 1 hour, last night: somewhat pugnacious, this morning.
" 24 Will not talk: Quiet, remainder of day. 4^00 Pm. Alcohol sponge-bath. Mar 24/96. Slept only 2 hours: is on light diet: (full quantity): passes urine in bed. Has been quite restless, all day.
" 25 11 am. Visited by friends: will not talk: seems stupid. Mar 25/96. Slept only 1 hour, last night.
" 26 Can notice no change, today: very restless, all day. Mar 26/96. Slept 5 hours. Restless and quite pugnacious, this morning: struck several times, at nurse. 10^30 Given Enema: required holding.
1^30 Pm. Put doors, in chair, for a bit while. Was fairly quiet, during afternoon: 9^45 Pm. Filthy.
" 27 Mar 27/96. Slept 6 hours. Very quiet & apparently stupid, all day: bowels did not move & he did not urinate, during day. Mar 28/96. Slept 5 hours: apparently no change. 2^30 Pm. Given shower-bath.
" 29 Mar 29/96. Slept none, during night. Behavior unchanged, this morning: very quiet & speechless, all day. Eats well. Mar 30/96 Slept only 3 hours: very quiet, this morning. Is perspiring freely.
" 31 2^00 Pm. Out doors, in roller-chair, for 1 hour. Quiet, until night. Mar 31/96. Restless, all night: slept none. Summary: From above notes, it will be seen that patient was,

Personal and Medical History of John T. Flanigan

1896

cont'd in admission, very restless & inclined to be pugnacious: had to be put in restraint for a time: very quiet, & apparently stupid on 4th-5th & 6th days: somewhat pugnacious, again, on 7th day - restless & apparently stupid on 8th & ninth days - pugnacious on 10th day & required holding. Was occasionally out-doors in roller-chair. Quite stupid on 11th day & remained so, until last day. Appeared quite weak, physically, when received & does not seem to have gained any great amount of strength during the 2 weeks. Was on strict liquid diet until 9th day, when he received light solids, with liquids between meals. Appetite was fair, throughout, tho' required considerable persuasion, at times. Bowels costive - did not move without aid of Physic & enema: had difficulty in passing urine & had to be catheterized (as noted). But he has passed urine, at irregular intervals since, by aid of Diuretics. Slept poorly throughout. Temp. varied: highest mark 101.8°: during second week, was about normal. Imagined he saw

Mar 31 snakes in his room, on 1st day: for remainder of 2 weeks, he would not talk. Mar 31/96. Has been very quiet & apparently stupid, all day. 1^30 Pm. Given alcohol & sponge bath: refused all food & medicines, between 1^00 & 4^00 Pm. April 1/96 Very restless, all night: had difficulty in keeping him in bed:

April 1 was filthy: slept none: perspired freely during day & part of night - 1^00 Pm. Became quite unruly: three men required to hold him until 3^00 Pm. Was given alcohol-sponge. Was comparatively
" 2 quiet, during night. April 2/96. 3^00 Pm. Mild & pugnacious. Put in restraint sheet 3^30 Pm.
" 3 April 3/96. Very restless, all night: slept none: made hard struggles. 8^30 am. Out of restraint.
" 6 Restless in forenoon: quiet in afternoon. April 6/96. Sleeps very poorly, only 3 or 4 hours, nights. Has been out-side some, in Roller-chair. Is very restless, at times & again more easy. —
" 7 April 7/96. Restless this am: tossing in bed. 3^00 Pm: violent & had to be held till 4^30 Restless,
" 11 remainder of Day & night. Slept only 1 hour. April 11/96. Had a "violent spell". Jumped out of bed; ran at onward & attacked nurses with chair: was held until quiet. April 14/96. No improve-
" 14 ment noticed. April 20/96. Has been somewhat better behaved, of late: is more obedient: appears
" 20 brighter. Is taken out in roller chair, during afternoon. April 21/96. Lies quietly in bed, tho'
" 21 becomes restless at times. Requires Enema, quite often. Is now on regular diet. Eats well.
" 24 Is given electrical treatment. April 24/96. Appears improving physically: behavior becoming better,
" 28 but will not talk. April 28/96. Still subject to occasional "violent spells", tho' usually well behaved of late: becomes uneasy & out of bed often: also stubborn. Appetite much improved, of late: habits
" 30 are dirty. April 30/96. No special change noted. Sleeping better, past 2 nights. Habits still dirty. (See nurse's record on file as 96).

Summary Nurses Notes by Dr Phelps. During May 96 upon infirmary: At times was quite wild & at others stupid & melancholy: and delirious behavior. Toward end of month improved somewhat: Behavior quite good: May 25 Became violent again, Trans. to 6:

June 16 Visited by brother today: No change in condition either mentally or physically: Behavior generally quite good but has occasional violent spells: Habits very filthy, Fed by Spoon to Eat & Sleep today - brought back by nurse: Visited by wife yesterday. Aug 1 Wt. 145 P. 110. Dr Herpel writes Patient somewhat emaciated: has tremor of lips & twitching of muscles: Skin greasy, heart somewhat irregular; murmurs as of mitral insufficiency: no signs of failure of compensation: Clean: fairly neat, very quiet: very seldom speaks & then in a whisper. Aug 25 Visited by friend: Talked rationally but very little. Aug 26 Asked for paper & pen & wrote home. Sept 3 Works on ward - Wt. 151 Pulse 104. Trans to B 6.

See page 104

Personal and Medical History of Ole Simle

ROBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4359.
Residence, Amherst, Minn.
Date Admission, 26th March 1896.
Admitted by Dr. Phelps — Hour, 3 P.M.
How Sent, E.V. Farrington, J.P. Fillmore County.
Sex, - Male -
Age, — 45 —
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Farmer
Degree Education, Limited: reads & writes.
Profession Religion, Yes: Lutheran.
Habits, not known
Nativity, Norway: (parents also born there).
Physicians Committing, J.H. Phillips and H. Jones.
Correspondents, none given in papers

No. for Year, 187.
Insane Relatives, not known
Cause Exciting, — not known —
Cause Predisposing, "chronic" -
Form, Dementia primary.
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, — Not —
Date of this Attack, about 3 weeks ago.
Duration, about 3 weeks.
No. of Attack, 1st.
No. of Admissions, 1st.
Age First Attack, (?)
Time of Leaving, Aug. 6' 96.
Time in Hospital, 4 mo. 11 da.
Result, Died. Phthisis Pul.

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps. 8/7/96.

MENTAL CHARACTERISTICS.

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

MEMORY:
Past Events,
Recent Events, } Seems Good -
Special Subjects,

PERCEPTIVITY:
Alert or Dull, } Not very good -
Correct or Illusive,

REASONING POWER:
Ordinary Subjects,
Own Mental State, } Rather Mat.
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Talks willingly & quietly. Can not be drawn out on subject of religion - Admits has been preaching - Feebleminded -

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 Ole Simle

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7½in. WEIGHT, 123½ lbs. NUTRITION, Fair - has weighed more.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, None. Coatings, White. Promptness Movement, Fairly prompt.
PUPILS, Equality, Equal. Size, Normal.
Response Light, Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms, Fairly good.
Legs, "
TREMORS, Hands, Slight Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Equal. EXAM. URINE,
Other
ARTICULATION, Fairly good.
Slurred,
Hesitating,
FACIAL EXPRESSION,
Slightly Simple
SENSIBILITY,
HEART, Normal.
LUNGS, Normal

TAKEN,

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) 53.5 (m) 62.5 H.-o.a. 34 Bi.a 30.5 Fmo.d. 14 Aur.p.d. 18.5 Bi.d. 13.6 F.L. 12.
Crown of head low - Rather flat — Long - Quite peculiar
HISTORICAL,
LENGTH OF INVASION, Long probably somewhat feeble minded ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any insanity
Mother or Mat. Relations, Dead -
Father or Pat. Relations, Dead -
Brothers or Sisters, Says 1 brother is worse than he

Personal and Medical History of Ole Simle

1896

This patient was brought here by Deputy Sheriff Edward Erickson, and attended by S. Farrington, with following history. Patient is in fair physical condition. As to consanguinity or heredity, nothing known. This is 1st attack; symptoms manifested about 3 weeks ago: wanders away from home: thinks his friends want to kill him. He has been slightly insane for years, but harmless. The disease seems increasing: not variable: no rational intervals; not for last 3 weeks. Derangement now shows on religion: thinks he must be instrumental in saving others, or they cannot be saved. Has delusions. Has made threats to injure others, but is not suicidal. No filthy or destructive habits. Patient has been peculiar for years: very religious: not been in right mind for years. Don't know of any history of intemperance. He has not been restrained or confined. Cause of the disease is not known: No medical treatment. Patient is suffering from Dementia.

Mar 26 On admission, was put on B 3/x (G.H.R.2%). Complexion dark: hair brown: (is bald): eyes brown: Condition of skin good though he has several light colored blotches on body: one scar on forehead, 3/4 inches long: is dirty: left shoulder-bone projects up: said "that it was broken". Behavior good: talks rationally. Was given bath: behavior good, tho' restless: talks fairly rationally. Mar 27/96 Slept 8 hours,
" 27 last night. Eat well: bowels move: is quite restless & mischievous. Talks rationally. Mar 28/96. very
" 28 restless & slept only 2 hours last night. Behavior about as usual. Mar 29/96. slept 7 hours. He was quiet,
" 29 today. Talks less: no delusions or hallucinations noticed. Mar 30/96. slept 7 hours: Pulse 84-80:
" 30 Eat well. Mar 31/96. slept 8 hours. P 80: bowels regular. Behavior good: habits fair, neat & clean.
" 31 Apl 1/96. Restless & slept only 3 hours, last night. Eat well: otherwise, no change noticeable.
Apl 1 Apl 2/96. Again restless, sleeping only 3 hours. Is very quiet, of late & goes out walking daily;
" 2 Apl 9/96. During this, the 2nd week, patient has been resting & sleeping well, about 8 hours nightly,
" 9 appetite has been good: bowels regular: behavior quiet: is stupid: out walking, daily. No complaints.
Summary: Behavior very good, during past 10 days: was quite restless & mischievous,
first 2 or 3 days. Is now very quiet. Physical condition good: mentally, is stupid. Sits on a
" 30 bench, most of day: talks little: no delusions noticed. Apl 30/96. Sleeps well. appetite good: bowels in
good condition. Remains in same condition, day after day. Talks none, unless spoken to. Is stupid &
foolish. Goes out on grounds, daily.

May 1 Wt. 136 lbs Pulse 80. May 2 Has boil on neck, also several sores on head. June 1 Appetite & bowels normal: Goes out on grounds daily: Is generally very quiet: Seems confused & cannot carry on a conversation: Is despondent. July 28 Habits untidy: Talks little & in a stupid, confused strain. Trans. to B 3. Aug 1 Wt. 115 lbs. Pulse 82.

Aug 5 Appetite very poor: Has refused all food for two days past. Is very weak.
Temp. 101/2 P 98 R. 24. Trans. to Infirmary. Restless most of night.
6 Temp. 99 4-96 P. 100-60 - R 21-18. Given milk & stimulants - Very weak & seems to be failing - given Lypo. Strych 1/20 gr. at 4 PM. & hot sand-bags applied to feet. Failed rapidly & died at 7:15 PM. Dr. Phelps notes Patient was feeble-minded - Seemingly imbecile He was not noted as failing especially at first. Lately he failed quite rapidly. The case was seemingly a kind of marasmus or simple failure of physical power. No special symptoms of special disease ever noted.

Died.

Personal and Medical History of Fred. Marge. or Mergo

ROBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4363.
Residence, Caledonia. Minn.
Date Admission, 28th March 1896.
Admitted by Dr. Phelps Hour, 7 3/5 P.M.
How Sent, Thos Ryan, Sh'ff Houston County
Sex, Male
Age, 21
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Farmer
Degree Education, limited: can read & write.
Profession Religion, Yes: Lutheran.
Habits, not stated.
Nativity, Minnesota (Parents born in Germany).
Physicians Committing, E.B. Johnston and W.W. Freeman
Correspondents, none given in papers.

No. for Year, 191.
Insane Relatives, None: (Father Cowkes)
Cause Exciting, Don't know
Cause Predisposing, not stated.
Form, Melancholia acute stuporous
Accompanying Bodily Disorder, Nervousness.
Suicidal or Not, — Not —
Date of this Attack, about Dec 19th 1895
Duration, about 3 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 21 (about)
Time of Leaving, March 30. 1897.
Time in Hospital, 1 yr. 2 da.
Result, Discharged Aug. 11. 1897
Improved

EXAMINATION ON ADMISSION.

Exam. by P.M. Phelps 4/3/96 **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: Slightly restless. keeps face covered. Knows everything that is said & will mind readily when asked but seems much depressed & afraid, is worried did not say a word

Personal and Medical History of Fred. Marge.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 10½ WEIGHT, 160 pds NUTRITION, Fair
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, No Coatings, None of note. Promptness Movement, Prompt.
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT, Probably good.
HEARING, "
COORDINATION, Arms, As a young man & motor signs are probably all good.
Legs, He is not in good condition to test.
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,



TAKEN,

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. (Ex. 24) 56 R. vc. a. 36.2 Bi. a. 35 Fo. a. d. 15.8 - Ant. p. d. 19.2 Bi. a. d. 12.5 F.L. 12.
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 Fred Mauge.

1896

This patient was brought here by Deputy Sheriff George Blexrud, with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is 1st attack; first symptoms manifested about December 19th 1895: Disease seems increasing: variable: but he is not rational. Derangement now shown by his being suspicious: has ran away. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. Before the accession of the disease, he was nervous, reserved & running away: his father drowned: Patient had pneumonia at age of 10 or 12 years. He has not been restrained or confined. Don't know Cause of the Disease. He has been under treatment by bromides, cathartics & croton oil blister on back of neck: (bromides given about 10 days). At time of examination he said nothing; did nothing: appearance & manner, excited & trembling: will not converse or follow his usual habits: will wander away: no further particulars given. " —

Mar 28 On admission, was put on B3 (G.S.B.N. Kpt. Complexion light: hair brown: eyebrows: Condition of skin good: no marks scars or bruises noticed: is clean: behavior stubborn: talks very little). —

" 29 Mar 29/96. Gave him bath, last night. Very restless & slept only 1 hour, last night. Patient is stupid: appears afraid: will talk none: Complains of pain in chest, or rather actions indicate a pain in the chest.

" 30 On regular & extra diet: Mar 30/96. Slept 6 hours, last night. Would talk a very little today. Went out walking: is very despondent: crying some. Says "his chest pains him". Mar 31/96. Slept only 2 hours: was restless all night & complaining of pain in chest. Bowels active. Was given seidlitz powder; bowels then moved. He is still despondent: cries a great deal. Wants to get out "and tries

" 31 door frequently. April 1/96. Restless, all night & slept none. Transferred to "Infirmary Ward" 7 P.M.

Apl 1 Be quiet: appears despondent. Was given bath & put to bed. Will not talk. Apl 2/96. Restless and disturbed & slept only 2 hours, last night. Condition appears unchanged this morning. Was given

" 2 shower-bath. Crying this P.M. (Wt 150½ pds). Apl 3/96. Slept only 4 hours, last night. Given shower-bath 1st P.M: Is despondent & crying. Very quiet, during afternoon. Eats well. Urinates regularly,

" 3 but bowels constipated. Apl 4/96. Slept 8 hours, last night. Bowel moved: no change noticed, today.

" 4 Makes no complaints. Apl 5/96. Slept 6 hours. Good appetite: bowels move: has been somewhat

" 5 restless, all day: was crying in P.M. Apl 6/96. Slept 8 hours, last night. Patient's behavior is

" 6 peculiar: at times, seems frightened: will not look one in the face: holds hands over eyes: cries occa-

" 7 -sionally: is continually shutting bed-room door, as if he wished to be alone. Apl 7/96. Slept 6 hours, last night. 10:30 A.M. Given Enema. No change noticed today. Bowels badly constipated.

" 8 Apl 8/96. Slept 7 hours. Bowels moved, today, by aid of Enema. No change in behavior noticed.

" 9/10 Apl 9/96. Slept 8 hours. Eats well. Condition about as usual. Apl 10/96. Seems brighter. Says "he feels

" 11 improved", seems to have recovered somewhat from his despondent state. Apl 11/96. Very quiet, but will

" 12 answer questions. Apl 12/96. No noticeable change. Appetite good but bowels still constipated.

" 13 Apl 13/96. Sleeps 7 & 8 hours, nightly, of late. Behavior unchanged. Up, dressed & out this P.M.

" 14 Apl 14/96. Very quiet, this morning: Up & dressed in P.M. 2:30 P.M. Was quite determined to leave

" 15 "Ward": made a hard struggle. Was quiet in a short time. Apl 15/96. Slept only 5 hours, last night

Summary: Behavior, for 2 weeks, peculiar: very quiet & despondent, till 13th Day, when he showed some signs of brightening up. While in B3 was trying doors, trying to escape. Then transferred to T.W. & put to bed. Had frequent "Crying Spells". Slight change for the better noticed up to last day.

Personal and Medical History of Fred Mauge.

1896

June 4th Physical appearance has been fair: for first few days. Complained of pain in chest. Appetite

Oct 16 good, throughout. Bowels irregular & constipated. Temperature about normal. From 15th has talked

" 18 very little, but rationally. Could notice no delusions. Apl 16/96. While at in afternoon, tried, several

" 21 times, to steal away. Apl 17/96. Quiet & despondent, but does not cry so much now: Continually asking

" 30 to go home. Apl 18/96. Behavior unchanged: still makes attempts to get away: Is out in afternoons. Physical health seems fair. Transferred to B3 today. Apl 20/96. Sleeps fairly well. Appetite very poor:

has to be coaxed into eating anything, at all. Bowels generally costive: (has been given pills, also salts). Patient appears very despondent. Is discontented & continually trying to escape, while out.

May 4/96 May 4/96. Wt 151 lbs. Bso. May 5/96. Appetite very poor: eats little, with much urging on the part of nurses.

" 15 Is very quiet: melancholy: will not carry on a conversation: will answer questions, at times.

" 29 May 15/96. Is on medicine, 3 times a day. (Has been visited by sister. on 7th 8th 9th 10th & 11th inst).

June 2 May 29/96. Has improved perceptibly, during past month: appears brighter. Eats fairly well, with considerable urging on part of nurses. Goes out on ground, daily. Medicine continued, 3 times, a day. Bowels in good condition. June 2/96. Appears Lame on left foot; says "he can not hurt it in any way".

" 5 June 3/96. Foot worse: is swollen some, on instep: cannot walk on left foot, today. is very painful.

" 10 Cannot keep shoe on foot. Transferred to T.W. at 2:30 P.M: was put to bed: foot bathed in

" 13 hot water & bandaged: he appears very despondent: does not wish to talk. June 10/96. Has been steadily in bed: leg & foot swollen & inflamed: he suffers much pain. June 13/96. Still refuses

" 16 to talk: is in much pain: habits dirty. Patient is emaciated. June 16/96. No improvement

" 18/19 noticed: visited by sister. June 18/96. Visited by brother. June 19/96. Lies quietly in bed: is

" 30 apparently easy: will not talk: has a bed sore. June 30/96. Has not seemed to suffer so much pain, of late. Still very quiet: Talks some: Urines some & feeds him: appears considerably better, today & is cleaner in his habits.

Summary Nurses Notes by Dr. Phelps. During July '96 patient was visited by sister several times. Temp. was about normal: Is content to lie quietly in a half stuporous way. During August rather more stuporous: Fed by nurse frequently: latter part of month taken up; exercise tried: No special change:

Nov 1 Patient has been about & more active Wt. 151½ lbs. Quite silly. Dec 1 Wt. 165 lbs. Dec 25 Put to bed. having a serious spell of vomiting & pain in chest. Temp. 104°. Diagnosis of lobar pneumonia made. Dec 31 Temp. has been up quite steadily, failing to have the usual reaction. Has been over 104 every day during last week. Visited by relatives each day. Rather restless & noisy of late. Jan 15 Patients temperature still 104° altho down as low as 102° on 9th. The lowest temp. taken this month. Active nursing & medical efforts necessary, of course, all this time. Jan 31 Patient has not had a recorded temp. below 102° during month: Coughs & expectorates some: Resp. varies from 22-28°: Pulse at times irregular. Feb. 7 patients temp. has been as low as 99°. Averaged 101 during first week of month. Feb. 14 Temp. averaged about 100 during week: Pulse intermittent at times: Feb 21 Temp. irregular: averaged about 100 last half of month. On 25th pleural cavity tapped & a large quantity of fluid drawn. Mch 14 Temp. quite nearly normal for past week: Still coughs. Has been up & about. Mch 29 Pleural cavity aspirated 56 oz. fluid drawn. Temp. usually below 100. Mch 30 '97 Went out on trial.

Discharged.

Personal and Medical History of *Charles Lang*

COSGROVE, PICKLER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4365.
Residence, St Paul Minn
Date Admission, 31st March 1896.
Admitted by Dr. Herzog Hour, 6 (45) P.M.
How Sent, G. Willrich, Jof P. Ramsey County
Sex, – Male –
Age, 51 Years
Civil Condition, married
Children, four
Age Youngest Child, 12. 9. 6 & 3 years
Occupation, – Carpenter –
Degree Education, – Some –
Profession Religion, Not a church Member
Habits, Intemperate –
Nativity, Germany: (parents also born there).
Physicians Committing, G. Stamm and O. A. Beal
Correspondents, none given in papers

No. for Year, 193.
Insane Relatives, Not known
Cause Exciting, alcohol
Cause Predisposing, previous attack
Form, Dementia alcoholic chronic
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, not attempted
Date of this Attack, about
Duration, – abo
No. of Attack, 2nd (Lad
No.
Age
Tim
Tim
Rest

DIAMONDS HIS MANIA.

Charles Lang Thinks Every Pebble Is Valuable.

Charles Lang, a carpenter fifty-one years of age, residing on the West side, was brought into the probate court yesterday and examined on information of insanity. Lang is said to have a very pleasant mania which causes him to believe that every little stone or pebble is a rich diamond, which he gathers carefully. His pockets were full of pebbles, and at his home he had a great variety of the same gems in a large beer glass. Although Lang's diversion is quite harmless, the probate court decided to send him to the asylum.

correspondent
Mrs. Pauline Lang (wife).
252 East Robie St.
Ill 3/96

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Ex by Dr Herzog

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,

ory of *Charles Lang*

Ernest Lang
% Union Stock Yards,
South St. Paul
Minn.

Correspondent for
Carl Lang. Feb '98

...N ON ADMISSION, CONTINUED.

...ISTICS.

...n. ...ebl 25/98
...klo Kellberg

Ich bitte mitzuschreiben wie lange mein Vater
in Winona mit zu bleiben ist bin ihn von 4/4 96
wird also nicht für mehr als von meinen Kindern
angenommen ½ 12 Mittags und für von meinen
Eigenes mit der Heckamt genommen, ist sehr
innen fest gefasst, und Notz dass sehr für
meine Kinder in Pflege und Religion
mehr ist es auf gezogen dies ist sehr
22. monat meine gearbeit ist sehr mit mir
Mann, 84. Berll Avant Einzelzimmer, in
und Ich bitte gearbeit, nun bitte ist Herr
Killberg, nur mein Entlassung, den meine
Kinder nimm nur Essen, Kleidung, und
so weiter, Ich bin so Gesund als nur einer

NUTRITION, Somewhat impaired
tonacele
um Promptness Movement, Slow, unsteady
Slightly contracted
modation, about normal

e, Quite weak.
al, ves

EXAM. URINE,

	...ean,	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 Charles Lang

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4365.
Residence, St Paul. Minn
Date Admission, 31st March 1896.
Admitted by Dr. Herzog Hour, 6 (45) P.M.
How Sent, G. Wilbrich, Jo P. Ramsey County
Sex, - Male -
Age, 51 Years
Civil Condition, married
Children, four
Age Youngest Child, 12. 9. 6 & 3 years.
Occupation, - Carpenter -
Degree Education, - Some -
Profession Religion, not a church Member
Habits, Intemperate -
Nativity, Germany: (Parents also born there).
Physicians Committing, G. Stamm and O. A. Beal
Correspondents, none given in papers

No. for Year, 193.
Insane Relatives, Not known
Cause Exciting, alcohol
Cause Predisposing, previous attack
Form, Dementia alcoholic chronic
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, not attempted, but propensity active.
Date of this Attack, about 6 weeks ago.
Duration, - abmt 6 weeks -
No. of Attack, 2nd (had one, 6 years ago)
No. of Admissions, 1st here.
Age First Attack, about 45.
Time of Leaving, Aug. 3. 1898
Time in Hospital, 2 yrs 4 m. 3 d.
Result, Discharged Feb. 8. 1898
Much Improved

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Ex by Dr Herzog

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,

...N ON ADMISSION, CONTINUED.

...ISTICS.

NUTRITION, Somewhat impaired -
...bonacele
...um Promptness Movement, Slow, unsteady
Slightly contracted
...modation, about normal

...e, Quite weak.
...al, ...us
EXAM. URINE,

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 Charles Lang

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4365.
Residence, St Paul Minn
Date Admission, 31st March 1896.
Admitted by Dr. Herzog Hour, 6(45) P.M.
How Sent, G. Wilbrich, Jo P. Ramsey County
Sex, – Male –
Age, 51 Years
Civil Condition, married
Children, four
Age Youngest Child, 12. 9. 6 & 3 years.
Occupation, – Carpenter –
Degree Education, – Some –
Profession Religion, not a church Member
Habits, Intemperate –
Nativity, Germany: (parents also born there).
Physicians Committing, G. Hamm and O. A. Beal
Correspondents, none given in papers

No. for Year, 193.
Insane Relatives, not kno
Cause Exciting, alcohol
Cause Predisposing, previous attac
Form, Dementia alcoholic chronic
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, not attempted
Date of this Attack, about 6
Duration, – abou
No. of Attack, 2nd (Las
No.
Age
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DIAMONDS HIS MANIA.

Charles Lang Thinks Every Pebble Is Valuable.

Charles Lang, a carpenter fifty-one years of age, residing on the West side, was brought into the probate court yesterday and examined on information of insanity. Lang is said to have a very pleasant mania which causes him to believe that every little stone or pebble is a rich diamond, which he gathers carefully. His pockets were full of pebbles, and at his home he had a great variety of the same gems in a large beer glass. Although Lang's diversion is quite harmless, the probate court decided to send him to the asylum.

correspondent
Mrs. Pauline Lang (wife)
252 East Robie St.
Ell 2/96

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Ex. by Dr Herzog

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 Charles Lang

EXAMINATION ON ADMISSION, CONTINUED.

RECEIVED FEB 7 1898 STATE HOSPITAL

Rochester N. Hospital d 5/2 98

Mr. Ingebrand vorit Dicklor Kilborn

Ich habe mit ihnen nichts zu thun, ich bin Arzt, will mich mit ihnen nicht sprechen, ich bin fix und fertig mit ihnen, ich habe nichts mehr mit ihnen zu thun, ich habe mit ihnen nichts zu thun, ich habe mit ihnen nichts zu thun, ich habe mit ihnen nichts

Personal and Medical History of Charles Lang

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4365.
Residence, St. Paul. Minn
Date Admission, 31st March 1896.
Admitted by Dr. Herzog Hour, (45) a
How Sent, G. Wilbrich, Jof P. Rams
Sex, - Male -
Age, 51 Years
Civil Condition, married
Children, four
Age Youngest Child, 12. 9. 6 & 3 years
Occupation, - Carpenter -
Degree Education, - Some -
Profession Religion, not a church Mem
Habits, Intemperate -
Nativity, Germany: (parents also born
Physicians Committing, G. Hamm and O. A.
Correspondents, none given in papers

No. for Year, 193.
Insane Relatives, Not kn.
Cause [illegible]

Ex. by Dr. Herzog

EXAMINATIO

MENTAL CI

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:

...ONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Ich Kann, ist fals in meinen Leben noch Keine Kopf Schmerzen gehabt also Kein Syntz von Apoplexie, oder Schlagfluss nur 2 Tage im Arbeitshaus für nichts, war bezahlt als mein Testament zu lange ist sind 83 von Europa als Mitglied und Ingenieur, bitte wegen uns Entlassung

Hochachtungsvoll
Carl Heinrich Lang
Tel Robe 252 west St
Paul

Personal and Medical History of Charles Lang

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 9¼ WEIGHT, 157 lbs. NUTRITION, Somewhat impaired.
WOUNDS OR ABNORMALITIES, Slight ptosis - Double bubonocele
TONGUE, Tremors, Quite marked. Coatings, Yellow over dorsum Promptness Movement, Slow, unsteady
PUPILS, Equality, Yes. Size, Slightly contracted
Response Light, About normal Accommodation, about normal
SIGHT, Impaired - myopic and presbyopic.
HEARING, Good
COORDINATION, Arms, Slightly Impaired
Legs, Slightly Impaired
TREMORS, Hands, Some Tongue, Quite weak.
Facial Muscles, no General, yes
REFLEXES, Patellar, Equal EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
Animated and changing
SENSIBILITY,
HEART, Sounds weak - Somewhat rapid. no distinct murmurs.
LUNGS, Green Good.

TAKEN,

...THALMOSCOPIC 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 *Charles Lang*.

1896

This patient was brought here by Deputy Sheriff W. N. Goss, with following history. Patient is in fair physical condition. No history of insanguinity: as to any heredity, unknown. This is not 1st attack: he had one 6 years ago, duration about ½ year; was then sent to workhouse. First symptoms of this attack manifested about 6 weeks ago. Previously, had been quarreling with everybody. The Disease seems increasing; not variable: no rational intervals: he is always in the same condition. Derangement now shown by delusions: finding "diamonds"; digging cisterns in the yard - time &c. Patient is disposed to injure others: has not attempted suicide, but propensity now active: no filthy or destructive habits. No history of intemperance in parents. Patient had a little influenza. As stated, was confined at workhouse six years ago, for ten weeks. Supposed cause of the disease is alcohol.

Mar 31 On admission, was put on T3 (G. S. N. Rpt. Complexion dark: hair dark: eyes blue: condition of skin good: has double hernia. Is dirty: behavior good). Apl 1/96. Slept 5 hours, last night. Appetite good: bowels regular. Is quite restless, today. Apl 2/96. very talkative &, at times, noisy: singing & whistling much. Apl 3/96. Slept 5 hours, last night. Shows his delusions. has several little pebbles & pieces of glass, which, he says, are diamonds & are very precious. He eats well: bowels regular. Apl 6/96. Sleeps about 5 hours, nightly. Continues very restless, by day & quite noisy, at times. Quite troublesome, requiring almost Continual attendance Apl 8/96. Still restless & noisy: Goes out walking, every day; will not say much Concerning his "diamonds". Apl 9/96. Restless, sleeping only 4 hours, last night. Still quite troublesome, noisy and restless. Talks very little. Apl 10/96. Again restless, sleeping only 5 hours. Talks very little with nurses & very much with patients. Apl 14/96. No change noticable. Sleeps quite well. behavior not good: is obstinate & stubborn: walks the hall much: is restless: sings & whistles quite noisily, at times. Summary. During past 2 weeks behavior, as stated, has not been good. Has quite communication, during first few days. Still holds to the delusion above noted. No other special delusions noticed. Talks quite rationally, generally. Physical condition is good: Muscles large & well-formed: bones large: Skin good. Apl 20/96. Has been sleeping very poorly, of late, (only 3 to 5 hours), nightly. Is very troublesome, generally. Restless & noisy, a great deal of the time. Steals everything he can put in his pockets or hide it somewhere: has pockets full of papers and trinkets of all sorts, that he picks up. Is stubborn & violent, at times. Apl 27/96. Still sleeps very poorly. Have trouble with patient, every day: Is very mean & mischievous. Apl 28/96. Transferred 2 & 3.

Apl 30/96 Patient is very troublesome & mischievous: at times, very noisy: untidy in dress and habits. Has many delusions. Physical condition apparently good.

May 1/96 Summary Nurses Notes by Dr. Phelps. Patients condition that of considerable restlessness Is occasionally troublesome & At times filthy May 3 Stole a knife out of dining room.

May 1/97 Patients condition during year Has been so uniformly the same as to need very few special notes: He works some: Is rather rational in talk but always irritable & always filling pockets with trash. Aug 3/97 Wt. 178 lbs. Rather noisy & troublesome: Is inclined to steal things: Sept 2 97 At times violent & incoherent; has however, a fair appearance of general intelligence & can work along in a fairly intelligent way. Aug 3/98 Works some. Has not of late seemed to have many

Personal and Medical History of

delusions: Has worked along in a quiet trustworthy way: Not violent of late.

Discharged.

Personal and Medical History of Ole Christenson or Christianson

ROBERT, FIELAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 436 J.

Residence, not known: (Lives a tramps).

Date Admission, 3rd April 1896. —

Admitted by D. Phelps Hour, 11 30 A.M.

How Sent, Eman Blackmer. Jeff. Freeborn County

Sex, Male

Age, 35

Civil Condition, single

Children, one

Age Youngest Child,

Occupation, Laborer

Degree Education, not known

Profession Religion, Not known

Habits, — Not known —

Nativity, Norway: (Parents also born there).

Physicians Committing, A.G. Wedge & G. W. Barck

Correspondents, none given in papers

Apr 2/96 C.G. Anderson Supervisor says "patient worked for Albert Anderson Dodge Center Minn + also for Dan. Watson (or Wastrom) Same place — when he came to this Country about a year ago. P.M.

No. for Year, 195

Insane Relatives, not known

Cause Exciting, not known

Cause Predisposing, not known

Form, Mania subacute.

Accompanying Bodily Disorder, none mentioned.

Suicidal or Not, not stated

Date of this Attack, not stated

Duration, not given

No. of Attack, not known

No. of Admissions, 1st, here

Age First Attack, not known

Time of Leaving, Dec. 26. 1900

Time in Hospital,

Result, Transferred to Hastings. OK/pw

EXAMINATION ON ADMISSION.

Evd by D. Herzog, April 4/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, somewhat sluggish

MEMORY:

Past Events, somewhat impaired

Recent Events, considerably

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, Correct in the main

REASONING POWER:

Ordinary Subjects, Slow

Own Mental State, does not understand

Special Subjects,

EMOTIONAL STATE:

~~Normal~~, Calm,

~~Indifferent~~,

Exalted,

Depressed, slightly

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS: "of vision" —

ILLUSIONS:

CONVERSATION:

~~Coherent or~~ Incoherent, slightly

~~Voluble or~~ Reticent, somewhat

GENERAL DESCRIPTIVE REMARKS:

Was reported as being maniacal before coming here. Has, since, been stupid + quiet. Hair unkempt; clothes ragged. Speaks no english. Was born in this Country but a short time. + has not done very well. At the beginning of this attack, he says "he saw spirits over a pile of stones on which he had been working + they frightened him". Says "has seen them before". Says "has never been in hospital or asylum before. Conversation not very satisfactory as interpreter was not too intelligent.

Personal and Medical History of Ole Christensen

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, fairly good, but somewhat impaired

WOUNDS OR ABNORMALITIES, see "G. H. U. Report"

TONGUE, Tremors, marked: fine + coarse Coatings, tongue large, whitish coat in centre Promptness Movement, flows: deviates to left

PUPILS, Equality, equal Size, slightly contracted

Response Light, very sluggish Accommodation, very sluggish

SIGHT, seems good —

HEARING, " "

COORDINATION, Arms, some incoordination: fingers to nose, eyes shut, hesitating + uncertain.

Legs, some incoordination: standing + gait with difficulty: staying, eyes shut, sways slightly.

TREMORS, Hands, some Tongue, fine + coarse

Facial Muscles, no General, slight, on standing —

REFLEXES, Patellar, q = equal EXAM. URINE,

Other slight clonus

ARTICULATION,

Slurred, } Sing-song Norwegian

Hesitating, } Dialect

FACIAL EXPRESSION, head - down: transverse furrows on forehead: not marked on right side —

SENSIBILITY, ✓

HEART, rapid — sounds good

LUNGS, seem good

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,	Record kept	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 Ole Christensen.

1896

This patient was brought here by Deputy Sheriffs E. H. Ellickson & W. B. Mitchell & was attended by Ole Soli. The following history comes with patient but it is pathetic meagre. He is in fair physical condition. As to residence, religion, education, consanguinity, heredity, number of attack, nothing seems to be known. Was found wandering about in the country, this morning. Disease appears to be increasing: if variable or there are rational intervals not known. Cannot find out much about him. Knows what way derangement is now & how is not known. He appears to be generally wild. Will injure others; appears to be combative; but if suicidal, is not stated. Is filthy and destructive in habits. If any peculiarities had been previously shown, if any history of intemperance, or of any severe disease, or head injury or if under any medical treatment, not known. He had to be bound today. He is just wild and ungovernable. Cause of the disease is not known.

April 3 On admission was put on B.V. (G. H. N. Rkt. Complexion light: hair brown: eyes gray: condition of skin fair: some marks on back, as if done by strap: 2 scars on right leg: 1 on left side of chest: and one on right arm: no ulcers noticed: bruises on both heels, as if done by shoes: no hernia noticed. no vermin on him, but hair dirty: no bodily peculiarities noted. Is quiet: Speaks but little English. Ate a good dinner: was given bath. Sat in Bay: was very quiet: Bowels moved at about 5 P.M.

" 4 April 4/96. Restless, sleeping only 3 hours, last night: 10 00 am. Had a "spell" & was somewhat noisy: Worked a little, onward. Out walking in afternoon: gave no trouble: Eats well: bowels regular.

" 5 April 5/96. Slept 5 hours, last night. Very quiet: makes no trouble. Apl 6/96 Sleeps poorly: No change noticed in his condition. Talks but little. Works onward. 12 M. Ate in dining-room:

" 7 was very quiet & behaved nicely. Apl 7/96 Slept 8 hours, last night. No change noticed.

" 8 No complaints. Works onward. Apl 8/96. Seems the about same, from day to day. Talks only when

" 9 spoken to. Does not speak English, but understands it. Habits clean. Apl 9/96 - Slept well, last

" 12 night. Works onward: no complaints. Appetite good: bowels regular. Apl 12/96. No change specially noticeable. Behaves well: very quiet: reads a good deal & seems interested in what he is

" 17 reading. Works willingly. Goes out walking. Makes no trouble. No complaints. Apl 17/96. Sleeps well, (7 & 8 hours), nightly. Seems to be gaining flesh: Well-behaved: quiet & apparently contents: Makes no complaints. Eats well: bowels regular. Summary. The first day, on the ward, he was very quiet: During 2nd day, he had a "noisy spell", which lasted only a few minutes, actions then very odd; jumping around "Bay" in a half-standing position. Since then, has been very quiet & well-behaved. Appetite Good during the 2 weeks. Has worked willingly, onward. Slow in movements & somewhat slow to comprehend. Sits with head hung down. Is hard to catch his eye: is apparently near-sighted. as, when reading, he holds the paper close to face. Has made no complaints & is apparently contents with Hospital life. Slept well, for past 10 days or so. Habits clean. He has delusions: plainest seen when talking in

" 30 his own language. Does not speak English. Apl 30/96. Appetite good: bowels regular. Behaves good. works onward: seems to understand fairly well. Slow in actions: Habits neat & clean, of late. Still shows delusions. Makes no complaints.

Apr 9 Summary Nurses Notes by Dr Phelps - Patient quiet & rather dull: Notes of past year show very little variation. Has worked most of time with masons & with Mr. Storey.

Personal and Medical History of

His health has been good: Is usually quiet: Wt. 199 lbs. May 1/97 Wt. 201 lbs Works daily with masons: Is quiet & well-behaved also dull & even stupid. Jan 31/99 Still working with masons. No change of importance during period.

Feb 1 - July 31 '99 (Dr Wasmons) Wt. 185 lbs Works every day with stone masons. Jan 1 Wt. 197 lbs Pulse 86. No apparent change in condition during period. Aug 1 - Jan 31 1900. (Dr Wasmons) Wt. 194 lbs. Is quiet: works outside: Feb 3. Remained indoors today on account of the cold - Appears brighter & more interested in surroundings: Reads & talks more.

March 06. Refused to work outside. Apr. 06 Trans. to Hastings

Personal and Medical History of James Rice

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4370.
Residence, Vermillion, Dakota County, Minn.
Date Admission, 9th April 1896.
Admitted by Dr. Phelps Hour, 6:30 PM.
How Sent, Thos. P. Moran. Jo P. Dakota County
Sex, Male.
Age, 22.
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Farmer
Degree Education, Common School.
Profession Religion, Yes: Catholic
Habits, Not Stated (uses tobacco & wines)
Nativity, Minnesota: (parents born in Ireland)
Physicians Committing, A.M. Adsit and A. VanBeeck.
Correspondents, (Father) Peter Rice
(See attached letter) Hastings, Dakota Co.

No. for Year, 198.
Insane Relatives, None: father occasionally drinks
Cause Exciting, Derangement of digestive organs & Excessive use of tobacco
Cause Predisposing, — not given —
Form, Pubescent insanity, Melancholia
Accompanying Bodily Disorder, Indigestion
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, — 22 —
Time of Leaving, Apr. 26. 1900
Time in Hospital,
Result, Transferred to Hastings. [illegible]

EXAMINATION ON ADMISSION.

Dr. Herzog, April 9 1896. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, somewhat confused
Quick or Sluggish, sluggish
MEMORY:
Past Events, fairly good
Recent Events, somewhat mixed
Special Subjects,
PERCEPTIVITY:
Alert or Dull, fairly alert
Correct or Illusive, Correct, in the main
REASONING POWER:
Ordinary Subjects, slow, but accurate
Own Mental State, realizes something is wrong
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Says "is much better than was on admission. Had been sleepless: imagined "he heard voices" in the night, but recognized them to be unreal. Had confused mixed feeling in the head, with attacks of dizziness. Had loss of appetite, tenderness of abdomen, no vomiting. At present, epigastrium is tender.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, slightly
DELUSIONS:
Systematized or Not,
Special Subjects, none noted.
Transitory or Not,
HALLUCINATIONS: had hallucinations of hearing?
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, coherent
Voluble or Reticent, somewhat reticent

Personal and Medical History of James Rice



THOS. P. MORAN, Judge.

XA OFFICE OF CC

JUDGE OF PROBATE

DAKOTA COUNTY, MINNESOTA.

Hastings, Minn. April 9th 1896

A. F. Kilbourne M.D.
Supt of Second State
Hospital for the Insane Rochester
Minnesota —

My Dear Sir: Herein attached
find duplicate copy of Examination in
the matter of James Rice who I have
committed to the Hospital to day —
In my Judgement Mr Rice is
a very sick man and needs
extra care and treatment for a
time, Kindly see that he is attended
to and greatly oblige —
Yours Truly
Thos P. Moran
P.S. Address of father of James Rice
is — Peter Rice Hastings
Dakota Co
Minn

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,



says" is much better than anodynes. Had been sleepless: imagined he heard voices" in the night, but recognized them to be unreal. Had confused mixed feeling in the head, with attacks of dizziness. Had loss of appetite, tenderness of abdomen, no vomiting. At present, epigastrium is tender.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6½ WEIGHT, 146½ lbs NUTRITION, somewhat impaired. anaemic: dark circle under eyes.

WOUNDS OR ABNORMALITIES, See "Gen. Hist. Report" —

TONGUE, Tremors, slight (very) Coatings, clean Promptness Movement, prompt

PUPILS, Equality, Yes Size, normal

Response Light, Yes Accommodation, Yes

SIGHT, good

HEARING, good

COORDINATION, Arms, good: finger to nose, eyes shut, good —

Legs, good: standing on foot, good: standing, eyes shut, good.

TREMORS, Hands, no Tongue, very slight.

Facial Muscles, no General, no

REFLEXES, Patellar, 8 = equal EXAM. URINE,

Other —

ARTICULATION,

Slurred, ✓

Hesitating,

FACIAL EXPRESSION, somewhat down-cast: occasionally vacant: will stand absent mouthed but finish a sentence

SENSIBILITY,

✓

HEART, Sounds low & clear: Aortic Sound somewhat rough: Pulsation of vessels distinct

LUNGS, Seem good

TAKEN,

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 James Rice

1896

This patient was brought here by Deputy Sheriff James Hyland, attended by John Fahey, with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is 1st attack: symptoms manifested about 4 weeks ago: inclined to wander from home. The disease seems increasing: variable & with rational intervals, but these at no regular intervals. He is depressed & suffers from indigestion. Derangement is now shown by inclination to wander; depression: "Conceives the presence of spirits". Patient is not disposed to injure others, nor suicidal, no filthy nor destructive no peculiarities had been previously shown. Father occasionally drinks. Patient has not been subject to any severe disease & nor had any head injury. Has not been restrained or confined. Supposed cause of the disease is derangement of digestive organs and excessive use of tobacco. No medical treatment. There are now, depression & loss of sleep.

Apl 9 On admission, was put on B3 | G. Sp. N. Rpt. Complexion dark: hair dark brown: eyes blue: condition of skin good: some slight bruises on nose: is dirty: behavior good: is nervous & afraid.
" 10 Apl 10/96. Slept only 5 hours, last night: was given bath. Eats poorly: bowels not regular: patient is
" 11 rather stupid & apparently afraid. Apl 11/96. Slept 8 hours, last night. Is discontented: says "he wants
" 12 to go home". Tries to open doors, frequently. Apl 12/96. Restless & slept only 4 hours, last night. Appetite only fair. Does not walking daily. Tries to escape & is under continual surveillance. Bowels
" 13 not regular. Apl 13/96. Slept 6 hours. Ate poorly, today. Is very quiet & dejected. No delusions
" 14 or hallucinations noticed. Apl 14/96. Slept 7 hours, last night. Is on medicine 3 times a day.
" 15 Apl 15/96. Slept 8 hours. Will not carry man extensive conversation but will answer questions
" 16 rationally. Apl 16/96. Slept 8 hours, last night. Appetite improving; bowels still irregular. Refused
" 17 medicine today. Makes no complaints. Appears brighter, of late. April 17/96. Slept well, last night.
" 19 Is very quiet: more contented: does not try to escape, as before. April 19/96. No change, during last few
" 22 days. Behaves well: out on ground, daily. Apl 22/96. Bowels fairly regular, of late. Patient is very quiet:
" 23 stays in same place, almost continually. Is cranky & saucy, occasionally. Apl 23/96. Talks a little foolishly: does not talk much: no delusions noticed. No change apparent, during past week.

Summary: Behavior has been fairly good: was, at times, cranky & inclined to violence. Physical condition fair: Is not in very good flesh: skin good: muscles fairly developed. Patient talks very little: no delusions or hallucinations noticed. Talk quite rational, but is a little foolish. No change during past week, tho' patient brightened up some, during 1st week.

" 30 April 30/96. Sleeps 8 hours, every night. Complains of constipation. Is very quiet. Otherwise, condition about as generally noted above.

May/97 Summary Nurses Notes by Dr Phelps. Nurses notes during past year show no very notable change: may/96 Wt. was 154#. Talks to himself a great deal, & especially during last of year, Talk has been very incoherent & silly. Has worked some during latter part of year: Wt. May 1st 97 - 141 lbs.

Aug 1/97 Wt. 137# Works in dining room: Rather noisy at times: Has many delusions
" 2/97 Transferred to Annex: Talks to himself but is usually, however, fairly well-behaved.
Jan 31/98. Intervening notes show no change, quite demented but behaves very quietly.
Feb 1- July 31/99. Wt. 140. Appetite good. Behavior quiet. Is stupid & maniacal.

Personal and Medical History of

1899

Aug 1- Jan 31/900. Wt. 136# Very demented: silly: degraded in habits. Well behaved. Works on ward. Physical health good. April 26: 1900. No change. Trans. to Hastings.

Personal and Medical History of Edward Wick

HERBERT, FIGLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4374.
Residence, Preston. Minn.
Date Admission, 14th April 1896.
Admitted by T. Linton - Phelps Hour, 3 P.M.
How Sent, E.V. Farrington Supt. Fillmore County
Sex, Male
Age, — 20 —
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farm - laborer (father, Stone-mason)
Degree Education, Common School
Profession Religion, Not a church - member
Habits, not intemperate —
Nativity, Dayton. Ohio: (Parents born in Posen, Germany)
Physicians Committing, J.C. Phelps & G. A. Love
Correspondents, Fred. Wick (father) Preston Fillmore Co. Minn

No. for Year, 207
Insane Relatives, one brother, paternal father's side
Cause Exciting, not known: probably Head injury.
Cause Predisposing, probably Heredity.
Form, Paranoia
Accompanying Bodily Disorder, had a head injury.
Suicidal or Not, not: but will injure others.
Date of this Attack, about 2 weeks ago
Duration, about 2 weeks
No. of Attack, 1st —
No. of Admissions, 1st —
Age First Attack, — 20 —
Time of Leaving, July 1 of. 1896
Time in Hospital, 2 mo. 16 da.
Result, Improved. Discharged Nov. 10' 96.

EXAMINATION ON ADMISSION.

Exly Dr. Herzog, Apl 15/96 MENTAL CHARACTERISTICS.

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

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

PERCEPTIVITY:
Alert or Dull, fairly alert
Correct or Illusive, Correct

REASONING POWER:
Ordinary Subjects, Connected & quick
Own Mental State, Clear
Special Subjects,

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

DELUSIONS:
Systematized or Not,
Special Subjects, } See note.
Transitory or Not,

HALLUCINATIONS:
ILLUSIONS:

CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, normal

GENERAL DESCRIPTIVE REMARKS:
Patient denies attempted arson: admits having words with his Employer but denies threats with deadly weapons. Claims his Employer Mr Grattan owes him $ 200. back pay. Says has been sleepy but can not sleep. Is getting "nervous" & has lost weight. Thinks has overworked. Is fairly bright & represents himself as handy with tools. Has made a turning lathe; repairs watches; makes various things of metal. Has made a perpetual-motion machine which almost works but has not worried or studied over it. Power of attention somewhat impaired. Memory somewhat impaired. Day has no enemies; but Mr Gratton who has it in for him.

Personal and Medical History of Edward Wick

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 10in WEIGHT, 153 lbs (Age Former Weight 172 lbs) NUTRITION, somewhat emaciated
WOUNDS OR ABNORMALITIES, See "G. H. U. Depot" - Chin somewhat small & weak: slight puffiness under eyes - slight puffiness under eyes & somewhat at high-arches. Right palate narrow
TONGUE, Tremors, Slight Coatings, Quite heavy yellow coat papillae prominent Promptness Movement, somewhat slow
PUPILS, Equality, Equal Size, Normal
Response Light, Sluggish Accommodation, Sluggish
SIGHT, Eyes tire easily, particularly at night.
HEARING, Good.
COORDINATION, Arms, Good: fingers & nose, eyes shut, good: notices some slight difficulty about fine work:
Legs, good: standing on foot, good: standing, eyes shut, good.
TREMORS, Hands, slight Tongue, slight
Facial Muscles, no General, no
REFLEXES, Patellar, / equal: no
Other pectoral exception reinforcement
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
somewhat heavy, dull & tired.
SENSIBILITY,
HEART,
Sounds clear; pulse tension somewhat high
LUNGS, seem good

EXAM. URINE,
TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,		Constipated,	Irregular,
APPETITE, Good,	Poor Voluptuous	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, per history

Personal and Medical History of Edward Wick

1896

This patient was received here at the hands of S. E. Farrington, attended by Fred. Wick, (father), with following history. Patient is in good physical condition. There is no history of consanguinity: one brother, on father's side, insane. This is 1st attack: hypochondriacal manifested about 2 weeks ago; threatened destruction of property: and other threats of murder &c. — The disease appears to be increasing: variable & with rational intervals, but these, irregular intervals. Derangement now shown in that he has hallucinations: sees devils sent by "his enemy": threatens to kill people & burn property. Is disposed to injure others: has not attempted suicide. Filthy & destructive in habits: no peculiarities had been previously shown: there is no history of intemperance in self or parents. Patient had an injury to head, about 4 months ago; complains of headache ever since: he has not been restrained or confined. Cause of disease not known. No medical treatment: He now has all the appearance of one out of his mind: very morose, sullen and very forgetful. ——

April 4 On admission, was put on T.B.[3] (G.H.N. Rpt. Complexion dark: hair dark-brown: eyes brown: Condition of skin good: of scars, one on each leg above knee & one on left arm: one small scar on head: is clean: behavior good: talks rationally). Was given bath. April 5/96. Slept 7 hours last night. Behavior good today: talks rationally: no delusions noticed. Bowels regular: appetite good.
" 16 April 6/96. Slept 8 hours, last night. Talks much about himself & his "accomplishments." —
" 17 April 7/96. Slept 8 hours: appetite good: bowels regular: is on medicine. He seems to have a serious
" 18 delete for a person in Preston, whom he worked for. April 8/96. Slept well. Makes threats to kill him
" 19 when he goes back. April 9/96. Slept 8 hours, last night. Behavior very good: works on ward:
" 20 Goes out walking daily. April 10/96. Had a "sulky spell" today. Says "he is going to run away".
" 21 April 11/96. Patient has occasional "sulky spells" when he is cross & cranky. Works on ward.
" 22 Home. April 12/96. Behavior generally good, as "sulky spells" last only a short time. —
" 23 Was visited by brother & cousin, today. April 13/96. Again visited by brother & cousin. Behavior
" 24 good: makes no complaints. April 14/96. Says "it is very lonesome for him here". Is well behaved.
" 25 April 15/96. No change noted. Medicine (tablets) discontinued. Bowels regular: appetite good.
" 26 April 16/96. Was quite despondent, today. April 18/96. No change especially noticeable.
/28 Summary: Behavior, during past 2 weeks, good. Has been quite restless, at times, and again, quite despondent: apparently brooding over his troubles. Seems rational. Talks well: no delusions or hallucinations noticed. As above stated, has made threats, in regard to a particular person: (formerly, his late employer). Physical condition good: skin good: muscles large & well-formed: bones large & he is in good flesh. (see attached Record for details).
" 30 April 30/96. General condition, conduct & behavior about as above described. —
May 4 (was transferred to C.[3], April 28/96.). May 4/96. Patient visited by father. Patient was taken sick, in the night, with a violent headache: became restless & nearly delirious: no fever noticeable. Grew somewhat, about 6 A.M. but did not get up until near noon. (Treated & given medicine by Dr. Hall).
" 5/30 May 5/96. No trace of yesterday's sickness visible, today. May 30/96. Patient has been rather quiet & thoughtful, of late. Has some peculiar ideas, (not exactly delusions), but does not appear to remember past events,
June 3 Memory seems very poor & short. Physical condition good. June 3/96. Wt 165 pds. Pulse 70. —
" 15 (he has gained 1½ pounds in flesh, since coming). June 15/96. (Note by Dr. Phelps: Patient anxious to go

Personal and Medical History of Edward Wick

June 15 home: admits having severe headache and being pun-down. Don't think was crazy exactly: thinks father lied, to get him in here: claimed he took things in order to hold back his $200 wages. Can't account for things his father claims: don't remember about them). June 18/96. Went to work, on the dray, today.
" 18
" 30 Is much improved. Works well: appetite good. June 30/96. No change noticeable, from day to day. Appetite good: no complaints. Talks rationally: works outside. Physical health is good. —
July 1 July 1/96. Allowed to go home with father, today.

Discharged.

Personal and Medical History of William C. Coon

(In previous Commitment "Clark Coon")

ROBERT, RIDLAN & CHANDLER, DAVENPORT, IOWA

Whole No. 4379.
Residence, Woodville, Minn.
Date Admission, 20th April 1896.
Admitted by D. Kilbourne Hour, 7 45 P.M.
How Sent, Geo. A. Wilson, Jo. Co. Waseca County.
Sex, Male.
Age, — 38 —
Civil Condition, married
Children, — 4 —
Age Youngest Child,
Occupation, Farmer
Degree Education, Common School
Profession Religion, not a church member
Habits, Intemperate
Nativity, Wisconsin: (Parents also born there).
Physicians Committing, D.S. Cummings and J.A. Swarthout.
Correspondents, none given on papers

No. for Year, 207.
Insane Relatives, None
Cause Exciting, — alcohol —
Cause Predisposing, previous attacks.
Form, Dementia alcoholic chronic
Accompanying Bodily Disorder, none mentioned.
Suicidal or Not, not: but will injure others.
Date of this Attack, about 3 weeks ago
Duration, about 3 weeks.
No. of Attack, 3rd: (probably more)
No. of Admissions, 2d here (was at Fergus)
Age First Attack, about 19 —
Time of Leaving, June 4th. 1896
Time in Hospital, 1 mo 14 da.
Result, Improved. Discharged Nov. 10 '96.

EXAMINATION ON ADMISSION.

Exby D. Herzog. Apr. 21/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, very slightly Confused
Quick or Sluggish, Quick —

MEMORY:
Past Events, Quite good
Recent Events, — do: —
Special Subjects,

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

REASONING POWER:
Ordinary Subjects, fairly good: slow
Own Mental State, realizes Condition
Special Subjects,

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

DELUSIONS:
Systematized ~~or Not,~~ somewhat
Special Subjects, of persecution
Transitory or Not,

HALLUCINATIONS: /
ILLUSIONS: /

CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, fairly voluble

GENERAL DESCRIPTIVE REMARKS:
Says he feels nervous: has been sleepless: Thinks has been drinking too much & up too late nights". Has had no trouble with anyone, but one of his neighbors, who, he thinks, is the cause of his being sent here. Doesn't know of any reason why this neighbor should molest him. Realizes that he is not so well as when he left here before. There is probably some mental impairment left after the previous attacks, which was aggravated by his irregular habits.

Personal and Medical History of William C. Coon

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ in WEIGHT, 167 pds NUTRITION, fairly well - nourished.
WOUNDS OR ABNORMALITIES, See "G.A.N. Rpt"
TONGUE, Tremors, Marked Coatings, Whitish Coat middle of Dorsum: tip & edges foul. Promptness Movement, somewhat slow
PUPILS, Equality, Equal Size, Contracted.
Response Light, about normal Accommodation, about normal
SIGHT, Seems good
HEARING, — Do —
COORDINATION, Arms, Slight incoordination: finger to nose, eyes shut, some inaccuracy.
Legs, Slight impairment: Standing on foot, some difficulty: Standing, eyes shut, fairly good.
TREMORS, Hands, Yes Tongue, marked
Facial Muscles, No General, very slight
REFLEXES, Patellar, 2 & 2: equal
Other Slight ankle clonus
ARTICULATION,
~~Slurred,~~ about normal
Hesitating,
FACIAL EXPRESSION, Forehead bulging. Cheeks hollow: Cheek bones prominent
SENSIBILITY, /
HEART, rapid, weak — No murmurs
LUNGS, Good

EXAM. URINE,
TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,		Constipated,	Irregular,
APPETITE, Good,	fleeting	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,

1896

This patient was brought here by Deputy Sheriff Geo. H. Good speed, attended by Gilbert James, with following history. Patient is in fairly good condition. As to Consanguinity, not known: No history of hereditty. This is not 1st attack: first one occurred at 19th year; second, at 35th year: first lasting 2 months, when he was at St Peter, and 2nd 2 months, when he was at Rochester Hospital.[x] Result of treatment was beneficial. First symptoms of this attack were manifested about 3 weeks ago, with loss of woman and irritability of temper. Disease seems increasing: variable & with rational intervals, but these, not at regular intervals. Derangement now shown on no special subject. Is suspicious of his neighbors, whose lives he has threatened. Is disposed to injure others: but not suicidal. No filthy or destructive habits. No peculiarities &c had been shown, before the accession of the disease. Patient uses tobacco largely, and drinks intemperately, at times. There is no history of any severe disease &c or head injury. Has been confined (as above) in Hospitals both at St Peter and Rochester. Supposed cause of disease is Alcohol: of medical treatment none, aside from hospital. Physicians examining remark as follows: "From our personal examination, we are unable to say that, at the present hour, he is really insane; but, from a careful consideration of the evidence offered as to his conduct during the past few weeks, believe him subject to occurring attacks of insanity, brought on by exciting circumstances, and particularly by indulgence in alcohol." ——

[x] Note — As above stated, patient was here before as "Clark Coon", from May 4/93. to May 26/93. (see Vol 23 Page 189 No 3339): at that time, was suffering from an attack of acute mania. Condition was quite bad, for 5 days or so after admission: he then gradually became quieter, yet seemed bewildered & stupid. He had no relapse & kept on improving steadily, up to the time of leaving. On admission, was put on B3 (G.S.N.Rpt. Complexion light: hair light brown: eyes blue: condition of skin good: large veins on both legs. Is clean: behavior good): Was given bath: April 21/96. Slept fairly well, last night. Mental condition

April 20
" 21
" 22 is fairly good. Talks rationally but is not over-bright. April 22/96. Appetite good: bowels regular: no pain or cough: makes no complaints: behavior good: no medicine, 3 times, daily.
" 23 April 23/96. Physical condition good: is apparently, strong & healthy: muscles large & well-
" 24 formed: skin good: bones large. April 24/96. about the same, from day to day. Quiet & well-behaved.
" 25 April 25/96. Appetite good: bowels regular: behaves well: action ground daily. April 26/96. No delusions
" 26/27 or hallucinations noticed. April 27/96. No change, from day to day. April 28/96. Transferred to C3.
" 30 April 30/96. Sleeps well: behavior good: no delusions noted. No complaints. Takes exercise.
May 4 May 4/96. Can perceive no change in patient from day to day: Quiet: talks rationally: no delusions noted. Summary: Patient has been quiet & well-behaved: up & about daily: clean tidy & of good personal habits: has made no complaints: has shown
" 15 no delusions or hallucinations: has talked rationally. May 15/96. Much improved.
" 20/30 May 20/96. Was visited by friend. May 30/96. Patient has improved a good deal, since coming
June 1 on ward. Looks well: no delusions noticed. Physical condition is good. Good appetite. Goes out walking. Can see nothing wrong with patient. June 1/96. Wt 170½ lbs. Wants like
" 4 to go home. June 4/96. Sent home today, alone.

Discharged

Personal and Medical History of Peter Lorimar.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4380.
Residence, Dakota County, Minn.
Date Admission, 21st April 1896.
Admitted by Dr. Herzog Hour, 7.45 PM.
How Sent, Thomas P. Moran. Jct. Dakota Co.
Sex, Male
Age, 28 years
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farming
Degree Education, Common School
Profession Religion, not a church member
Habits, not intemperate
Nativity, Dakota Co Minn. (Parents born in Scotland)
Physicians Committing, J. C. Fitch & A VanBeeck
Correspondents, address of patient's mother is Jane Lorimar, Northfield, Rice Co Minn

No. for Year, 208.
Insane Relatives, None
Cause Exciting, Dates from hemorrhages
Cause Predisposing, "chronic"
Form, Paranoia
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, Not
Date of this Attack, about 14 years ago
Duration, — about 14 years —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 14.
Time of Leaving, June 6. 1900
Time in Hospital, Helper
Result, Transferred to Hastings

EXAMINATION ON ADMISSION.

Exd by Dr. Herzog. April 22/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, somewhat confused.
Quick or Sluggish, slightly sluggish
MEMORY:
Past Events, Impaired
Recent Events, — do —
Special Subjects,
PERCEPTIVITY:
Alert or Dull, fairly alert
Correct or Illusive, Correct in the main
REASONING POWER:
Ordinary Subjects, weak & poor
Own Mental State, fails to realize
Special Subjects,

EMOTIONAL STATE:
~~Normal, Calm~~,
~~Indifferent~~,
~~Exalted~~,
Depressed, Slightly
DELUSIONS:
Systematized ~~or Not~~, somewhat
Special Subjects, "of persecution"
Transitory or Not,
HALLUCINATIONS: "of hearing"
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, fairly coherent
Voluble or Reticent, rather voluble

GENERAL DESCRIPTIVE REMARKS:
Somewhat simple: Easily abashed. Says he hears the wheels of machines buzzing in his head. "They are very loud this morning." Does not quite know who put the machines in his head, but thinks it was his uncle. Feels as though there was a hole in the back of his head, through which "they" took out his brains & put in wheels. Is surprized that there is no scar visible.

Personal and Medical History of Peter Lorimar

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8 in WEIGHT, 133 lbs. NUTRITION, not just rate
WOUNDS OR ABNORMALITIES, See "G. H. N. Report" — Fore pointed palate narrow & high.
TONGUE, Tremors, quite marked Coatings, clean Promptness Movement, somewhat slow
PUPILS, Equality, Yes Size, about normal
Response Light, very mobile Accommodation, very mobile
SIGHT, seems good
HEARING, — Do —
COORDINATION, Arms, slight impairment: fingers bruise, eyes shut, slight hesitation
Legs, slight impairment: staggering upon feet, slight difficulty: staggering, eyes shut, fairly good.
TREMORS, Hands, slight Tongue, Yes
Facial Muscles, No General, No
REFLEXES, Patellar, δ - ♀ equal EXAM. URINE,
Other
ARTICULATION,
~~Slurred~~,
Hesitating, & stammering
FACIAL EXPRESSION, somewhat excessively mobile: slightly dyscrasic
SENSIBILITY,
HEART, rapid, weak, slight murmur 1st mitral sound
LUNGS, Seem good

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good, Record kept	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 *Peter Lowmar.*

1896

This patient was brought here by Deputy Sheriff James Law with following history. Patient is in fair physical condition. There is no history of consanguinity or hereditty: This is 1st attack: never has been to a hospital: first symptoms manifested 14 years since: then he had nose-bleed, after which he developed the first symptoms of attack: The disease seems increasing: not variable: no rational interval. Derangement now shown in that he has a fixed idea that there are machines in his head: Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. He seemed perfectly normal until he had severe hemorrhage from the nose. There is no history of intemperance in self or parents. He says "when he was six years of age, he was thrown from a Spring-board and fell upon his head." He has not been restrained or confined. Cause of disease dates from hemorrhages. Has been given general constitutional treatment: results negative. He is constantly calling attention to the machines that are at work in his head. —

Apl 21 On admission, was put on B.3 (G.H.R. K'bl). Complexion light: hair gray: Eyes gray: Condition of skin good: 2nd & 3d fingers of right hand amputated below 1st joint and thumb on same hand crushed at end. Is clean. Behavior good.). April 22/96. Appetite good:
" 23 bowels move. Patient is rather foolish: laughs when he converses with anyone. Apl 23/96. No
" 24 marked delusions noticeable. Complains of stomach feeling sour. Apl 24/96. Behavior good:
" 25 goes out walking daily. April 25/96. Complains today of dizziness & sickness at his stomach.
" 26 April 26/96. Is generally confused. Says "he has a buzzing in ears" and eyes are blurred. —
" 27 Is on medicine, 3 times a day, before meals. April 27/96. Complained of costiveness: was
" 29 given Salts; bowels then moved Copiously. April 29/96. Behavior good: he sleeps quite well:
" 30 No change from day to day apparent. April 30/96. Behavior good: is foolish & simple: Habits
May 5 neat & clean. Talks little in an unsteady manner. May 5/96. No change noticeable from day to day. Is out on grounds, daily. Summary. Patient has been very well-behaved, during past two weeks: has been quiet & obedient: Physical condition not very good: is run-down some. Has a Chronic Stomach-Complaint. Has no apparent delusions or hallucinations. Is rather simple & foolish: laughs to himself, occasionally. Seems to be quite nervous.

May 1/97 Summary Nurses Notes by Dr. Phelps. Patients record during past Twelve months shows quite uniform behavior. At times rather obstinate & foolish. Made several attempts to escape: Is always rather simple in manner & talk. During Feb'97 received massage with hand, with a gain of only 1½ lbs. during several wks of this treatment. Wt. May 1st 113 lbs. May 31'97 Wt. 114 lbs. Is of fairly good disposition & behavior: Has many delusions & is rather demented. July 4'98 Visited by friends
Jan 31'99 Is now at Annex: General health seems good: Behavior same in every way.
Dec. July 31'99. (Dr. Wanous) Wt. 119 lbs. Is working on farm: Talks in a rambling manner: Sleeps well: Appetite good: General physical condition good.
Aug Jan 31 1900 (Dr Chapple) Wt. 106 lbs. Nov 1. 116 lbs. Sept 16 Visited by friends. Has been in only fair physical health. Very inactive: Habits rather untidy. Quiet & well-behaved. Appears much demented & silly in manner & speech.

Personal and Medical History of *Peter Lowmar*

1900

Feby/June 6 Wt 118 lbs. Pr. Mar 2. Ten days temperature shows variations to 100 to 102 - Apl 10. Tooth extracted. Dental abscess. June 6. No change noted. Physical condition fair: is rather thin. Eats & sleeps well - Is very quiet and well-behaved: works on ward. Is cleanly. Will answer questions, but talks very little. —

— Was, today, transferred to Hastings Hospital —

Personal and Medical History of George Goebel

EGBERT, FIELD & CHAMBERS, DAVENPORT, IOWA

Whole No. 4385.
Residence, Rochester, Minnesota
Date Admission, Dr. H. H. Herzog
Admitted by 27th April 1896. Hour, 5:15 P.M.
How Sent, Thos. Fraser, Jo. Co. Olmsted County
Sex, Male
Age, 35
Civil Condition, single
Children, none
Age Youngest Child,
Occupation, Tin-Smith
Degree Education, not educated
Profession Religion, Do not know
Habits, not known
Nativity, Germany (Parents also born there)
Physicians Committing, J. K. Mosse and C. T. Granger.
Correspondents, none given in papers

No. for Year, 213.
Insane Relatives, Do not know
Cause Exciting, Do not know
Cause Predisposing, not stated
Form, Dementia paretic.
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, not
Date of this Attack, about one year ago
Duration, about one year
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 34 — about
Time of Leaving, May 29. 1900
Time in Hospital, 3 yr. 11 mo. 2 da.
Result, Died. Inst. Parisis.

EXAMINATION ON ADMISSION.

Exd by Dr. Herzog 4/18/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, } very poor
Recent Events, }
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, very poor
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
~~Normal, Calm,~~
~~Indifferent,~~
Exalted, Yes
~~Depressed,~~
DELUSIONS:
Systematized or Not, unsystematized
Special Subjects,
Transitory ~~or Not,~~
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Incoherent
Voluble or Reticent, somewhat reticent

GENERAL DESCRIPTIVE REMARKS:
Patient is markedly paretic. Speech very disconnected. Says he saw Mr. Mills kill 4 men. Wanders in about various subjects. Impossible to get him to talk connectedly or get any information from him.

Personal and Medical History of George Goebel

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4½ WEIGHT, 126½ lbs. NUTRITION, Considerably impaired: anaemic.
WOUNDS OR ABNORMALITIES, Ex G. A. R. Report — Has pointed ears and pensile.
TONGUE, Tremors, Coarse & fine Coatings, Clean Promptness Movement, Slow
PUPILS, Equality, right is larger when dilated Size, about normal
Response Light, Sluggish Accommodation, Sluggish
SIGHT,
HEARING,
COORDINATION, Arms, Considerably impaired. Can scarcely control hands.
Legs, Ditto: Stands only when with great difficulty: Walking backwards: Ditto: Stationary: eyes shut, sways somewhat. Turns quickly, decides about face.
TREMORS, Hands, Marked & fibrillary tint tongue Tongue, Coarse & fine
Facial Muscles, of lips and speaking General, on Stationary
REFLEXES, Patellar, left about 4: right about 9 — Difficult to test.
Other Slight Coma: both ankles
ARTICULATION,
Slurred, Yes
Hesitating, Yes
FACIAL EXPRESSION, Blank
SENSIBILITY,
HEART, Somewhat rapid. No murmurs.
LUNGS, Seem good

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,		Constipated,	Irregular,
APPETITE, Good,	Fed & kept	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 George Gebel

1896

This patient was brought here by Sheriff C. N. Stewart, with following history. Patient is in fair physical condition. In some respects, history is rather meagre. As to consanguinity, heredity, if any family history of intemperance, if he has had any severe disease or any injury to head, nothing seems to be known. This is 1st attack: symptoms manifested about one year ago; wandering away from home; incoherent speech; delusions: - the disease appears to be increasing: not variable: no rational intervals. Derangement now shown in that he imagines he has seen murders: threatens violence: maniacal laughter, at night-time. Patient is disposed to injure others, but is not suicidal - no of filthy or destructive habits. No peculiarities &c had been previously shown: he has not been restrained or confined, nor under medical treatment. Do not know cause of the disease. On personal examination, he talks & laughs, concerning murders he has seen. Tremors of muscles of face are noted. ——

Apr 27 On admission, was put on P.D.[3] (G.H.N. Dpt. Complexion light: hair brown: eyes blue: Condition of skin good: no marks scars or bruises noticed. Is clean: Behavior good).

" 28/96 Apr 28/96. Slept 9 hours, last night: Mental condition muddled & confused. Is stuporous. Apr 29/96 Slept quite well. Is very restless & nervous. No pain apparent: no cough: Behavior good. Cannot stand with firmness or steadiness. Wanders about in an aimless manner. April 30/96. Slept & shows, last night: was talking

" 30 some, during the night: was out on grounds, daily. (Symptoms of General paresis). May 1/96. Slept

May 1 only 4 hours last night: was talking some. Apparently no change: speech incoherent: has little control of

" 2 voice, or, in fact, of limbs. May 2/96. Slept 7 hours, last night - no change noticed in his condition -

" 3 Is confused & muddled: says, "he feels all right" May 3/96 Slept 6 hours: has delusions: says

" 4 "certain people in Rochester are murderers & very bad men". May 4/96. Slept 7 hours. No change noted.

" 11 May 11/96. During this the 2nd week, patient's condition has shown no special change: has been sleeping well. (7 to 8 hours) nightly. Behavior good. Speech incoherent & very unsteady. Talks considerably, in a "muddled" sort of way. Eats well: bowels regular. Appears quite contented & cheerful: has, apparently, gained flesh, since he came. (Was visited by a friend, an afternoon of 5th inst).

Summary: Behavior has been very good, during past 2 weeks: he seems quite contented with his surroundings & appears to enjoy himself. Physical condition not good: has not good control of his limbs or of any part of the body, tho' he is in good flesh. Mental condition not good. He has delusions; incoherent speech: always appears muddled & confused.

May 1/97 Summary Nurses Notes by Dr Phelps. Patient came here as an paretic: Was rather dull & stupid at first & has continued with very little progression of trouble during year. After settling down in the life here he gained somewhat in flesh & drifted along in a dull, restless way not as yet being stupid enough to go to bed. May 31 97 Wt. 130.# July 28 Patient about same: rather dull, quiet & demented. Has to be helped up & down stairs; is quite paretic. Sept 23 Trans. to Infirmary: Is very paretic and run down: Has slight rise of temperature: Has swelling on right side of back. Sept 29 Temp. goes up above 100, at times to 102 in P.M. Wt. 111.# Seems to be failing. Oct 31 Patient's temperature has gone down almost to normal: Seems very quiet, dull & demented. Nov. Wt. 102 Dec. 1 97 Wt. 111. Temp. occasionally up to 100. Jan 1, 98 Wt. 115.#

Personal and Medical History of

Feb 1/98 Wt. 119.# Lying steadily in bed in a dull listless way: Apr. 98 123.# Still in bed stupid & dirty: May 2 Wt. 138.# June 2 Wt. 147.# July 2 150.# Still in bed: Dull, stupid demented & filthy. Oct 5 Wt. 136.# Jan 31 99 133.# Sits about in a quiet, thoroughly demented way. Feb 1 - July 31 99 (Dr Mawhinney) Wt. 146.# Talks very little: Is stupid - Condition does not change. Aug 1 99 - Jan 31 1900. (Dr Mawhinney) Oct 1 Wt. 115.# Neat & clean in habits. Feb 1 appears very stupid & dull & very feeble. Refused nourishment on Oct 13th Trans. to Infirmary on Oct. 15th Put upon eggnogs. Refused solid food. Temp & pulse normal. Given laxatives regularly. Mch 28 Had a severe convulsion which lasted an hour following which he became comatose: Convulsions continued at short intervals. Died Mch. 29th 1900 at 3:10 P.M.

Died

Autopsy Mar 30, 1901 10:30 A.M.

General Condition of patient. Is apparently well nourished. Shows slight sore on left hip. Rigor mortis present. Some subdilation in back and shoulders. Scalp thick. very adherent. Calvarium thick, very adherent to dura. Duba twice its normal thickness. Pia shows several whitish areas extending about an inch and one-half laterly from the middle sinus about two inches antero-posteriorly. These will not strip, some small areas of calcification shown here, also in the right fissure of Sylvius. Ventricles enlarged. More than normal amount of fluid present. Some atrophy of the frontal lobe.

Thorax. Adhesion at base of right lung, also adherent to diaphragm. Heart normal size. Muscles and walls show some fatty adhesions.

Abdominal Region. Liver somewhat enlarged. Some adhesions on posterior side. Spleen enlarged, soft, fatty. Left kidney normal, capsule strips easily. Right kidney small, very adherent to wall, on removal shows scar on posterior side: probably due to an old abscess. This accounts for right sided adhesions all over organ. Stomach full, distended. Appendix displaced towards median line and extending beneath colon.

Personal and Medical History of William Conners

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4386.
Residence, Janesville, Minn
Date Admission, 27th April 1896.
Admitted by Dr. Phelps Hour, 6.45 P.M.
How Sent, Geo. A. Wilson, Jo. P. Waseca County
Sex, Male
Age, 70 Years
Civil Condition, Married
Children, — 8 —
Age Youngest Child,
Occupation, Farmer
Degree Education, Not educated —
Profession Religion, Yes: Roman Catholic
Habits, Some history of Intemperance
Nativity, Ireland: (Parents also born there).
Physicians Committing, J. B. Lewis and J. A. Reynolds
Correspondents, Wife —

No. for Year, 214.
Insane Relatives, None
Cause Exciting, Sunstroke, Augt 1893
Cause Predisposing, Chronic
Form, Dementia alcoholic chronic Simple
Accompanying Bodily Disorder, has had head injury —
Suicidal or Not, Not
Date of this Attack, In August 1893
Duration, — Nearly 3 years —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 67.
Time of Leaving, Jan. 6. '97.
Time in Hospital, 8 mos. 10 da.
Result, Died. Peritonitis

EXAMINATION ON ADMISSION.

Seen by Dr. Herzog 4/28/96.

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
~~Normal, Calm~~,
~~Indifferent~~,
~~Exalted~~,
Depressed, Yes
DELUSIONS:
Systematized or Not, Nothing definite
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Incoherent
Voluble or Reticent, fairly voluble

GENERAL DESCRIPTIVE REMARKS:
Patient is markedly demented: has vague terrors: scarcely understands what is said to him. Impossible to get any connected statement from him. Sensorium: doesn't like bed pan. Refused, last night, to stay abed. His wife says he has been a very hard drinking man & has lain out doors, over night, when drunk. Says she noticed, 3 years ago, a difficulty in walking & in speech. About 4 years ago, had an apoplectic form attack: was completely unconscious & afterwards has been demented, being better, at times, but never right — Symptoms suggest a progressive trouble, similar to paresis. —

Personal and Medical History of William Conners

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 9½ WEIGHT, 134 lbs. NUTRITION, Considerably impaired —
WOUNDS OR ABNORMALITIES, bump over left eye: several scratches on chest: scratch on neck & chin
TONGUE, Tremors, Coarse & fine Coatings, yellow mid or scum heavy Tone, Promptness Movement, Slow
PUPILS, Equality, right slightly larger Size, Slightly dilated
Response Light, both sluggish; right one more so Accommodation, right pupil slightly oval
both sluggish: right more so.
SIGHT, ✓
HEARING, fair: some impairment.
COORDINATION, Arms, much impaired: Difficulty in buttoning clothes &c.
Legs, much impaired: Standing at first, almost impossible: Walking backward, great difficulty - Standing, eyes shut, sways considerable: turning quickly - makes a wide circle quite marked
TREMORS, Hands, Tongue, Yes
Facial Muscles, of lips & eye brows General, on standing
REFLEXES, Patellar, ? equal EXAM. URINE,
Other Right ankle - Clonus: abdominal reflexes exaggerated -
ARTICULATION,
Slurred, Yes
Hesitating, Yes
FACIAL EXPRESSION, Somewhat Anxious: Transverse wrinkle on forehead
SENSIBILITY, ✓
HEART, Marked murmur & pulsation
Sound: Slight murmur Mitral Sound
LUNGS, arteries stiff
a few scattering large moist Rales

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good, Poor & capt	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 *William Conners*

1896

This patient was brought here by a Deputy-Sheriff, attended by wife of patient, with following history. Patient is in fair physical condition. As to consanguinity, don't know. No insane relatives. This is 1st attack; Symptoms manifested, Augt. 1893. The disease seems increasing. No rational intervals, at all. Derangement now shown by running away from home, & getting lost, without any clothes. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. No peculiarities had been previously shown. There is history of intemperance in parents, also in self. He was kicked by a horse, when a boy. He has not been restrained or confined. Supposed cause of the disease is sunstroke in August 1893. Patient has had no medical treatment. No facts learned by a personal examination.

Apl 27 On admission, was put on B3 (G.M. N. & W.) Complexion dark: hair gray: eyes blue: condition of skin good: moles, on back & left shoulder: Is clean: Is restless, excited and confused: weak and unsteady on his legs). Later in night, was transferred to C!— as he would not stay in bed: very troublesome: 10 PM visited by D.H., who ordered him a sedative.

" 28 April 28/96. 10:00 am. Transferred to B3. Behavior restless & inclined to be pugnacious. Easily excited: has delusions: talks at random: heart seems weak. Apl 29/96. Slept in C: was filthy & destructive:

" 29 Slept only 4 hours. Apparently the same, this morning: refused to have Temp. taken: Same had to be taken by force: urinates regularly. Bowels move. (Temp. 100 4). Was given bath. Apl 30/96. Again,

" 30 slept in C: was restless 5 hours: would not stay in bed. Slept only 3 hours. Seems a little quieter, this morning: Still "muddled & talks incoherently: Face slightly marked, this morning (was struck

May 1 by N. Tuscano, last Sat). Is unsteady in walk. Bowels regular. Eats quite well. May 1/96. Was put in "C" hall for the night: Slept 5 hours. Apparently better, this morning: is not as restless and

" 2 seems brighter. (Weight, Dressed, 164 lbs. Psy.) May 2/96. Put in "B" hall during night. Slept only 4 hours. Is about the same, today: very restless & troublesome. 2:00 PM. Went out with crowd: behaves still

" 3 worse than in hall. May 3/96. About as usual: speech much "muddled". Has delusions.

" 4 Slept 6 hours, last night. May 4/96. Had to be assisted up & down stairs: also while walking.

" 5/6 May 5/96. Slept 7 hours. No change: habits fairly clean. May 6/96. about the same, from day to day.

" 7 May 7/96. Slept only 2 hours, last night. Is still very much muddled in his remarks & actions

" 8 show it very plainly, when dressing & undressing: does not seem to know how. May 8/96. Still about the same: restless & troublesome; unbuttoning his clothing. Habits inclined to be dirty.

" 9 May 9/96. Seems much weaker, this morning & inclined to be drowsy. 2:00 PM Transferred to F W. Is quiet: seems confused. Given bath & put to bed: On regular & extra diet: PM. Has remained

" 10 very quiet: May 10/96. Slept 5 hours, last night. Lies very quietly in bed: no complaints.

" 11 Was quite restless in afternoon: pulling bedding about &c. May 11/96. Restless & slept only 4 hours, last night. Restless & out of bed frequently, during day. Talks very irrationally. Does not seem

" 12 to realize anything that is going on. May 12/96. Slept only 3 hours, last night: was very restless.

Summary: On admission, was restless & excited: at times, pugnacious: dirty, at times, also filthy & destructive: there were periods when he was troublesome & excited & others when he was more quiet. Condition has been confused, mentally & more so, of late. & is also very troublesome. Appetite has been fair, throughout: bowels irregular. Physical appearance not

Personal and Medical History of *William Conners*

Summary Oct 12 not very good. Walk has been unsteady. He seemed to fail on 12th day & is still weak. Has delusions. Talks very irrationally & incoherently.

May 4 No change in condition. Still very troublesome: Appetite is good. May 25 No change in behavior: Condition seems about same: Is probably a little stronger. June 1 Still in bed but very restless & continually getting up & tearing bed to pieces: Bowels constipated: Enema given. Wt. 132½ #. June 6 Visited by friend. No change. June 15 Patient is doing nicely: Seems strong. Is still restless & out of bed most of time.

June 15 Trans. to B3. June 27 Appetite good: Bowels quite regular: Behavior restless & troublesome. Requires constant watching: Is very weak & has to be assisted up & down stairs. Limbs swollen. July 1 Wt. 146 #. Talks a great deal but incoherently: Very restless & uneasy. Seems a little stronger of late. Aug 15 Note "Dr Herzog" Senile & alcoholic dementia, paretic form. Goes incoordination, quite feeble. Untidy, wears straight suit: Has continued mitral murmur: Arteries somewhat stiff: Memory of both recent & remote events very poor: Is slightly improved in behavior since admission, not filthy, nor as restless: Stays abed nights: Appetite good: Bowels regular. Sept. Wt. 146. P. 68.

Sept 8 Visited by friend. Sept 28 No change. Oct 29 Appetite good. Eats on hall: Bowels regular. No change in behavior: Still requires constant care. Nov 1 Habits untidy. Is restless & troublesome. Kept in bed: Talks incoherently: Is quite feeble & requires a great deal of care as to person & clothing. Appetite good. Bowels regular. Sleeps well. Wt. 149 lbs. P. 80

Dec 1 Wt. 153 lbs. No change.: Dec 16 Visited by wife: Dec 26 Nose slightly swollen: Seems to be growing weaker. Dec 28 Quite weak: Rt. ear & face red & swollen: Ate light breakfast. Fell down on floor & too weak to get up. Was put to bed at 9 AM. Temp. 102° P. 82. Quite restless during day. 8 PM. Temp 103.4 P 99 R. 24. Dec 29 Trans. to Infirmary. T. 100 P. 80. Is delirious & constantly pulling at bed-clothes. Abdomen much swollen & tympanitic. Tenderness not localized. No Statements as to pain. (Note by Dr Herzog) Enema given & turpentine stupe applied to abdomen. Takes only liquid nourishment. Dec 30 Face repainted with Ichthyol: Habits filthy. Temp. 102.4-103. Enemata given. Dec 31 Patient appears about same: Three Enemas given during day. good results. Patient very restless. Jan 1 Very weak today: Twitching movements of limbs at times: Wets bed frequently. Jan 2 Lies in bed in a semi-unconscious state: Groans & moans continually. Jan 3 Temp. 100.6-102. Takes liquid nourishment only: Appears about same. Jan 4 Does not seem to change much: Sores on lips bathed with alcohol: Erysipelas on face repainted: Jan 5 Temp. 105-105.4 P 96-102 R. 60-36 Hypos, strych given at 12:00, 2:00, 4:00, 6:00, 8,30 & 10:30 PM. Patient much weaker: In comatose condition: Prepared for death by Father Riordan: Visited by son. Jan 6 Died 2:25 A.M. Dr. Herzog Notes: Had some general peritonitis: had facial erysipelas & was a senile dement, paretic form. Cause of death: General peritonitis.

Died.

Personal and Medical History of J. Andrew Monette

BIBBERT, PICKAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4387.
Residence, Olmsted County, Minn.
Date Admission, 30th April 1896.
Admitted by Dr. Herzog Hour, 3.30 P.M.
How Sent, Thomas Fraser, Jo. P. Olmsted County.
Sex, Male.
Age, 27 Years
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Farmer
Degree Education, Common School
Profession Religion, Yes; Roman Catholic.
Habits, Not intemperate
Nativity, Olmsted County, Minn: (Father's Canada: Mother's N.Y. State)
Physicians Committing, Christopher Graham & E. T. Granger
Correspondents, none given in papers

No. for Year, 215.
Insane Relatives, none
Cause Exciting, not known
Cause Predisposing, not known
Form, Pubescent insanity
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, not
Date of this Attack, about 2 months ago
Duration, about 2 months
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 27, about
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exd by Dr. Herzog April 30/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, fairly clear
Quick or Sluggish, somewhat sluggish
MEMORY:
Past Events, fairly good
Recent Events, fairly good
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, correct
REASONING POWER:
Ordinary Subjects, fairly good
Own Mental State, fails to realize
Special Subjects,

EMOTIONAL STATE:
~~Normal, Calm,~~
~~Indifferent,~~
Exalted,
Depressed, Yes
DELUSIONS:
Systematized or Not, systematized
Special Subjects, see note
Transitory or Not, fixed
HALLUCINATIONS: "off hearing"
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, slightly reticent

GENERAL DESCRIPTIVE REMARKS:
Patient is somewhat exhausted. has been sleepless for some time past and has been drinking Considerable - He has usually been accounted an intelligent young man in spite of his somewhat badly shaped head. His family is respected in the community. His manner is heavy & dull, occasionally yawning, but he will brighten up for a few minutes. His main delusion is that his father committed incest with his sister. Refuses to say in details. Says while he was abed he heard his sister enter his father's room, which is below his: gives dates &c. Says the spirit of his mother came

Personal and Medical History of J. Andrew Monette

At a special term of the Probate Court for the County of Olmsted, on Monday, the 20th July, 1896 at 2 o'clock in the afternoon, will be heard & considered - The verified petition of Felix Monette to be appointed Guardian of J. Andrew Monette - Dated at Rochester the 3rd day of July A.D. 1896
"Thomas Fraser"
Judge of Probate

in of what his father was about to do - wants to ... for the purpose of filing a complaint. Realizes ... is willing to be here as it is too expensive at ...). Says he had an attack of the "Blues" a ... said he could come here but did not think

spoiled
lightly reacting
to known.
upt.

tis -

way slightly -

General, no

EXAM. URINE,

FACIAL EXPRESSION,
Wearied & heavy
SENSIBILITY,
HEART, somewhat rapid.
Slightly irregular: impulse forcible: no murmurs
LUNGS,
Seem good.

TAKEN,

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 J. Andrew [illegible]

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4387.
Residence, Olmsted County, Minn.
Date Admission, 30th April 1896
Admitted by Dr. Herzog Hour, 3.30 P.M.
How Sent, Thomas Fraser, Jopr. Olmsted County
Sex, Male.
Age, 27 Years
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farmer
Degree Education, Common School.
Profession Religion, Yes: Roman Catholic.
Habits, Not intemperate
Nativity, Olmsted County, Minn: Father's Canada Mothers N.Y. State
Physicians Committing, Christopher Graham & E. T. Granger
Correspondents, none given in papers

No. for Year.
Insane Re
Cause
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go
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Age Fi
, about
Time of Lea
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Eddy & Herzog April 30/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Fairly Clear
Quick or Sluggish, Somewhat sluggish

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

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

REASONING POWER:
Ordinary Subjects, Fairly Good
Own Mental State, Fails to realize
Special Subjects,

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

DELUSIONS:
Systematized or Not, Systematized
Special Subjects, See note
Transitory or Not, Fixed

HALLUCINATIONS: "Of hearing"

ILLUSIONS: —

CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, Slightly reticent

GENERAL DESCRIPTIVE REMARKS:

Patient is somewhat exhausted. Has been sleepless for some time past and has been drinking considerable — He has usually been accounted an intelligent young man in spite of his somewhat badly shapen head. His family is respected in the community. His manner is heavy & dull, occasionally frowning, but he will brighten up for a few minutes. His main delusion is that his father committed incest with his sister. Refuses to say in details. Says while he was abed he heard his sister enter his father's room, which is below his: gives date &c. Says the spirit of his mother came

Personal and Medical History of J. Andrew Monette

came to his bedside & warned him of what his father was about to do & wanted him to prevent it: come to town, for the purpose of filing a complaint. Realizes that he is in poor health and is willing to be here as it is too expensive at the other Hospital (St. Mary's). Says he had an attack of the "Blues" a year ago and his physician said he need come here but did not think it necessary.

REFLEXES, Patellar, 6 – 7 = Equal.
Other —
ARTICULATION,
Slurred,
Hesitating, Somewhat
FACIAL EXPRESSION,
Wearied & heavy
SENSIBILITY,
—
HEART, Somewhat rapid.
Slightly irregular: impulse feeble. No murmurs.
LUNGS,
Seem good.

General, —

EXAM. URINE,

TAKEN,

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 J. Andrew [illegible]

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 438

Residence, Ols

Date Admission, 3[illegible]

Admitted by Dr.

How Sent, Thro[illegible]

Sex,

Age,

Civil Condition,

Children,

Age Youngest Child,

Occupation,

Degree Education,

Profession Religion, Yes: Roman Catholic.

Habits, not intemperate

Nativity, Olmsted County, Minn: (Father's Canada Mothers Ky State)

Physicians Committing, Christopher Graham & E. T. Granger

Correspondents, none given in papers

Time of [illegible]

Time in Hospital

Result,

EXAMINATION ON ADMISSION.

Eddy D. Henry April 30th 96:

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, fairly clear

Quick or Sluggish, somewhat sluggish

MEMORY:

Past Events, fairly good

Recent Events, fairly good

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, correct

REASONING POWER:

Ordinary Subjects, fairly good

Own Mental State, fails to realize

Special Subjects,

EMOTIONAL STATE:

~~Normal, Calm,~~

~~Indifferent,~~

Exalted,

Depressed, Yes

DELUSIONS:

Systematized or Not, systematized

Special Subjects, see note

Transitory or Not, fixed

HALLUCINATIONS: "of hearing"

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, slightly reticient

GENERAL DESCRIPTIVE REMARKS:

Patient is somewhat exhausted. Has been sleepless for some time past and has been drinking considerable — He has usually been accounted an intelligent young man in spite of his somewhat badly shaped head. His family is respected in the community. His manner is heavy & dull, occasionally yawning, but he will brighten up for a few minutes. His main delusion is that his father committed incest with his sister. He refuses to say in detail. Says while he was abed he heard his sister enter his father's room, which is below his: gives dates &c. Says the spirit of his mother came

Personal and Medical History of J. Andrew Monette

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 10½ WEIGHT, 166 lbs (usual Wt. 180 lbs) NUTRITION, Considerably impaired

WOUNDS OR ABNORMALITIES, scar 1½ in long, over right eye, extending upward from line of the hair: forehead low: slightly receding: prominent just over eyebrows.

TONGUE, Tremors, Coarse Coatings, large, load, slight yellowish Coat Promptness Movement, fairly prompt.

PUPILS, Equality, right somewhat larger Size, dilated

Response Light, excessive Accommodation, excessive

SIGHT, "Much impaired": left Eye has always been "weak": has catarrhal Conjunctivitis.

HEARING, Good

COORDINATION, Arms, fairly good: fingers to nose, eyes shut, fairly good.

Legs, slightly impaired: standing on foot, some difficulty: standing, Eyes shut, sways slightly.

TREMORS, Hands, slight Tongue, Coarse

Facial Muscles, No General, No

REFLEXES, Patellar, 6 – 7 = equal. EXAM. URINE,

Other —

ARTICULATION,

Slurred,

Hesitating, somewhat

FACIAL EXPRESSION,

Wearied & heavy

SENSIBILITY,

HEART, somewhat rapid. Slightly irregular: impulse feeble. No murmurs

LUNGS, seem good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	kept Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Poor 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 J. Andrew Monette

1896

This patient was brought here by Sheriff C.N. Stewart, with following history. Patient is in fair physical condition. No history of consanguinity or heredity. This is 1st attack; has not been in hospital before. First symptoms manifested about 2 months ago, by irrational talk. The disease seems increasing: not variable; nor at regular intervals. Derangement now shown in that he has delusions: imagines his father has had intercourse with one of his daughters. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. No peculiarities had been previously shown: no history of intemperance in self or parents, nor of any severe disease or head-injury. He has not been restrained or confined, nor under treatment. Do not know cause of the disease. He accuses his father of incest, (no examination today): ——

(Apl) 30 On admission, was put in B3 (S. H. R. 2 Ft. Complexion dark: hair black: eyes gray: condition of skin good: had right ankle broken. In clean: behavior good). May 1/96. Slept 7 hours, last night.
" 2 Eats well: behavior good. Is despondent; mental condition inclined to stupidness. May 2/96. He has sore eyes. Habits fairly neat and clean. Complains of dizziness. Is on medicine.
" 3 May 3/96. In a stupor all day: ate nothing, today. Was perfectly helpless: bathed in bed.
" 4 May 4/96. Fed him a fair breakfast this am: (was fed by nurse, today). Still in stupid condition.
" 5 May 5/96. Given hourly air water: bowels then moved: forced bet during night. Fed with spoon, by nurse. Remains in stupor: will not talk or move of his own accord. To exercise in grounds, daily. May 6/96. Refused breakfast. Ate nothing, today. May 7/96. Would eat nothing, today: still in stupor: will not speak. Visited by priest. May 8/96. No change. Fed by tube.
" 9 Visited by father & priest: would not talk with either. May 9/96. Still no change. In a continued stupor. Will eat nothing (fed by tube). Out on ground daily. May 10/96. about the same. Lies down much of the time, while out doors. Still has to be fed by tube.
" 11 May 11/96. Transferred to T.W. at 11 11 am. Refused dinner & supper (had been put to bed).
" 12 Is very quiet: apparently stupid. Given enema: no effect. May 12/96. Slept 7 hours, last night. Has remained in same stupid condition, all day. Refused all meals, today.
" 13 May 13/96. Slept 6 hours, last night. Still stupid: was fed fair meals, today. 1 00 pm. Given shower-bath. 8 00 pm. Enema given: bowels then moved. May 14/96. Slept 7 hours, last night. Was again fed fairly, today. No change noticeable in his condition. Summary: Patient was received on B3, in a stupid condition & has remained so. Appears strong, physically. Was placed on regular diet: ate well on 1st & 2nd days: refused all nourishment on 3rd day. on 4th & 5th days, was fed by nurse: ate nothing on 6th or 7th days: fed by tube on 8th 9th 10th & 11th days. Then transferred to "Infirmary ward", & refused to eat until 13th day — fed by nurse on 13th & 14th days.
" 15 Will not talk, but seems despondent. May 15/96. Is fed by nurse: very quiet: will not talk.
" 16 10 30 am. Injected 3/4 pt. salt solution, in left hip: May 16/96. very bright & talkative, this morning. Talks quite rationally & remembers almost all that happened, during past 2 weeks. Sleeps fairly.
" 17 well, at night. May 17/96. Seems still better, today. 11 00 am. Up & dressed, for remainder of day.
" 18 Is well-behaved. May 18/96. Remains in bed, today: very quiet, but bright & willing to talk when spoken to. May 20/96. Wt 110 3/4 lbs. May 23/96. Is steadily improving: seems quite
" 23 rational: Is up & out some afternoon. Behavior very good. May 23/96. 10 30 am. Complains of headache: appears unwell: was put to bed. Up again at 4 00 pm. No complaints.

Personal and Medical History of J. Andrew Monette

1896
May 29-31 May 29/96. Visited by relatives. May 31/96. Condition & behavior do not seem to change. Appears quite well somewhat restless & wishes to be out doors: talks quite rationally. Transferred to C3. —
June 1 June/96. Transferred to T.W. Appeared somewhat melancholy: said he would not go out, unless he could go alone. Is on regular & extra diet. June 4/96. Went out of his own accord, (4 30 pm): appeared very stupid. Refused supper — Temp. 99 6. June 5/96. 8 00 am. Temp. 98 7. Very quiet, all day — appears brighter. 4 00 pm. Temp. 99 6. — Wt 161 1/2 lbs. June 6/96. In bed: will talk: Temp. about normal. June 8/96. Has appeared well enough to get up, but did not wish to do so. June 11/96. 1 30 pm Up & dressed — June 12/96. Works some outward: asks for parole: Patient is very quiet — June 13/96. Condition does not seem to change. June 23/96. While in the City, receiving the Circus, Patient attempted to escape. June 24/96. Works some outward: always walking slow, when not working. Tried to elope, while out walking, after supper. June 29/96. Still very restless: walks slow, most of time. (Dispensed B3). Goes out with crowd every day. Works outward: appetite good. bowels regular. June 30/96. Visited by father, this afternoon. Later, he got out of window in hall: was brought back and transferred to B3 (at 8 00 pm).

July 1/99 Summary Nurses Notes by Dr. Phelps. Patient since November 96 has lived along quietly - Wt. Nov. 96 178 lbs. Has delusions - During September 96 noted as having less appetite & sleeping poorly - Trans. to B3. During September changed notably, becoming quite active & talking & laughing to himself. During latter part of year, however, became more quiet - Is always an inactive sort of patient, quite stupid mentally. May 31 99 Wt. 133 lbs. July 31 has been working outside of late: Visited by father July 99. Is in good health: Has delusions of which are quite permanent but does not talk about them.
Aug 1 Visited by father. Sept. 11 At work in laundry. Sept 27 Trans. to C1. Jan 31 99
Jan 31 99 Has worked most of time in laundry & part of time in dining room. Is slow & stupid. Laughs foolishly: No change in condition or behavior.

On B3 (Jan 1/00) Is somewhat irritable. March 31. Mental condition shows no change. Physical condition
Nov 1 99 - Taken to Worcester Insane Hospital - Nov. 14 99 - Returned by father. Was not very stubborn & contrary. Finally had to return him with aid of sheriff
1900 is good. Nov 1/99. Transferred to C1. Dec 2. Is still working in laundry. Jany 10/1900. Has small ulcerous
Jan 31 on right leg; dressed & improved. Jany 31/1900. Above notes hold good at the date. Patient still works in laundry
Sept 4 1901 Is in good Physical health: Sept 4/1900. Wt 208 lbs. Is very quiet & taciturn: habits somewhat slouchy.
Jan 31 No change to note in any way, during the period. Works steadily in laundry: health is good:
Sept 1 Still slouchy in appearance. Seems quite contented here. Feb 1. Wt 209 lbs. P80 —
May 31 Patient seems contented. Works regularly in Laundry. Physical condition good.
July 31 No change to report, in either mental or physical condition. Still works as usual.
Aug 31 1902 Wt 225 lbs. — Jany 31/02 — Is quiet: talks dull: works regularly at laundry: In
Jany 31 manner, indifferent: health good: habits slouchy. Is changing none.
" 31/03 Patient has been in fairly good condition during the whole period. Worked in laundry and more recently about lawn. Laughs & talks in a silly way. Is a good worker.

Personal and Medical History of George Masten

HERBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4388.
Residence, Dodge Co. Minnesota
Date Admission, 30th April 1896
Admitted by Dr. Phelps Hour, 7.45 PM.
How Sent, Sivert Olson, Jo P. Dodge County
Sex, Male
Age, — 50 —
Civil Condition, married
Children, — Three —
Age Youngest Child,
Occupation, Sta: Engineer
Degree Education, not educated —
Profession Religion, Methodist
Habits, Not Intemperate
Nativity, Virginia: (Parents also born there) —
Physicians Committing, J. F. Vanfleet and Chas. D. Wright.
Correspondents, none given in papers

No. for Year, 216.
Insane Relatives, none
Cause Exciting, not stated
Cause Predisposing, probably age
Form, Dementia organic
Accompanying Bodily Disorder, Weakness —
Suicidal or Not, — not —
Date of this Attack, some 2 years ago
Duration, Coming on gradually for 2 years
No. of Attack, not stated —
No. of Admissions, 1st
Age First Attack, (?)
Time of Leaving, 19th June 1896
Time in Hospital, 1 month & 10 Days —
Result, Died: hemiplegia:

(was at home for 10 Days)

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 George Masten

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 7½ WEIGHT, 132 lbs. 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, EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,

TAKEN,

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 George Masten

1896

This patient was brought here by Deputy Sheriff Joel Tucker, attended by Vandellen, with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. First symptoms of this attack manifested 2 years ago, by loss of memory: attack has been coming on gradually for 2 years. Disease seems increasing: is variable. Derangement now shown in subject of religion: he is also very choleric. Patient is not disposed to injure others, nor suicidal: no filthy or destructive habits. He wanders about without knowing where he is. There is no history of intemperance in self or family: nor of any severe disease or head-injury. Have had to keep him locked up, at the Poor-farm. Cause of disease is not stated. —

Apl 30 On admission, was put on B³ (G.N.R.R'pt. Complexion dark: hair gray: eyes blue: condition of skin fair: some bruises on right knee. Is clean: 2 small moles on left shoulder: behavior good).

May 1 May 1/96. Slept 5 hours, last night. Seems rational: talks well: is partially blind. May 2/96. Patient
" 3 is quite feeble, requiring assistance when going more than a few yards. May 3/96. Appetite good:
" 4 bowels fairly regular: makes no complaints. At times, one or other of his legs will fail him, for
" 5 several minutes. May 4/96. About the same. May 5/96. Out on grounds, daily. Lies down much, while
" 6 on hall, asks says "it tires him to be up for any length of time". May 6/96. No change noted. Talks
" 7/8 rationally. May 7/96. Behavior good: is very quiet: sleeps much of the day, while in room. May 8/96. Com-
" 9 plains of bowels being costive: also, of pains in abdomen. (Was given pills, but no effect from them)
May 9/96. Bowels badly constipated: again given pills: no effect. Complains also of retention
of urine. Patient is nearly helpless, requiring assistance in rising and retiring, eating and
" 10 walking, and everything that requires any exertion, at all. May 10/96. Bowels still constipated.
" 11 Was given salts, but no effect: May 11/96. Was given enema: bowels then moved copiously:
" 12 leaving patient much exhausted. Keeps out on ground, daily. May 12/96. 5³⁰ Pm. Transferred to B 4.
" 13 May 13/96. Is very feeble. Has to be dressed & undressed: goes out on ground, but has to be led: seems
" 14 rational: talks very little. May 14/96. No change noted: sits or lies in bed, most all day.

Summary: Patient was quite feeble, on admission and is still so. Bowels were obstinately constipated for several days & could only be moved by enema. He requires much assistance, as he is almost helpless. Talks and seems rational. Has complained, from time to time, of his bowels, pain in abdomen, retention of urine &c. Appetite has been good. Irregular diet.

" 17 May 17/96. Bowels have been badly constipated, requiring frequent enemata. Has also been given
" 24 pills. Bowels moved copiously, today, and left patient in a very weak condition. May 24/96. Was
" 29 visited, today, by his wife. May 29/96. Complains of being very weak & seems to be failing.
" 30 May 30/96. Had several vomiting "spells" this afternoon. Gave him a powder at 7 Pm.
" 31 Tea & brandy every ½ hour, until he went to sleep. May 31/96. Was again visited by wife.
Went home with her, this evening.

June 10 June 10/96. Was brought back, today: 3³⁰ Pm. Received on T.W. Given bath & put to bed. Hardly able
" 11 to walk: seems to have lost powers of legs. Ate a fair supper: & a regular & hearty diet. June 11/96. Com-
plained of headache, during night: slept only 3 hours. Very restless, this morning. Gets bed: Given
Enema: (N.G.). Has eaten fairly, today. Restless, all day. Talks rationally: had slight bad dreams.
" 12 June 12/96. Slept only 3 hours, last night. Behavior unchanged, today. Seems more irrational
than usual. Became very noisy towards night. Refused supper. Enema given: bowels moved.

Personal and Medical History of George Masten

1896

June 13 June 13/96. Slept none, last night. Is quite helpless, this morning: Does not seem to realize anything
that happens: Speech is impeded & irrational: ate fairly well, today (7.12 M.) Bowels do not move.
" 14 June 14/96. Extremely noisy, all night: slept none. Seems to be failing rapidly, very weak & helpless.
very noisy most of day. Given enema: no effect: Bed sores treated daily: Is still fed by nurse.
" 15 June 15/96. Slept none: noisy most of night: Appears worse, today: seems unable to talk: was
"hallooing" considerably, this Pm. Still fed by nurse. Feet & legs are quite cold. Bowels constipated.
" 16 June 16/96. Extremely noisy & hours, in night: Slept none: Is much worse, today. Can not talk.
Is quite helpless: appears unconscious: Has Cheyne-Stokes breathing: Visited by wife -
" 17 Refused his meals today. Was given whiskey in milk - June 17/96. Slept 2 hours, last night.
Seems some better. Talks some: very restless, all day: noisy: 12 Pm. Given a sponge-bath.
attended by wife, night & day - Bed sores becoming worse. Is given beef, milk & whiskey frequently
" 18 During the day: June 18/96. Slept none, last night. Appears worse, today. Is apparently
" 19 unconscious. Noisy, all day. Still attended by wife. 5 Pm. T 101⁶. June 19/96. Is failing
steadily, tonight: slept none. 10 Am. Respiration is becoming quick: has rattling in chest.
Is perspiring. T 102⁶. Has been failing rapidly, during the day: Has been unconscious,
since Yesterday. Took no nourishment, during day. Wife continually with him.
Patient continued to fail rapidly & Died at 2 Pm. (See attached record).

Died.

Personal and Medical History of Andrew Westrum

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4390.
Residence, Hayward, Minn
Date Admission, 9th May 1896
Admitted by D. C. G. Eby — Hour, 7:25 P.M.
How Sent, Herman Blackmer. Jof P. Freeborn County
Sex, Male
Age, 33
Civil Condition, married
Children, Three
Age Youngest Child,
Occupation, Farmer
Degree Education, partly educated.
Profession Religion, Yes. Lutheran
Habits, not intemperate
Nativity, Norway. (Parents also born there).
Physicians Committing, G. W. Barck and H. H. Wilcox
Correspondents, None given in papers.

No. for Year, 218.
Insane Relatives, Mother reported to have had temporary delusions.
Cause Exciting, Religious delusions.
Cause Predisposing, Previous attack: heredity?
Form, Mania subacute
Accompanying Bodily Disorder, None Mentioned
Suicidal or Not, — Not —
Date of this Attack, About a week ago.
Duration, — about a week —
No. of Attack, 2nd
No. of Admissions, 1st
Age First Attack, about 31
Time of Leaving, Aug. 10th. 1896.
Time in Hospital, 3 mo. 1 da.
Result, Discharged Feb. 3 '97. Improved.

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog. May 11 '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:

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 Andrew Westrum

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 11½ WEIGHT, 146½ lbs. NUTRITION, Considerably impaired.
WOUNDS OR ABNORMALITIES, —
TONGUE, Tremors, Coarse & fine Coatings, slight grayish, breath foul Promptness Movement, somewhat slow
PUPILS, Equality, Yes. Size, somewhat contracted
Response Light, About normal Accommodation, about normal.
SIGHT, Seems good.
HEARING, Seems good.
COORDINATION, Arms, Slight impairment
Legs, slight impairment
TREMORS, Hands, slight Tongue, yes
Facial Muscles, No. General, no.
REFLEXES, Patellar, 9 Equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Sounds are weak - somewhat rapid & irregular - No murmurs -
LUNGS, Seem good.

TAKEN,

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 Andrew Westrum.

1896

This patient was brought here by Deputy Sheriff E. H. Ellickson, attended by H. C. Nelson, with following history. Patient is in fair physical condition. There is no history of consanguinity, but some of insanity: mother is reported to have had temporary delusions. This is not the 1st attack: he had one, about 2 years ago: duration about 6 weeks. First symptoms of this attack were manifested about a week ago: he talked foolishly on religion. Disease seems stationary, not variable: no rational intervals. Derangement now shown in the subject of religion. He talks unreasonably & disconnectedly & is especially mixed up on religious matters. Patient is not disposed to injure others, nor suicidal, nor filthy, nor destructive in habits. No peculiarities &c had been previously shown. There is no history of intemperance in self or parents, nor of any severe disease or head-injury: he has not been restrained or confined. Supposed cause of the disease is religious delusions. Patient has had no medical treatment. ——

May 9 On admission, was put on B3 (G. H. N. Rpt. (May 10 96) Complexion light: hair light: eyes blue: Condition of skin good: no marks scars or bruises noticed: is clean: behavior good. Slept only 2 hours, last night: was very troublesome, most of the night: got up & dressed, several times. Was quite tiresome, during day, requiring continual attendance. May 11/96. Behavior restless & mischievous: this afternoon, patient would disrobe himself at every opportunity & would resist when made to put them on again.
" 10
" 11
" 12 Transferred to B1 at 6.30 PM. May 12/96. Was restless most of the night & slept only 1 hour. Is a medicine. Eats well: Is still restless: has delusions: keeps looking & pointing to the ceiling: Outwits crowd.
" 13 8.00 PM. Pugnacious: refused to go to bed & force had to be used. May 13/96. Slept 7 hours, last night. Seems quieter & more rational this morning. Has given baths. Eats well: bowels move: Behavior
" 14 good, when out. May 14/96. Was quiet, during night & slept 8 hours. Behavior much better (Is eating in dining-room). Has delusions & talks on religion. Walks slow, when out with the crowd. Still on restraint.
" 15 May 15/96. Quiet, during night & slept 7 hours. Condition apparently the same, this morning. Is not as talkative. Was enquiring for his folks. Asked if they had been here & when he was going home.
" 16 May 16/96. Slept 7 hours, last night. Eats well: bowels seem regular. Is still on medicine. Behavior
" 17 good: habits neat & clean. Still inclined to be slow, when out walking. May 17/96. Slept 6 hours, last night. Is apparently the same, physically. Talks about home & wants to know when he can go.
" 18/19 May 18/96. Slept 7 hours. No change noticed in his condition. May 19/96. Slept 6 hours. More talkative
" 20 and restless, this morning. Asked to be let make a speech on religion. May 20/96. Slept 7 hours. Still restless & talkative, when on hall: mixed contentedly out with crowd. Quiet & sleeps good, night.
" 21 May 21/96. Appetite good: bowels regular. Behavior somewhat quieter. Habits regular & neat & clean.
" 22 Was visited by friends. May 22/96. Slept 8 hours, last night. Behavior fairly good: thinks he is
" 23 well enough to go home. Does no work. Again visited by friends. May 23/96. Is sleeping well:
" 24 also, is doing very nicely. Behavior good: talks quite rationally. May 24/96. Apparently, the same. Was visited by friends. Makes no complaints. Summary: Behavior was very restless and somewhat noisy & he was inclined to be pugnacious, from date of admission to the 13th, when he quieted down & has remained so. Appetite has been good: bowels regular: He has delusions as to religion, and talks a great deal on that subject, until a few days ago, when he became more rational. Has been on medicine - Visited by friends, as above. Slept well, from 14th to 24th.

Personal and Medical History of Andrew Westrum.

1896

May 25 June 1 Trans. to B3. May 29 Patient quite restless: Behavior good. Asks frequently if wife is here: Visited by wife, child & friend June 28 Appetite good. Physical condition not very good: frequently complains of feeling sick & exhausted: Lies down during day.
July 6 Wt. 108 lbs. Pulse 84. Aug. 1 Patient quiet & well behaved. Habits clean: Appetite good. Sleeps well. Physical condition improved Aug 4 Wt. 185. Trains to A'.
Aug 10 Went home. Dr Phelps notes - "Appears fairly well recovered.

Discharged.

Personal and Medical History of Andrew Kauphusman

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4392

Residence, Rushford, Minn.

Date Admission, 13th May 1896.

Admitted by Dr. Phelps Hour, 3 oc PM.

How Sent, E. V. Farrington, Jofp. Fillmore County

Sex, Male

Age, 30

Civil Condition, single

Children,

Age Youngest Child,

Occupation, Farmer

Degree Education, Comgnon School

Profession Religion, Yes. Catholic

Habits, Not intemperate

Nativity, Winona Co. Minn / Father, St Louis Mo. Mother Bohemia

Physicians Committing, J. H. Phillips and G. A. Love

Correspondents, none given in papers

No. for Year, 220.

Insane Relatives, None

Cause Exciting, Dont know

Cause Predisposing, previous attacks

Form, Paranoia

Accompanying Bodily Disorder, None Mentioned

Suicidal or Not, not

Date of this Attack, Last December

Duration, about 5 months

No. of Attack, Not 1st. has several during last 4 years.

No. of Admissions, 1st

Age First Attack, about 26.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exby D. Herzog May 1st 96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, slightly Confused

Quick or Sluggish, Quick

MEMORY:

Past Events, Good

Recent Events, fairly good

Special Subjects,

PERCEPTIVITY:

Alert or Dull, alert

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State, Does not realize condition

Special Subjects, Nothing particular

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Slightly

Depressed,

DELUSIONS:

Systematized or Not, systematized

Special Subjects, see note

Transitory or Not, fixed

HALLUCINATIONS: none noted

ILLUSIONS: " "

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, fairly voluble.

GENERAL DESCRIPTIVE REMARKS:

Patient has a somewhat haggard look: hair grows up from forehead: stands fairly erect & in a peculiar fashion: is able to converse calmly & quite intelligently until the subject of his delusions is touched: he insists that a child is the son of himself and an unmarried woman & that this child is Jesus. He admits never having had intercourse with this woman: says he prayed to God that she might have a child & this prayer was answered. The reason he was able & have his prayers answered is because he has always lived a most exemplary & truly Catholic life. He says other people are trying to take the child from him & that it is a conspiracy of the protestants to deprive him of the child. Says if he cannot have the child peaceably, he is bound to have it the other way. He says other people try to make him believe the child is a girl but he knows better than that.

Personal and Medical History of Andrew Kauphusman

...ION, CONTINUED.

...ERISTICS. (somewhat)

NUTRITION, slightly impaired.

...ysh, Promptness Movement, Prompt

...arban: broad - normal -

...mmodation, Normal

TREMORS, Hands, Slight

Tongue, Yes

General, — No

EXAM. URINE,

Careless,

Irregular,

Poor,

Irregular,

Temp.,

ONSET GRADUAL OR SUDDEN,

Paralysis," or "Inebriety,")

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Re Andrew Kauphusman.

Petition of Liborius Kauphusman, that Owen Mohan be appointed guardian of said Andrew Kauphusman, & be heard on June 4/96 at the Probate Court at Preston, Minn.

E. V. Farrington
Jof Probate

Preston, Minn 16th May 1896

Notice issued May 20/96.

February 4 1898

Dear Clara if you want $5 00.00 what I did too you you can get the money or else if you want too get married too me I will ask you you was afraid of me I know that but I wont hurt a hair on your body I aught too bee too home cutting fire wood

Your friend
Andrew Kauphusman

whose babie was that that was at Charley Ebners I want too know the truth about it I know you tried too hide yous boy from me boy I want too

Personal and Medical History of Andrew Kauphusman

EGELEY, FICKAS & CHAMBERS, DAVENPORT, IOWA

Whole No. 4392

Residence, Rushford, Minn.

Date Admission, 13th May 1896.

Admitted by Dr. Phelps Hour, 3oo PM.

How Sent, E. V. Farrington, Sheff. Fillmore County

Sex, Male

Age, 30

Civil Condition, single

Children,

Age Youngest Child,

Occupation, Farmer.

Degree Education, Common School

Profession Religion, Yes. Catholic

Habits, not intemperate

Nativity, Winona Co. Minn. Fathers, St Louis Mo.: Mothers, Bohemia

Physicians Committing, J. A. Phillips and G. A. Love

Correspondents, none given in papers

EXAMINATIO

Eddy D. Herzog May 1896 MENTA

MENTAL ACTIVITY:

Clear or Confused, slightly C

Quick or Sluggish, Quick

MEMORY:

Past Events, G

Recent Events, Fairly

Special Subjects,

PERCEPTIVITY:

Alert or Dull, alert

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State, Does not realize Condition

Special Subjects, Nothing particular

Time

T

CONVE

Coherent or Coherent

Voluble or Reticen Fairly voluble.

noted

GENERAL DESCRIPTIVE REMARKS:

Patient has a somewhat haggard look: hair grows up from forehead: stands fairly erect & in a peculiar fashion: is able to converse calmly & quite intelligently, until the subject of delusions is touched: he insists that a child is the son of himself and an unmarried woman & that this child is Jesus. He admits never having had intercourse with this woman: says he prayed & God that he might have a child & this prayer was answered. The reason he was able & have his prayers answered is because he has always lived a most exemplary & truly Catholic life: he says other people are trying & take the child from him & that it is a conspiracy of the protestants & deprive him of the child. Says if he cannot have the child peaceably he is bound & have it some other way. He says other people try & make him believe the child is a girl but he knows better than that.

Personal and Medical History of Andrew Kauphusman

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8¼ WEIGHT, 155 lbs. NUTRITION, slightly impaired. (somewhat)

WOUNDS OR ABNORMALITIES, none noticed

TONGUE, Tremors, tremulous Coatings, Entire dorsum fraenah Yellow brownish coating, edges broad - Promptness Movement, prompt

PUPILS, Equality, equal Size, normal -

Response Light, normal Accommodation, normal

SIGHT, Good

HEARING, " "

COORDINATION, Arms, Good: usual tests

Legs, " " "

TREMORS, Hands, slight Tongue, Yes

Facial Muscles, No General, — No

REFLEXES, Patellar, 9 = equal EXAM. URINE,

Other very slight ankle-clonus

ARTICULATION,

Slurred, ✓

Hesitating,

FACIAL EXPRESSION,

✓

SENSIBILITY,

✓

HEART, Sounds somewhat muffled no murmurs.

LUNGS, seem good

TAKEN,

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 Andrew Kauphusman.

19[6]

This patient was brought here by Sheriff H. Nupson attended by Wm Houck, with the following history. Patient is in fair physical condition. No history of consanguinity or heredity. This is not 1st attack: he has had several attacks during last 4 years. First symptoms of this attack were manifested last December: Claims several children are his own: makes demands for the children + attempts to take them by force. Disease seems increasing: variable + with rational intervals, but of regular intervals, not known. Derangement now shown in that he claims a child, as his own, and also that it is the Christ + attempts to take it by force. Claims that the child is his own + a young lady of good character. Has made threats to injure others. Is not suicidal: no filthy or destructive habits. Patient has always been hard to control. Showed very strong religious impressions. No history of intemperance in self or parents, nor of any severe illness or head-injury. He has not been restrained or confined. Cause of disease is not known. Homocidal to attend. He is now very excitable. Has strong delusions in regard to the child. —

May 13 On admission was put on B[3] (G.H.N.Kpp. Complexion dark: hair black: eyes blue: Condition of skin good: little finger of right hand off: has a scar, at back of head, an inch long: is dirty: behavior good: Took bath, on admission May 13/96. Slept 8 hours, last night: (Had been given bath on admission). Talks rationally, on most subjects. Behavior good. Is very quiet. Makes no complaints as to physical condition. Is on regular diet + eats well. May 15/96. Slept 8 hours, last night. Refused his medicine. Patient became quite excited today, because he was asked to take some medicine.
" 16 Says "he dont need any medicine". May 16/96. Slept 8 hours. Again refused medicine. Appetite good: bowels regular. Has delusions "of Persecution". Says, also, that "he is the father of a Savior
" 17 who has just come into the world". May 17/96. Slept 8 hours. Behavior good. Goes out on the
" 18 grounds daily. Physical condition good: plays cards some, while in-doors. May 18/96. Is stubborn,
" 19 at times, though not exactly troublesome. Says "he is going to get out of here". May 19/96. No change:
" 20 talks little: out on grounds daily: habits neat + clean. May 20/96. No change noticeable. Sleeps well.
" 27 May 27/96. During this, the 2nd week, patient has been resting + sleeping well, about 8 hours, nightly. Behavior usually good, though cranky + obstinate, at times: generally very quiet but recently became very excited because he could not find his cat. Appetite good: bowels in good condition. Has delusions, but will not talk about them. Summary. Behavior fairly good during past 2 weeks; though stubborn + obstinate, at times, yet he was not troublesome. Will not talk much about himself. Physical condition good. Still holds delusions, as above mentioned, but will not talk of them.

May 1/97 Summary Nurses Notes by Dr. Phelps. Patient has been always, a quiet, rather intelligent appearing patient, able to answer questions quite readily. On further talk with him, however, he shows considerable mental weakness + some confusion. During August was on parole. In Sept. trans. to B[3]. Being peculiar in behavior. Dec 1796 trans. to B' having become quite loquacious + excited with no special cause. At times appears quite stupid but is able to answer questions in an intelligent manner, with only occasional spells in which he does queer things impelled by his delusions.

May 31/97 Wt. 193[#]. Rather uncertain in behavior: Works a good deal. Has bright + intelli

Personal and Medical History of Andrew Kauphusmann.

quet appearance but is full of vague delusions. Occasionally is noisy + abusive.
Jan 31/99 A good many notes of active + quarrelsome behavior, otherwise no change. Feb 1-July 31/99 (Delusions) Wt. reg. Bowels regular. Appetite good. Is pugnacious + noisy at times. Feb 7. Trans. to B[3]. No special change in general condition.
Aug-1900 - Jan 31/1900 (Dr. Schapple). Oct 15 Trans. to C'. Attempted to interfere with nurses. No change of
-Jo- note during period. Usually quiet + well behaved. Is very inactive + sits in room
Jan 31 most of time. Says nothing unless addressed. Is deluded: neat in habits:
Feby 1 occasionally stubborn + ugly. Feb/1900. Wt 210[#] P78. July 31. No change of importance.
July 31 During period, except that he is rather more quiet and works on ward; tho' has been quite troublesome, at times, making threats of bodily injury to physicians and nurses and talking noisily. Physical
Aug 1 condition very good. Augt. Wt 200[#] Jany 31/1901. Quite well-behaved: habits cleanly: works on
Jany 31 ward: speech very irrational; talks to himself considerably: at times, is very threatening
Feby 2 and abusive. Feby. Wt 204[#]. Apl 30. Has been quite troublesome: talks much to himself: is
Apl 30 abusive: confused: no work. Augt. Wt 175[#] - Nov 2 Wt 179[#] - Nov 10. No change: rather
Nov 10 quarrelsome: confused: irrational: Dec 6. 2 B's. Jan 31/02. Has been more quiet, of late.
1902 Jan 31 Plays cards a good deal: does not associate with other patients: very incoherent in talk: does no work.

Aug 1902 Weight 160[#]

Jan. 9. 03 Visited by brother + son.

Jan. 31. 03 During first part of year seemed in good physical health + condition; inclined to be violent + of ugly disposition; Lately has been failing in health; + has been somewhat more peaceable, however will not permit an examination — becomes very abusive and threatening if molested. Says he is well - will take no medicine

Personal and Medical History of George Mc Michael (Jr)

EGBERT, FIELAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4396

Residence, Frontenac, Minn

Date Admission, 16th May 1896 — 6th

Admitted by Dr Eby — Hour, 7.35 to 11.45 PM

How Sent, Abel Haller, Jo P. Goodhue County

Sex, Male

Age, 62

Civil Condition, married

Children, six

Age Youngest Child,

Occupation, Wheat-buyer

Degree Education, Common School

Profession Religion, not a church-member

Habits, not intemperate

Nativity, Scotland (parents also born there)

Physicians Committing, N Juell & J V Anderson

Correspondents, none known in papers

No. for Year, 224

Insane Relatives, Two sisters have been insane.

Cause Exciting, not known

Cause Predisposing, Heredity & previous attacks.

Form,

Accompanying Bodily Disorder, Dyspepsia, Insomnia &c.

Suicidal or Not, Very suicidal & propensity active.

Date of this Attack, about 4 weeks ago

Duration, — about 2 weeks —

No. of Attack, 4th or 5th

No. of Admissions, 3rd

Age First Attack, about 34

Time of Leaving, June 10. 1897.

Time in Hospital, 1 yr. 25 d.

Result, Discharged Sept. 28 '97 - Recovered.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exby Dr R. M. Phelps

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, Hypochondriac — No delusions

Own Mental State, noted except the delusion idea

Special Subjects, that he is sick

GENERAL DESCRIPTIVE REMARKS:

Says has had dyspepsia all life & catarrh. In 1891 first time ever was this way. Very hypochondriac and despondent

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 George Mc Michael

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 9 in WEIGHT, Not taken NUTRITION, Failed some

WOUNDS OR ABNORMALITIES, Skin — some dryness

TONGUE, Tremors, Coatings, Patchy, red. irritated Promptness Movement,

PUPILS, Equality, Equal Size, normal

Response Light, normal Accommodation,

SIGHT, Failing

HEARING, Some defective.

COORDINATION, Arms,

Legs,

TREMORS, Hands, None of special note — Tongue,

Facial Muscles, Chronic mation's - Nervous unrest General,

REFLEXES, Patellar, 7-8 EXAM. URINE,

Other

ARTICULATION, Good

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Strong and palpitating.

LUNGS, Good

TAKEN,

Arteries - Somewhat full and slightly resistant - Some atheroma -

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Cir.(h) 56.5 (v.m) 65.5. Nas. or. a. 35.7 Bin. a. 36. Ant. post. d. 19.7 Transv. d. 15.0 Bin. d. 13. Occ. l. 13.6.

HISTORICAL, Contracted rectum (Miles operated on in Lake city just before coming here. Headaches all the time - more since February -

LENGTH OF INVASION, Since February Recurrent since 1891 ONSET GRADUAL OR SUDDEN, Gradual

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

Mother or Mat. Relations, Lived till 81 yrs of age. Other maternal relations all long lived.

Father or Pat. Relations, Died of Brain Fever when he was five years old.

Brothers or Sisters, Two sisters went insane over money problems and religion. Two brothers dead - One of consumption - Two brothers living. Seem healthy.

Personal and Medical History of George McMichael

1895

This Patient was brought here by Deputy-Sheriff R.J. Lundquist, with following history. Patient is in fair physical condition. There is no history of consanguinity, but one of heredity. two sisters have been insane. This is 4th or 5th attack: first symptoms manifested about 28 years ago: has since had 2 attacks (one, 5 years ago and one 3 years ago: duration of 1st attack, 7 weeks; and of 2nd attack 8 months): was then at this (Rochester) hospital: was returned, improved, both times. First symptoms of this attack manifested about 4 weeks ago: attempted to drown himself in a cistern. Disease seems to be increasing: is variable and with rational intervals, but these not at regular intervals. Derangement now shown by his suicidal tendency: attempted it by drowning: & propensity now active. Is not disposed to injure others, nor of filthy or destructive habits. Before the accession of disease, no peculiarities had been shown: no history of intemperance in self or parents, nor of any severe disease or head-injury. No restraint has been used, but he has been watched for 4 weeks. Cause of the disease is not known. He has been treated by Dr. A.C. Dockstader, of Lake City: no improvement. He now complains of headache, dyspepsia, insomnia, loss of flesh: "wants to go to the hospital because he is afraid he would drown himself." NOTE. As above stated, patient was here before: 1st time, from June 26/91 to Aug 17/91. (See Vol 17 p 25 No 2744); and the 2nd time, from June 4/93 to Feb 17/94. (See vol 23 p 293 No 3388). Symptoms of each attack have been about similar, and strong Suicidal tendencies have been shown. Discharged last time, "Legally Committed."

May 16 On admission, was put on B3 (G.H.R.P.M.). Complexion dark: hair black: eyes gray: condition of skin good. Is clean: 1 finger on left hand & 3 on right hand crooked: behavior good. appears weak & complains of headache. Pulse 100. Temp 100. Received on ward 7 30 P.M. Was in a nervous condition. Says "he does not feel well & is despondent". Drank a little milk. Was given bath.

" 17 May 17/96 Was given sleeping dose, but slept only 3 hours, last night. Complains of costiveness: is quite despondent: Complains also of sleeplessness. Appetite fair: was out on ground, today. P.M. T 100: Mastin Diet.

" 18 May 18/96. Was given sleeping dose at 9 P.M. & another at 11 P.M., last night: slept 6 hours. Was also given a peristaltic powder: bowels moved freely. Is on medicine, 3 times a day. Is despondent. Says "he can't live long".

" 19 T. 99 4: 99 5. May 19/96. Behavior good: habits neat & clean: goes out on ground daily: Talks rather confusedly.

" 20 May 20/96. Slept 4 hours, last night: was very restless. Very despondent, today. Says "he can not last long". Was given salts: bowels then moved.

" 21 May 21/96. Slept only 1 hour: restless 7 hours, last night. No change noticed. Is still very despondent. Complains of "burning feeling" in head,

" 22 during night, causing sleeplessness. May 22/96. Slept only 2 hours: very restless, during the night.

" 23 Still no change noticeable. Habits neat & clean. May 23/96. Slept 6 hours, last night. Bowels costive.

" 24 Is given medicine, 3 times daily. Is on regular & extra diet: is quiet: behavior good. May 24/96. Slept only about 2 hours, last night. Still complains of bowels being costive: is very despondent, at all

" 25 times. Says "he is in very bad condition". May 25/96. Slept 1 hours. Appetite poor. Eat a very light diet,

" 26 usually bread & milk. Behavior quiet & despondent, as usual. May 26/96. Slept 7 hours, last night. Appears some brighter & more cheerful. May 27/96. Slept 2 hours. Was given dose of

" 28 salts & bowels moved, during the night. Is still on medicine, 3 times a day. May 28/96. Slept 6 hours.

" 29 No change especially noticed. May 29/96. Slept only 4 hours, last night. Patient apparently brighter. Talks now & is less despondent. Summary. Patient has been quiet & orderly, at all times,

Personal and Medical History of George McMichael

since he came. Has been very despondent, at times: Says "he can not last long". Complains of feeling feverish in head & of sleeplessness during night: also of Chronic constipation, all of which he exaggerates considerably. Physical condition fairly good. Talks rationally, though confused, at times. (See attached record) June 4 Wt. 152 lbs. Pulse 80. Appetite fair: Bowels fairly regular: Physical condition has improved perceptably during past three weeks. Patient is very despondent & thinks his condition worse than it really is. June 25 Patient doing well: Complains of bowels being costive: gives salts. July 1 Complains of stomach trouble: breath foul. July 5 Has Rheumatism in legs, walks with great difficulty. July 10 Still complains of rheumatism: Trans. to Infirmary: Ointment applied to knees & legs which are badly swollen & easy bandaged with flannel. Cannot move without help. July 11 Very restless all day; seems to suffer a great deal. Is upon milk diet: Gives hypo. Morphine 1/8 gr. at 8.30 P.M.

July 17 Appears somewhat better today. Limbs bandaged daily & ointment applied.

" 18.- Is growing better but very restless at times: Habits filthy. Slept some during day.

" 23 Has been very restless since last wrote & slept very little - moans most of time.

" 31 No change. Orig & Since last note patient has been fed daily by nurse: Is quite helpless but is quieter than formerly: Talks quite rationally: Up in chair today.

Aug 8 Patient out in chair daily - Still quite helpless but is able to feed himself a little

" 22 Able to walk a little today. Seems improving physically.

Sept 5 Wt. 173 lbs. Sept 15 Electrical treatments given 3 x per week. Is improving slowly. Complains a good deal of various ailments. Oct 5 Visited by friend. Goes out daily with crowd now: Behavior good. Appetite good. Oct. 10 In bed today complains of pain in limbs

Nov 1 Wt. 173 lbs. P. 84. Patient sleeps & eats well. Talks rationally: No delusions noted.

" 29 Trans. to A 4. Dec 1 Wt. 149 lbs. No change in behavior or mentally or physically.

Dec 29 Complains of soreness in throat: On medicine 4 x day. Jan 1 Wt 154 lbs. - No change.

Feb 1 Wt. 158. Physical condition quite good. Appetite good: Bowels regular. Feb 4 Has had a sore throat since Feb 4th. Uses gargle 3 x day. Apr 1 Appetite good: Sleeps well. Says he feels much improved: Talks rationally. Wt. 162 lbs. Apr 10 Was out for walk (1½ miles) today: Has not been out since last fall. Apr 13 Trans. to A 4

Apr 30 Goes out daily: No change. Dr Eby notes "Still very hypochondriacal but not as melancholy as sometime back" May 1 Wt. 165. Complains of Rheumatism in hands & limbs: Talks rationally on most subjects: Slightly childish: Appetite good: Bowels regular. June 10 No change since above note. Must home today

Discharged.

Transferred from Fergus Falls State Hospital

Personal and Medical History of John Ebersold

BERRY, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4397.
Residence, Eloquent, Minn
Date Admission, 18th May 1896.
Admitted by Dr Phelps Hour, 3 PM.
How Sent, Transferred from Fergus Falls Hospl C. Bradley J. of Probate
Sex, Male
Age, - 48 -
Civil Condition, married
Children, Two
Age Youngest Child,
Occupation, Laborer
Degree Education, not stated
Profession Religion, not a church - member
Habits, not intemperate.
Nativity, Switzerland: (Parents also born there).
Physicians Committing, L. A Lukeforth & A B. Allen.
Correspondents, none given in papers

No. for Year, 225.
Insane Relatives, None
Cause Exciting, in Augt '74, bitten by a dog.
Cause Predisposing, "Chronic"
Form, Melancholia chronic
Accompanying Bodily Disorder, none mentioned.
Suicidal or Not, - Not -
Date of this Attack, Invasion Gradual
Duration, - Probably long -
No. of Attack, 1st
No. of Admissions, 1st here
Age First Attack, (?)
Time of Leaving, Oct 1. 1897
Time in Hospital, 1 yr. 4 mo. 13 d.
Result, Discharged Oct. 9' 98 Unimproved -

EXAMINATION ON ADMISSION.

Exam. by P M Phelps. 5/20/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Slightly sluggish
MEMORY:
Past Events,
Recent Events, } Seems good -
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Slightly dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State, } Poor.
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 John Ebersold

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 11 in WEIGHT, 152 pds 1st 156 185 about typ. NUTRITION, Some impaired. Condition of skin fairly good
WOUNDS OR ABNORMALITIES,
TONGUE, ~~Tremors~~, Pale & anaemic. Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Accommodation,
SIGHT, Failing some - One eye inflammed - watery - some trouble with nasal duct - Right eye.
HEARING, Fair.
COORDINATION, Arms, Good.
Legs,
TREMORS, Hands, No. Tongue, No.
Facial Muscles, General,
REFLEXES, Patellar, 2-3 sluggish EXAM. URINE,
Other
ARTICULATION, Good -
Slurred, -
Hesitating, -
FACIAL EXPRESSION,



TAKEN,

SENSIBILITY,
Arteries, No atheroma detected.
HEART, no murmurs. Sounds good.
LUNGS, Expans. fair. Sounds harsh. especially on left side. but no marked symptoms.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ-(h) 55.5 from Gl R. occa. 36 Bi a. 36.2 Ant f.d. 12.4 Front. d. 11.6 Bi. d. 14.3 Fac. C. 13.4
HISTORICAL, Had Typhoid fever in Kansas in '75 - Taken sick suddenly in harvest field - Does not know if had sunstroke. Suffered most in winter of 77 - caught in Blizzard - Never as bad as this last year - Spells of being dull & unable to work. "Feels tired & unfit for working" "Feels now this way" First felt so about 1870 -
LENGTH OF INVASION, Typ(?) Went to F. Falls in 1895 ONSET GRADUAL OR SUDDEN, Gradual - a defective (?)
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Don't know of any insanity.
Mother or Mat. Relations, Died when he was young -
Father or Pat. Relations, Died in Kansas of Dysentery.
Brothers or Sisters, 1 brother 1 sister - 2 half brothers.

Personal and Medical History of John Ebersold.

1896

This patient was brought here by Wm Johnson: he has been confined in the Hospital at Fergus Falls, having been sent there 26th August 1895 by C. Bradley, Judge of Probate, Carlton County, Minn: and received there at the hands of Wm McKinnon Sheriff, attended by Wm Ebersold. (A copy of the Warrant, receipt of Supt & annexation Papers & history Goes with him). There is no history of Consanguinity or heredity. This is 1st attack. the Invasion was gradual. he became suspicious of everyone: feared injury to himself & family. Disease appears to be increasing, not variable: no rational intervals. Derangement now shown by fears, insomnia, restlessness and morbid depression of spirits. Patient is not disposed to injure others, nor suicidal nor filthy nor destructive. No insane relatives. Previously, he showed, for years, a very irascible temper. There is no history of intemperance in parents or self, nor of any severe disease or of head injury. He has not been restrained or confined. Supposed cause of the Disease is as follows. In August 1894, he was bitten by a dog, in the leg: this was followed by Sciatica & he has feared hydrophobia. Patient has had no treatment. (see attached history Aug 22/95 – Adl 866)

May 18 On admission, was put on B³ (C.S.K.N.R&T. Complexion dark: hair brown: eyes blue: Condition of Skin good: Some excess on right heel. Is clean: behavior good). Gave bath on admission May 19/96. Slept 8 hours, last night. Bowels regular. Behaves well: talks rationally: No complaints: Out on the grounds.

" 20 May 20/96. Slept 6 hours. Appears contented: Is very quiet, & Despondent, generally. May 21/96. Slept 6 hours: Behavior good. Habits neat & clean. Causes no trouble onward. May 22/96. Slept 6 hours. Patient is very quiet: makes no complaints. May 23/96. Slept quite well, last night. Says "he is worrying about his family & wants to go home". Behavior good. May 24/96. No change noticed, from day to day: Remains quiet, while onward. Does walking. Bowels regular. May 31/96. Since last noted, no change is specially observable. Behavior has been good: Condition remains about same, day after day. Talks very little, but rationally. Is very quiet: at times, cranky towards other patients. Goes out on ground, daily. Walks about considerably, when out of doors. June 1/96. Was disturbed & slept only 4 hours, last night. —

June 1 Summary. Behavior has been good, during past two weeks. Patient has been quiet & orderly: physical condition fairly good, though he is not in good flesh. Is despondent & worries much over confinement.

June 1/96 Summary Notes by Dr Phelps. Patient visited by wife & child: Mentally patient is rather depressed: Has some delusions – July 30 Noted as having improved somewhat but is still restless & melancholy. Oct. 31 Patient has changed somewhat, rather more restless. Has refused meals at times & is somewhat sullen. Pulled out part of his moustache one night. Jan 31 Patient has changed very little. Mch 17 Noted as becoming noisy & violent during last few days: Trans. to B¹. Apr 17 Patient transferred to Infirmary being very restless & complaining at times of feeling badly, without any very definite symptoms however. May 1st 97 In bed since 17th Always complaining & irritable: Thinks food is poisoned: No very prominent symptoms.

May 5/97 Patient restless & noisy at times: On infirmary: Rather disagreeable, talking & scolding in a noisy way. Lies in bed. Temp. at times sub-normal. June 1 Wt. 122# Is quite emaciated. Is very anaemic & a diagnosis of pernicious anaemia seems fairly probable. July 1 Wt. 119#. General condition & behavior the same:

Aug 1 Wt. 116 – Behavior same in every way. Sept 1 Wt. 115 lbs. Has been vomiting

Personal and Medical History of John Ebersold

ally – Oct 1 Patient improved: Is

Synopsis of history of

John Ebersold while at Fergus Falls State Hospital.

1895

Aug. 22. In fair physical condition, much depressed, speaks in a low voice and in a hesitating manner. Says that he was bitten by a dog several years ago, that lately he has been much worried for fear of hydrophobia. Has slept poorly and appetite has been variable. Ten years ago was caught on a blizzard in N.D. and nearly frozen, since then he has had a constant headache. Now says that he worries about his little boy. Tongue coated white, hands and feet cold.

Aug. 28. Is less depressed. Speech is quicker.

Sept.3. Allowed up about the ward. Has apparently quite recovered from his depression.

Sept. 10. Doesn't appear as well this morning. Breaks down and cries.

Sept. 18. Is more cheerful to-day.

Sept. 27. Continues to be depressed. Worries about his family. Thinks he has done wrong.

Oct. Had a newspaper to-day and pointed out an article in it on adulteration of milk, said that is what he did and is worring about it.

Nov.6. Is quite depressed, says that he can never get well and wants nothing more done for him.

Nov.13. Told one of the nurses that he would kill himself. Says that he has done sin enough to send him and his family to states prison for a hundred years.

Nov.25. Still very much depressed. Asks that the sheriff may come and get him and punish him for what he has done. Will not tell what it is. Sleeps poorly.

Nov.27. Imagines that he has been accused of setting a lumber yard on fire.

Feb.14. Does not improve. Says he must dies for his past sins, and constantly worries about his family. Physically he holds his own

March 25. For past week has seemed brighter and less depressed. Worked well in dinning room.

April 8. Not as well.

Personal a

1896

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Becom
Transferred to
Badly, without any
complaining & irritable
May 5/96. Patient restless & noisy at times
scolding in a noisy way. Lies in
Is quite emaciated. Is very anaemic & a diagnosis of pernicious anaemia
seems fairly probable. July 1 Wt. 119#. General condition & behavior the same:
Aug 1 Wt. 116. Behavior same in every way. Sept 1 Wt. 115 lbs. Has been vomiting

Personal and Medical History of John Ebersold.

occasionally of late. Talks a little more rationally. Oct 1 Taken home today by wife: Condition not especially improved. Is thoroughly anaemic.

Discharged.

Personal and Medical History of Joseph Sejkora

ROBERT, FIDLAR & GRABBERS, DAVENPORT, IOWA

Whole No. 4398.
Residence, Steele County, Minnesota
Date Admission, 18th May 1896. -
Admitted by Dr. Herzog Hour, 7.30 P.M.
How Sent, W.B. Chadwick. Jail. Steele County
Sex, - Male -
Age, 26 years
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Farmer: father's also farmer
Degree Education, Common School.
Profession Religion, not a church member
Habits, not stated
Nativity, Steele Co. Minn. (Parents', Bohemia, Europe).
Physicians Committing, C.M. Smith and J.P. Johnson
Correspondents, None given in papers

No. for Year, 226
Insane Relatives, None: father a hard drinker
Cause Exciting, not known
Cause Predisposing, "Chronic"
Form, Imbecility
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, - not -
Date of this Attack, Five Years ago
Duration, - Five Years -
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, - about 21 -
Time of Leaving, Apr 26. 1900
Time in Hospital,
Result, Transferred to Hastings. OK pm

Retransferred Oct 13-1902. pk pm
No 6352 (file system)

EXAMINATION ON ADMISSION.

Dr. Herzog May 18 96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Somewhat confused
Quick or Sluggish, Sluggish -
MEMORY:
Past Events, Impaired
Recent Events, - " -
Special Subjects,
PERCEPTIVITY:
Alert or Dull, - Dull -
Correct or Illusive, in the main Correct
REASONING POWER:
Ordinary Subjects, Slow
Own Mental State, says "is better, than he has been"
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Indifferent
Exalted,
Depressed, Slightly
DELUSIONS:
Systematized or Not,
Special Subjects, None noted
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:
Slow: Dull: attention poor: Patient is stupid. Masturbator. approaches to pubescent insanity. Probably considerable defectiveness. Was born in this country & has been to school. knows very little about manners &c. Did not know there was such a town as Rochester.

Personal and Medical History of Joseph Sejkora

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, 159 lbs (usual wt 170 lbs) NUTRITION, Fair
WOUNDS OR ABNORMALITIES, retreating forehead: high arched palate: acne & comedones on forehead skin greasy
TONGUE, Tremors, Slight Coatings, light yellow coating Promptness Movement, sluggish
PUPILS, Equality, Equal Size, normal
Response Light, Slow Accommodation, Slow
SIGHT, Seems good
HEARING, -do-
COORDINATION, Arms, fair: finger to nose, eyes shut, fair.
Legs, fairly good: standing on one foot, good: standing, eyes shut, good.
TREMORS, Hands, no Tongue, slight
Facial Muscles, no General, no
REFLEXES, Patellar, 6 - equal
Other
ARTICULATION, Slow
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, no murmurs: sounds dropped & muffled. Apex beat 5th interspace a little to left & slightly irregular.
LUNGS, Seem good

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless, Drinks & smokes slightly
BOWELS, Normal,	Constipated, Costive	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, at present	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, (occupation - as farmer)
LENGTH OF INVASION, probably long ONSET GRADUAL OR SUDDEN, gradual: headaches & vertigo formerly -
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, } nothing obtainable from patient.
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Joseph Sejkora.

May 96 This patient was brought here by Sheriff J.Z. Barnard, attended by Frank Sejkora, with following history. Patient is in fair physical condition. No history of consanguinity or heredity, but father was a hard drinker. This is 1st attack: (Duration five Years). First symptoms of the attack manifested five years ago, by despondency & melancholia. Disease seems increasing: not variable: no rational intervals: worse, at intervals, but not entirely free from disease. Derangement now shown in that he is dull of intellect & has restless and sleepless nights. Patient is not disposed to injure others, nor suicidal: propensity not active: no filthy or destructive habits. No peculiarities had been previously shown: he has not been subject to any severe disease or head injury. He has not been restrained or confined: Cause of disease not known: has had medicine, but refused to take it. He is dull of intellect, listless and takes no notice of surroundings.

May 18 On admission, was put on B3 (G.A.R. Ward). Complexion dark: hair dark brown: eyes blue: condition of skin good: scars on right side of head: is clean: behavior good). Gave him bath.
" 19 May 19/96. Slept 3 hours; was restless 5 hours, last night. Is on regular diet: eats well: bowels move: mental
" 20 condition slightly confused: is stupid: talks some, in a foolish way: no complaints. May 20/96. Restless 7 hours & slept only 2 hours, last night. Patient tries to walk away, while out-doors; requires continual
" 21 surveillance from nurses. May 21/96. Again restless, sleeping only 4 hours, last night. Appetite good: bowels in good condition. Behavior good. Is very dull, mentally & slow to perceive anything.
" 22 May 22/96. Slept 6 hours, last night. Has not delusions or hallucinations noticeable, but mental faculties
" 23 are apparently very slow & dull: (apparently, he never did know much). May 23/96. Slept 6 hours. Behavior good: habits neat & clean. Goes out on grounds, every day. Tried to elope today: was caught and
" 24 brought back, by Nurse Smith. May 24/96. Slept 7 hours. Says he must go home in the next train.
" 25 Is quite restless today: makes no complaints as to physical condition. May 25/96. Slept 4 hours, last
" 31 night. Behavior good. May 31/96. Since last noted, patient has been somewhat restless, at night, but sleeping 4 to 5 hours, each. Seems more contented. Appetite good: bowels in good condition. On Extra Diet: also on medicine, 3 times a day. Makes no complaints. Physical condition good. Talks
June 1 little. Is dull & stupid. June 1/96. Slept 4 hours, last night. No change officially noticeable. —

Summary: Patient has been very quiet. Behavior good. Will talk, though in a dull, stupid manner, appearing confused. Was quite restless, for several days, after he came & made several attempts to elope. Physical condition good. muscles large & well formed. Skin good. Mental faculties dull & slow & to all appearance, have always been so. No delusions or hallucinations noticed.

May 1/97 Summary Nurses Notes by Dr. Phelps. Patient during past year has been uniformly quite restless & somewhat excited but rarely making any special trouble. Since Jany. has been in annex & has wandered about in an aimless manner there. May 1 97 Wt. 158# July 31 Health good. Works daily on farm: is rather restless in behavior: Talks none: somewhat untidy. Dec 29/97 Visited by friends. Mch 31/98 Visited by friends. May 7 do. Sept. 28 Visited by relatives. Jan 31/99 Quite stupid in behavior. No change in patient. Feb 1 — July 31/99 (Dr. Malone) Wt. 164#
Feb 27. Visited by friends. Apr. 27. Received bruise on eye — from mushroom knife.
June 15 Cut on nose. Cause mushrooms. July 31 Appetite good: sleeps well: works on

Personal and Medical History of Joseph Sejkora

4/1900 farm. Mentally stupid. Aug 1 — Jan 31 1900. (Dr. Chipple) Wt. 164# Feb. Visited by uncle Mch 1. No
Jan 31 change or improvement. Is much demented: does not talk. Very stupid: health & behavior good. Has worked a little on farm: habits untidy. Apl 26. Above notes still
Apl 26 hold good, at this date. Was, today, transferred to Hastings Asylum.

By order of Board of Control Oct 4/1902 this patient
Apl 1903 was transferred again to this Hospital, being received here Oct 13/02.
He is, at this date, given a new number 6352 & continued on the
Records under the "file System"

P.M.

Oct. 13-02 (Dr. Chipple) Received from Hastings Asylum - said to be violent;
Oct. 25-02 Jo Annex; Dec. 12 - Ugly spell; attacked Robt. Davison, knocked
him down, also struck A.B. Holbrook & Ernest Sable & nurse, John
McNitt; Dec 14 Attacked R.A. Cross without provocation.
Jan 31-03 Has been quiet and peaceable - has nothing to say.
very indifferent to surroundings - is a persistent masturbator.

Personal and Medical History of John Walker

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4399. No. for Year, 227.

Residence, Chatfield, Minn.

Date Admission, 20th May 1896.

Admitted by D. Phelps Hour, 11 oc am.

How Sent, Thomas Fraser, Jo. P. Olmsted County

Sex, Male

Age, 35

Civil Condition, married

Children, one

Age Youngest Child,

Occupation, Farmer

Degree Education, Common School.

Profession Religion, R. Catholic

Habits, Not Intemperate

Nativity, Canada: (Parents born in Ireland).

Physicians Committing, A.W. Stuckfield and Chas. Graham

Correspondents, none given on papers

Insane Relatives, not known

Cause Exciting, not known

Cause Predisposing, not stated

Form, Mania acuta

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, not

Date of this Attack, one week ago

Duration, one week

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 35

Time of Leaving, June. 6th. 1896.

Time in Hospital, 16 da.

Result, Discharged. Jan 5. 1897. Rec.

Ady. De Herzog. May 21/96.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, impaired

Recent Events, very much impaired

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, correct

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Exalted

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

None noted

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:

Is timid & frightened: Patient is much better than he was last night: Was extremely confused: Very weak: Tongue heavily coated: Sores on teeth & lips: Has been struggling with his meat: Was very much frightened when almost refuses to speak. Holds hands to head. Says "feels like a whirling in head" with occasional darting severe pains. Abdomen is tender. Seems in acute low-grade maniacal condition. Was a hardworking, intelligent farmer. Knows much can't tell.

Personal and Medical History of John Walker

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Too violent & excited to have these taken WEIGHT, (283) NUTRITION, Much impaired; skin somewhat dry

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Quite marked Coatings, slight coat: dry Promptness Movement, prompt

PUPILS, Equality, Equal Size, normal

Response Light, Increased Accommodation, increased

SIGHT, Seem good

HEARING,

COORDINATION, Arms, much impaired: usual tests not used: can hardly walk or use hands.

Legs, Do.

TREMORS, Hands, Quite marked Tongue, quite marked

Facial Muscles, no General, on standing.

REFLEXES, Patellar, q = equal EXAM. URINE,

Other abdominal reflexes increased

ARTICULATION,

Slurred,

Hesitating, Yes

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs: Sounds weak: apex beat 6th interspace 3½ in. to right Dullness line = regular

LUNGS, breath sounds somewhat harsh.

TAKEN,

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, probably sudden

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

Mother or Mat. Relations, No information obtainable

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of John Walker

This patient was brought here by Sheriff Stewart attended by John Healey, with following history. Patient is in fair physical condition. There is no history of consanguinity: as far as heredity, not known. This is 1st attack: first symptoms manifested one week ago, by sleeplessness. Disease seems increasing: not variable: no rational intervals. Derangement now chiefly hallucinations "of fear". Patient is disposed to injure others, but not suicidal, nor filthy or destructive habits. No peculiarities had been previously known. There is no history of intemperance in self or parents, nor of any severe disease &c or head-injury. He has been restrained & confined; friends watching him a few days. Cause of the disease is not known. (Dr Dickson of Chatfield has treated him). Patient needs constant restraint.

May 20 On admission, was put on C. (G.S.W.R.Ry). Complexion light: hair gray: eyes blue: condition of skin fair: has several bruises on back: is dirty: nervous & restless. Will not talk: only asks for wife & child). Is very nervous & irritable: ate no dinner: took 1 qt milk for supper. Bowels seem constipated. Is an emaciated condition. No cough. Complained of headache: Temp. 98.4 T.W. at 7 eo Pm. Appears frightened & confused. Was given hot bath (100°) & put to bed. also given enema.
" 21 after which bowels moved: mouth also washed. Temp. 99°. May 4/96. Slept 7 hours, last night. Am. Temp. 99. Very quiet, but still appears frightened. 10 30 am. Given mustard foot-bath.
" 22 Pm. Quiet all day. T 98.7. Has eaten well, today. May 17/96. Restless & slept only 3 hours, last night. Am. T 97.8. 10 am. Mustard foot bath. Bowels moved twice. Pm. Behavior still good:
" 23 has talked very little, during day. Seems improved mentally. May 23/96. Slept 6 hours. Am T 98.2
" 24 Pm. Very quiet, all day: talks very little, but seems quite rational. No complaints. May 24/96. Slept 6 hours, last night. Am. T 98.7. Pm. T 98.8. Eats well. Given Hungador water &c: bowels moved. Patient still very quiet. Answers questions quite rationally. Complains of slight dizziness.
" 25/26 May 25/96. Slept 8 hours. Seems much brighter, today. Read a great deal. Wishes to get up. May 26/96. Slept 7 hours, last night. Is improving daily: talks rationally: sat in Roller-chair in Pm. Says dizziness has left him". May 27/96. Can see no change: was given shower-bath. May 28/96. Quiet & well-behaved.
" 27/28 today. Seems to improve steadily. Says he can remember nothing that happened while being brought here". Out in Pm. May 29/96. Visited by friend. May 30/96. Still seems to improve: says he
" 29/30 feels stronger each day". May 31/96. Continues to improve. Out doors in afternoon. Sleeps well, at night.
" 31 June 1 June 1/96. Slept 8 hours, last night. Has been eating well. Bowels move. He seems rational: wishes to go
" 2 home, but seems to have no inclination to elope. Out in afternoon. June 2/96. Is doing nicely:
" 3 Up during day: out in afternoon. June 3/96. Sleeps 6 to 7 hours, nightly. Says "he never felt better". Visited by friend. Abt 143 3/4 lbs.

Summary: Was quite irritable, violent & excited, when received & was put in bed. Later, transferred to T.W. Same evening (20th). Became very quiet & seemed frightened & confused. Given bath & put to bed. Remained in same confused state until 2nd day, when he seemed to regain his reason & talked quite rationally. Continued to improve mentally, & up to last day, has been rational. Says he can remember nothing that transpired while here up to May 22nd". He seemed somewhat emaciated when received, but has gained flesh & strength during the two weeks. Has had no cough. Complained of dizziness, for first few days. Was somewhat constipated when received. Since that time, bowels have been irregular up to 4th day: in good condition, from 4th day. Appetite good, throughout. Temp. & Pulse about normal. Has slept well. (See attached Record.

Personal and Medical History of John Walker

June 4/96. Patient in bed, though up & out in afternoon. Physical appearance is good: Appetite good: (is on regular & extra Diet). Bowels fairly regular. Sleeps well: talks rationally. Visited by friends. June 5/96. No special change noted. June 6/96. Went home with Cousin (Mr Thompson)

Discharged.

Personal and Medical History of August Telkie

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4400.
Residence, St. Paul. Minnesota
Date Admission, 21st May 1896. —
Admitted by Dr Herzog Hour, 6.45 P.M.
How Sent, G. Willrich. Jo. P. Ramsey County.
Sex, Male
Age, 1 mf
Civil Condition, Widower
Children, —
Age Youngest Child, —
Occupation, Laborer
Degree Education, fair in German & English
Profession Religion, Lutheran
Habits, Not intemperate
Nativity, Germany: (parents also born there).
Physicians Committing, E.K. Buckley and Justus Ohage
Correspondents, none given in papers

No. for Year, 228
Insane Relatives, apparently not
Cause Exciting, Family Troubles
Cause Predisposing, not
Form, Paranoia
Accompanying Bodily Disorder, No
Suicidal or Not,
Date of this Attack, Jan
Duration, about
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about
Time of Leaving, Feb. 24 1899
Time in Hospital, 2 yr. 9 m. 3 d.
Result, Died. Uraemia.

SAID TO BE INSANE.

Telke, the Man Recently Before the Court on a Serious Charge.

Information of insanity has been filed against August Telke, and he has been lodged in the county jail awaiting examination.

The case is above the ordinary, as Telke is the man who was tried on an indictment charging him with incest, his young daughter appearing as the principal witness against him. The jury found him not guilty.

Telke on the trial appeared to be a man of a low order of intelligence, and there was some question at the time of his sanity, although the official inquiry was started.

The information in the probate court was filed by Phillip Bardon, of Rice street, with whom he has been living.

August Telke was committed to the asylum this afternoon.

William Telkie was committed to the insane asylum yesterday by Judge Willrich. Telkie believes that he is being persecuted by Deputy Sheriff Picha, whom he says haunts him day and night, and runs a red hot iron down his spinal cord and threatens to kill him. The medical men believe that with proper treatment Telkie will recover from his present condition.

Aug Telkie.
E. E. McDonald.
91 Germania Life Bldg.
St. Paul. Minn.

EXAMINATION ON ADMISSION.

Exd by Dr. Herzog, 21st May 1896. — **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Clear
Quick or Sluggish, Slightly sluggish
MEMORY:
Past Events, good
Recent Events, do
Special Subjects,
PERCEPTIVITY:
Alert or Dull, fairly alert
Correct or Illusive, in the main correct
REASONING POWER:
Ordinary Subjects, fairly good
Own Mental State, fails to realize
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, slightly
DELUSIONS:
Systematized or Not, systematized
Special Subjects, of persecution
Transitory or Not, fixed
HALLUCINATIONS: "of hearing"
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:
a moderate drinker. headaches, fevers, 3 years ago. has been a laborer living in poor sanitary surroundings. was recently tried for incest & acquitted. admits having slept with his 18 yr old daughter & attempted intercourse. now claims that Deputy Sheriff Picha has ruined his daughter & that they are trying to get him out of the way. says he hears Picha and his daughter & others talking about him at night. has heard him twice coming to Germany to Washington re treasure answers. Condition paranoiac. probably aggravated by his domestic troubles. Previous mental grade probably not good.

August Telkie

ON, CONTINUED.

RISTICS.

NUTRITION, somewhat impaired

Promptness Movement, responds prompt
normal: slight Conjunctivitis left eye
mmodation, normal

HEARING, good
COORDINATION, Arms, fair: finger to nose, eyes shut, fair.
Legs, slight impairment: standing on one foot, some difficulty. Standing, eyes shut, sways slightly.
TREMORS, Hands, slight — Tongue, slight
Facial Muscles, No — General, No
REFLEXES, Patellar, 5-6: equal
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. strength-sound good: impulse forcible
LUNGS, Impaired & Harsh. Stiff & Hortaceous.
breath sound good

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, had Typhoid when 14-15 years old
LENGTH OF INVASION, probably long — ONSET GRADUAL OR SUDDEN, probably gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Mother died. Dropsy.
Father or Pat. Relations, Father died of Cholera
Brothers or Sisters, one seems high tempered

Personal and Medical History of August Telkie

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4400.
Residence, St. Paul. Minnesota
Date Admission, 21st May 1896. —
Admitted by Dr Herzog Hour, 6th PM.
How Sent, G. Willrich. Jo P. Ramsey County
Sex, Male
Age, 1 mt
Civil Condition, Widower
Children, —
Age Youngest Child, —
Occupation, Laborer
Degree Education, fair in German & English
Profession Religion, Lutheran
Habits, Not intemperate
Nativity, Germany: (Parents also born there).
Physicians Committing, E.W. Buckley and Justus Otage
Correspondents, none given in papers

No. for Year, 228
Insane Relatives, apparently not
Cause Exciting, Family Troubles
Cause Predisposing, not stated.
Form, Paranoia
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not
Date of this Attack, January 1896.
Duration, about 4 months
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about
Time of Leaving, Feb. 24. 1899
Time in Hospital, 2 yr. 9 mo. 3 d.
Result, Died. Uraemia.

EXAMINATION ON ADMISSION.

Edley D. Herzog, 21st May 1896. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Clear
Quick or Sluggish, Slightly sluggish
MEMORY:
Past Events, good
Recent Events, Do
Special Subjects,
PERCEPTIVITY:
Alert or Dull, fairly alert
Correct or Illusive, in the main correct
REASONING POWER:
Ordinary Subjects, fairly good
Own Mental State, fails to realize
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly
DELUSIONS:
Systematized or Not, Systematized
Special Subjects, of persecution
Transitory or Not, fixed
HALLUCINATIONS: of hearing
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:
a moderate drinker: headaches, fevers 3 years ago: has been a laborer living in poor sanitary surroundings. Was recently tried for incest & acquitted. Admits having slept with his 12 yr old daughter & attempted intercourse. Now claims that Deputy Sheriff Picha has ruined his daughter & that they are trying to get him out of the way. Says he hears Picha and his daughter & others talking about him at night. "He heard them twice coming here". "knows they are in the building". Says he can talk & correspond to Washington & receive answers. Condition paranoia: probably aggravated by his domestic troubles. Previous mental grade probably not good.

August Telkie

ON, CONTINUED.

RISTICS.

NUTRITION, Somewhat impaired

Promptness Movement, responds prompt
normal: slight conjunctivitis left eye

mmodation, normal

Good

INATION, Arms, Fair: fingers tremor, eyes shut, fair.
Legs, Slight impairment: standing on one foot, some difficulty: standing, eyes shut; sway, slightly.
TREMORS, Hands, Slight — Tongue, Slight
Facial Muscles, No — General, No
REFLEXES, Patellar, 5-6: equal — EXAM. URINE,
Other
ARTICULATION, /
Slurred,
Hesitating,
FACIAL EXPRESSION, /
SENSIBILITY, /
HEART, no murmurs. strength-sounds good: impulse forcible. Temper somewhat stiff & hortatorious.
LUNGS, breath sounds good —

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, has Typhoid when 14-15 years old
LENGTH OF INVASION, probably long — ONSET GRADUAL OR SUDDEN, probably gradual
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Mother Died: Dropsy.
Father or Pat. Relations, Father Died of Cholera
Brothers or Sisters, one or two might terrow.

Aug Telkie.
E. E. McDonald.
91 Germania Life Bldg.
St. Paul. Minn.

...on the other,
...that the pair conspired to
...nest and defraud him out
...forth of notes and mort-
...the defendants say that he
...and freely assigned them
...pt his securities and $800 in
...a box in his house, on the
...of Seventh and Grove streets,
...ys that the defendants forged
...ments of the notes and mort-
...to Hochkirch, who had the mort-
...placed on record in Todd county.
...e the bulk of the property was
...ided. This was done while the
...tiff was away visiting in Kan-
...whither he had gone in domestic
...guides on account of his domestic
...sundred times, that he was "living
...ing that report read: "In connection
...I can publish about convincing you I
...stand on my rights here, and in connection
...on tremendously." He was "glad to
...the note was sent to be taken when
...was finest" in

Personal and Medical History of

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 44400.
Residence, St Paul. Minnesota
Date Admission, 21st May 1896. —
Admitted by Dr. Herzog Hour, 6:45 PM.
How Sent, G. Willrich. Jof P. Ramsey County.
Sex, Male.
Age, 1 mf.
Civil Condition, Widower
Children, —
Age Youngest Child, —
Occupation, Laborer
Degree Education, Fair in German & English
Profession Religion, Lutheran
Habits, Not intemperate.
Nativity, Germany: (Parents also born there).
Physicians Committing, E.W. Buckley and Justus Ohage
Correspondents, none given in papers

No. for Year,
Insane Relatives,
Cause Exciting,
Cause Predisposing,
Form, Paranoia
Accompanying Bodily Disorder,
Suicidal or Not,
Date of this Attack,
Duration,
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack,
Time of Leaving, Feb. 24 1899
Time in Hospital, 2 yr. 9 m. 3 d.
Result, Died. - Uraemia.

Ter.

Informatio.
against August
in the county jai.
The case is above
is the man who was tri.
charging him with incest,
ter appearing as the principal
him. The jury found him not g.
Telke on the trial appeared to be
a low order of intelligence, and there was
some question at the time of his sanity, al-
though the official inquiry was started.
The information in the probate court was
filed by Phillip Bardon, of Rice street, with
whom he has been living.
August Telke was committed to the asylum
this afternoon.
William Telkie was committed to the insane asylum yesterday by Judge Willrich. Telkie believes that he is being persecuted by Deputy Sheriff Picha, whom he says haunts him day and night, and runs a red hot iron down his spinal cord and threatens to kill him. The medical men believe that with proper treatment Telkie will recover from his present condition.

EXAMINATION ON ADMISSION.

Ordered D. Herzog, 21st May 1896. — **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, — Clear —
Quick or Sluggish, Slightly sluggish
MEMORY:
Past Events, — good —
Recent Events, — do —
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly alert
Correct or Illusive, In the main Correct.
REASONING POWER:
Ordinary Subjects, Fairly good
Own Mental State, — Fails to realize —
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly
DELUSIONS:
Systematized or Not, Systematized
Special Subjects, of persecution
Transitory or Not, fixed
HALLUCINATIONS: "of hearing"
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:
a moderate drinker. Headaches, fevers, 3 years ago. Has been a laborer living in poor sanitary surroundings. Was recently tried for incest & acquitted. Admits having slept with his 15 yr old daughter & attempts intercourse. Now claims that Deputy Sheriff Picha has ruined his daughter & that they are trying to get him out of the way. Says he hears Picha and his daughter & others talking about him at night. Has heard them twice coming here". "knows they are in the building". Says he can talk to Germany to Washington &c & receive answers. Condition paranoia. Probably aggravated by his domestic troubles. Previous mental grade probably not good.

Personal and Medical History of August Telkie

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7in WEIGHT, not taken (usual Weight 145 lbs) NUTRITION, Somewhat impaired
WOUNDS OR ABNORMALITIES, Skin somewhat greasy
TONGUE, Tremors, Coatings, slight white coat Promptness Movement, responds prompt
PUPILS, Equality, Yes Size, Normal: slight Conjunctivitis left eye
Response Light, Normal Accommodation, normal
SIGHT, Some presbyopia -
HEARING, — Good —
COORDINATION, Arms, Fair: finger to nose, eyes shut, fair.
Legs, Slight impairment: standing on one foot, some difficulty. Standing, eyes shut, sways slightly.
TREMORS, Hands, Slight Tongue, Slight
Facial Muscles, No General, No
REFLEXES, Patellar, 5-6: equal EXAM. URINE,
Other
ARTICULATION,
Slurred, /
Hesitating,
FACIAL EXPRESSION, /
SENSIBILITY, /
HEART, No murmurs. Strength — Sound Good: impulse forcible. Temporal Somewhat stiff & Hortaceous.
LUNGS, Breath Sound — good —
TAKEN,
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, — had Typhoid when 14 - 15 years old —
LENGTH OF INVASION, Probably long ONSET GRADUAL OR SUDDEN, Probably gradual
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Mother died: Dropsy.
Father or Pat. Relations, Father died of Cholera
Brothers or Sisters, one son has night terrors.

Personal and Medical History of *August Telkie.*

This patient was brought here by Deputy Sheriff Emanuel Johnson, with following history. Patient is in fair physical condition. No history of consanguinity: This is 1st attack: first symptoms manifested in January 1896, by hallucinations. Disease seems increasing; is variable: he seems to have constant hallucinations. Derangement now shown by fear of personal punishment and of being killed. Patient is not disposed to injure others, nor suicidal, nor of filthy or destructive habits. Apparently, no insane relatives. No peculiarities had been previously shown. There is no history of intemperance in parents or self, nor of any severe disease or head-injury. He has not been restrained or confined. Supposed cause of the disease is "family troubles." He had no "treatment." Nothing of special interest.

May 21 On admission, was put on B[3] (G.H.N. Kpt. Complexion dark: hair brown: eyes blue: condition of skin good: vaccination marks on both arms: scars on back of head: no Eruptions &c noticed: is sixty. Behavior good). May 22/96. Slept 8 hours, last night. Behavior good: is quiet & orderly: will not talk much: seems quite rational. Says "he is not crazy & cannot be kept here long". May 23/96. Slept only 3 hours, last night. Behavior good. Habits neat & clean. Makes no complaints. Says "he has friends in St. Paul, who will effect his release". May 24/96. Slept 6 hours; Talks rationally on every subject except that of his commitment here, which, he says, "was a mistake" as he was only doing what was right". May 25/96. Slept only 3 hours. Appetite good: bowels in good condition: Goes out on ground, daily: makes no complaints. May 26/96. Slept only 3 hours. Behavior delusions, but is quite guarded in talking of them. Says "he holds conversations with his friends in Lake City & elsewhere". May 27/96. Slept only 4 hours, last night. Behavior good. Says "he can see and talk to people who are miles away from him". Converses quite rationally, on other topics. May 28/96. Slept 8 hours. No change noted, from day to day. Says "his friends are going to release him, very soon". May 31/96. No change noticeable, from day to day: Appetite good: bowels regular: Makes no complaints.

June 1 June 1/96. Since last note, patient's condition has shown no special change. He sleeps only from 4 to 6 hours, nightly. Makes no complaints. Goes out on ground, daily. Physical condition is good.

Summary: Behavior has been good, during last 6 weeks. He is quiet, though not cheerful & contented. Physical condition good: skin good: Muscles large & well formed, but he is not in very good flesh. Patient has delusions & illusions: Says "he can see & talk to his friends, when they are long distances away from him."

May 1/97 Summary Nurses Notes by Dr Phelps. Patient during past year was continually rather irritable in manner & somewhat active & restless but not violent nor especially troublesome. So free of vague complaints. Talk incoherent.

May 31/97 Wt. 140[lbs] July 30/97 Has changed almost none of late: Has various delusions Talks quite freely. Says he owns building and grounds & talks in a very officious way: Is rather irritable in conduct. Jan 31/99 Patient practically the same in every way. Feb 1.99. Wt. 141. Is quiet & well behaved: Imagines he owns the institution. Feb 12. Complained of headache & general malaise. & after breakfast returned to bed. Had convulsion at 7:45 A.M. Feb 15. Trans. to Infirmary Has been coughing considerably & raises streaks of blood. Found in sputum. Pain in left side about 5th rib in axillary region. Bronchial resonance impaired breathing. Heart sounds rough: put in cotton jacket & put on treatment. 19th Appeared in much pain: expectorated a great deal. Feb 20 Constipated - also necessary to catheterize him. Turpentine stupes placed on abdomen. 22nd Is Very much depressed. Is gradually failing. Died Feb 22 at 12 o'clock

Condition of body. Skin slightly discolored - small bed sore on left hip - at base of spine. Teeth in poor condition.

Died.

Personal and Medical History of

Personal and Medical History of John Roseth

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4440 1.
Residence, Lanesboro, Minn.
Date Admission, 22nd May 1896.
Admitted by D. Luitow-Phelps Hour, 2.30 PM
How Sent, E.V. Farrington, Jo P. Fillmore Co.
Sex, Male.
Age, 47.
Civil Condition, married
Children, 12.
Age Youngest Child, —
Occupation, Farmer
Degree Education, Common School.
Profession Religion, Yes: Lutheran
Habits, Not Intemperate
Nativity, Norway: (Parents also born there)
Physicians Committing, Jno. A. Love and Henry Jones
Correspondents, None given in papers

No. for Year, 229.
Insane Relatives, none
Cause Exciting, Financial worry
Cause Predisposing, Not given
Form, Melancholia acute stuporous
Accompanying Bodily Disorder, Weakness &c
Suicidal or Not, Not.
Date of this Attack, Last January
Duration, about 5 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 46+
Time of Leaving, July 9th 1897
Time in Hospital, 1 yr. 1 mo. 7 da.
Result, Died Exh. in Chronic Melancholia.

EXAMINATION ON ADMISSION.

Ex'd by D. Herzog May 23/96.

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Much depressed
DELUSIONS:
Systematized or Not,
Special Subjects, Seems to have delusions of poisoning
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:
Refuses entirely to speak: Little is known about the patient: his son could not give a good account: said he had been depressed since January last, on account of business matters: & gradually grew worse: he probably is of fair mental capacity.

Personal and Medical History of John Roseth

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 11in WEIGHT, 132 lbs NUTRITION, Considerably impaired.
WOUNDS OR ABNORMALITIES, — See U.S.A.N. Report. — Skin, dry & scurfy.
TONGUE, Tremors, Yes Coatings, dry, red; lip, dry Promptness Movement, refuses to protrude
PUPILS, Equality, Equal Size, Slightly Contracted
Response Light, Sluggish Accommodation, Sluggish
SIGHT, ✓
HEARING, ✓
COORDINATION, Arms, much impaired: } usual tests not made: can scarcely
Legs, Do. : } stand alone.
TREMORS, Hands, Slight Tongue, Yes
Facial Muscles, No General, No
REFLEXES, Patellar, 9 = Equal EXAM. URINE,
Other no abnormal reflex.
ARTICULATION,
Slurred,
Hesitating, ✓
FACIAL EXPRESSION, ✓
SENSIBILITY, ✓
HEART, Slight soft murmur 1st pulmonic sound: Sounds (strength) fairly Pos. - Size about normal: apex-beat 5th intercostal space nipple line
LUNGS, somewhat at bottom temporarily respirations shallow breath-sound seem good
TAKEN,
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, Yes Irregular, For three days previous
APPETITE, Good, Kept record Medium, Poor, to admission, did not eat
SLEEP, Good, Poor, Irregular, drink nor sleep.
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Probably short ONSET GRADUAL OR SUDDEN, Probably Gradual
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Unknown. — Son, accompanying
Father or Pat. Relations, him, was not bright.
Brothers or Sisters,

Personal and Medical History of John Roseth.

1896

This patient was brought here by Sheriff's Deputy S.E. Farrington attended by Olof Roseth (patients Son). Patient is in fair physical condition. The following history comes with him. There is no history of consanguinity or heredity. This is 1st attack: first symptoms manifested last January, by melancholy, sleeplessness & neglect of business. Disease seems increasing: variable & with rational intervals, but these not at regular intervals. — Derangement now shown in that he has delusions that someone is trying to injure him & he refuses to talk, sleep, eat or drink: tries to run away & secrete himself. 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, nor of any severe disease or head-injury. He has not been restrained or confined. Cause of the disease is financial worry: has had nothing in the way of treatment. On personal examination, patient is anaemic, debilitated, also emaciated & has not slept, eaten or drank anything, for 3 days.

May 22 On admission, was put on T.W. (S.H.R. Rft. Complexion light: hair dark-brown: eyes blue: Condition poor: good. Vaccination marks on right arm: scars on little finger, left hand: also on knees. no eruptions observed: Dentity: has a mole on chest: also, on back. behavior good; he is emaciated & weak). Is very quiet. Given bath & put to bed. Is on regular & extra diet; will not eat voluntarily.

" 23 May 23/96 Slept only 4 hours, last night. Was fed by nurse today: bowels moved: is still very quiet: spoke a few words, this morning: can not talk English. May 24/96. Slept only 2 hours, last night. Was fed also today. Given Thompson's water: bowels moved. Has been very quiet, but somewhat restless, during day. Given Enema: also

" 25 is given water, between meals. May 25/96. Slept only 3 hours, last night. Was also fed, today. Bowels move.

" 26 no change in behavior: no improvement noticed, in condition. May 26/96 Slept nine, last night. Still

" 27 quiet: will not talk: ate meals voluntarily. May 27/96. Slept 4 hours. Behavior unchanged. 10:30 am. a salt solution injected in left buttock. Ate a fair breakfast; a good dinner also a good supper.

" 28 May 28/96. Slept 8 hours. Is very quiet, today. Will not talk. Was given Enema: bowels then moved.

" 31 May 31/96. Condition & behavior do not seem to change. He sleeps 8 to 6 hours, nightly. Appetite good. Bowels irregular. Habits clean. June 1/96. Appears some brighter, but will not talk. June 2/96. Very restless, all day: out of bed frequently: appeared confused. June 3/96. Slept only 3 hours, last night.

June 1 " 3 " 4 was very quiet, during the day. Still refuses to talk. (Wt 135 3/4 pds). June 4/96. No noticeable Change.

" 5 June 5/96. No change in behavior. Seems to realize all that happens, yet he will not talk.

Summary: When received, patient was very quiet, would not talk - but did not appear stupid. Was given bath & put to bed. Behavior unchanged, on following day. Would not eat voluntarily until May 26th & ate well, from that date. Remained very quiet, through entire 2 weeks. Very restless & apparently confused on June 2nd: with this exception, seemed to realize all that happened. Has had no cough and made no complaints. Bowels have been costive, throughout. Slept (average) about 12 hours, nightly. Temperature has been a trifle above normal, from the 1st Day. June 12 Trans to B3 E,

" 18 Appetite poor: Bowels irregular: Physical condition poor: Is in poor flesh: Does not talk - remains quietly in one place, while on ward: Goes out on grounds daily. July 6 Wt. 150 lbs. July 14 Very quiet all the time: Answers questions only in monosyllables. Appetite poor: Bowels not regular: Sleeps well. Aug 1 Very quiet: Sits on bench all day: Cannot be induced to talk. Aug 4 Wt. 151/2 lbs. Sept 1 Patient very quiet: Talks none: Bowels irregular:

Personal and Medical History of John Roseth.

Is given electrical treatment 3 times a week (abdominal galvanism) Oct 1 No change: Shower baths & electrical treatment continued: Appetite fair: bowels regular:

Nov 1 Patient very stupid: Habits slouchy: Needs constant attention: Physical condition good: Wt. 164 lbs. Dec 1 No change. Wt. 171 lbs. Jan 1/97 Remains the Same. Feb 1 Still very stupid: Is slouchy in dress & habits. Does no work but sits quietly in one place all day, talking to no one. Receives massage & electrical treatments 3 times a week. Wt. 170 1/2 lbs. Feb 20 Has lost two pounds in weight since beginning treatment. March 1 No improvement in patient, either mentally or physically. Wt. 166 lbs - Massage discontinued. April 1 No change mentally or physically. Wt. 161 1/2 lbs. May 1 Still stupid & talks none: Is very slouchy in habits & dress: Appetite good: bowels regular: Wt. 156 lbs. May 22 Appetite seems failing. Has to be told to go to meals. June 1 Wt. 151 lbs Appetite still failing.

June 10 Has not eaten for 3 days. Trans to Infirmary & put to bed: Skin greasy. Eats well: Lies quietly in bed. June 12 Physical condition fair: bowels costive. Pulse good.

" 14 Up & out on lawn this PM. June 23 Has been up part of each day since last note: Moves about very slowly: Given massage: Appetite failing: Bowels very constipated.

" 27 Patient continues to grow weaker: Is very stupid: Habits filthy - Vomited at 6:45 & 7:15 PM. June 28 Refuses to Eat: Still growing weaker. June 29 Patient seems in distress vomited: In bed today. July 1 Wt. 132 lbs Lies quietly in bed: Does not talk: Is quite weak & can retain nothing on stomach. July 2 Asks to take nourishment today

July 3 No change, except is growing weaker. July 4 Is restless today - Tongue coated, mouth filthy, washed out with listerine: Given Peptonized milk every two hours:

" 5 Very weak this am. Shows some pain & difficulty in swallowing. Temp. 99°-102°. P. 98. 130 R-17-20. Alcohol sponge bath given every two hours -

" 6 Temp. 101-101,4. Eats well: Cold Sponge baths given every three hours: Seems to have pain in abdomen. Bowels loose. July 7 No change. July 8 Temp. 102°-102.8 Refused meals: Coughs, with difficulty. Given 1/40 gr. strych hypo. every 4 hrs - also milk & peptonized milk. July 9 Same treatment continued - Patient grew rapidly weaker & died at 8. AM.

Died.

Personal and Medical History of Eugene Irish

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4403.

Residence, Mantorville, Minn.

Date Admission, 23rd May 1896.

Admitted by Dr C. B. Eby. Hour, 7.35 PM

How Sent, Swift Olsh. Jeff. Dodge County

Sex, — Male —

Age, — 52 —

Civil Condition, Married

Children, — one —

Age Youngest Child,

Occupation, Farmer

Degree Education, Common School.

Profession Religion, Yes: Cong: —

Habits, not intemperate

Nativity, Michigan: (fathers, New York: Mothers, Vermont)

Physicians Committing, J. H. Vanfleet and J. Bedient

Correspondents, none given on papers

No. for Year, 231.

Insane Relatives, Mother.

Cause Exciting, overwork

Cause Predisposing, heredity.

Form, Melancholia acute agitated.

Accompanying Bodily Disorder, body covered with small pimples

Suicidal or Not, — Not —

Date of this Attack, In January

Duration, about 4 months —

No. of Attack, 1st.

No. of Admissions, 1st.

Age First Attack, about 52 —

Time of Leaving, Sept. 11: 1896.

Time in Hospital, 3 mo. 19 da.

Result, Discharged Feb. 3 '97 Unimproved.

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 Eugene Irish

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7in WEIGHT, 126 lbs 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, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

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 Eugene Irish

1896

This patient was brought here by Deputy-Sheriff Joel Tucker, attended by S.W. Irish, with following history. Patient is in fair physical condition. No history of Consanguinity: but there is, of heredity; his mother was insane. This is first attack: first symptoms manifested in January: began to be melancholy. Disease seems increasing: variable with rational intervals. Bowel derangement is now shown, is not stated. Patient is disposed to injure others, but is not suicidal, nor of filthy or destructive habits. No peculiarities had been previously shown. There is no history of intemperance in parents or self; no of any severe disease or head injury. He has not been restrained or confined. Supposed cause of the disease is overwork.

May 23 On admission, was put on T.W. (G.H.N.R.Ref. Complexion dark: hair black: eyes blue: Condition of skin fair: no small scar on inside of right thigh; and one, a more recent scar, but body covered with small pimples. Behavior good. When received upstairs was quiet: seemed frightened: was given bath & put to bed: 8^00 PM. T 100^4. P. 104. R 24. May 24/96 Moaned considerably during night: slept only 1 hour: Is on regular extra diet. Complains of headache. 8^00 AM. P 98 R 24 T 102^4. Given hunyadi water. ate a light breakfast & dinner: refused supper. Talks irrationally: "seems to think that he was brought here to be killed". Appeared very uneasy: 4 PM. P 112 R 28 T 102^6. 4^30 PM. Became restless & noisy: was held in bed until 5^00 PM. Put in restraint sheet. May 25/96. Very noisy, greater part of night: Slept none. 5^00 AM. Taken out of restraint sheet: Urinated about ½ pint: apparently clear blood: bowels moved: Could not take temperature &c. Refused all nourishment. Talks quietly & quite rationally: seems to realize all that happens: says "he remembers everything": Quiet all day: Says "he has no appetite for anything". May 26/96. Slept 6 hours last night. 8 AM. T 99.4 P 80. R 28. Very quiet, all day. 11^00 AM. Sponge-bath (tepid). Talks rationally. Slept 2 hours this PM: has eaten well, to day.

" 27 May 27/96. Slept only 3 hours, last night. AM. P 90. R 24 T 99.2. Refused breakfast. Is very uneasy, to day. Moaned continuously from 2^00 AM till night. "Imagines he is going to be killed". Took light dinner but refused supper. 5 PM. T 99.6. May 28/96. Noisy, most of the night; sleptsome. AM. T 100. Behavior has not changed much, to day. Still moaning: (10^30 AM). Sponge bath. Ate light breakfast & dinner; refused supper. May 29/96. Slept only 2 hours, last night. AM. T 99.5. Given hunyadi water: bowels moved: ate a light breakfast, but refused dinner & supper. 5 PM. T 100.4 No change in behavior: appears weaker.

" 30 Visited by brother. May 30/96. Slept only 4 hours, last night. AM. T 99.8. PM. T 100.8. Refused breakfast & dinner ate a light supper. Has been moaning continuously during day: not as noisy as usual. Urinates.

" 31 May 31/96. Slept only 3 hours: Still very uneasy & somewhat noisy: 10^45 Wet Pack: perspired some. Refused breakfast. 1 PM. 1 quart eggnog: 5^30 PM. 1 quart eggnog. Is on straight liquid diet.

June 1 June 1/96. Slept only 4 hours. Behavior does not change. Temp: ranges high: drinks freely of eggnogs:

" 2 still moaning & imagines something terrible is about to happen to him. June 2/96. Noisy, all night. Slept none. 10^30 AM. Enema: bowels then moved: 11^15 AM: wet pack: perspired some: Noisy, all day,

" 3 & carrying on as usual. June 3/96. Slept 8 hours, last night. Behavior unchanged. 11^00 AM. Wet pack. Was perspired quite freely: was extremely noisy for 1 hour in afternoon. Is on a diet of eggnog, Mellin's food & soups. June 4/96. Noisy, most of night & slept only 3 hours. No improvement noticed: Still

" 4 noisy & apparently frightened. Says "there are people preparing to kill him". Wet, to day, 110½ lbs.

" 5 June 5/96: Slept only 1 hour last night: Has been some easier, to day, but still has delusions.

" 6 June 6/96. Somewhat noisy, during night: Slept only 1 hour: has been restless & noisy, all day.

1896

June 6 1^30 PM. Given enema: bowels moved. Face & hands bathed several times, during day: Forehead bathed in camphor. Is still given diet of milk, eggnogs & Mellin's food. Summary: As stated, patient, on coming onward, appeared frightened: was put to bed: subsequently, became wild & noisy, & was put in restraint sheet, for a time. At times, he was quiet & again very restless & uneasy. Held to the delusion that he was going to be killed. Moaned almost continuously up to last day. Has taken all medicine offered. Talked quite rationally, during 2^nd & 3^rd days; said "he remembered all that had happened". Still believed he was going to be killed: said "he could hear them sharpening knives" - and he still holds to the same belief. He has complained continually of severe headache. He eats considerable nourishment, but does not seem to relish it. Bowels have been in poor condition. Slept poorly. Temperature has been high, throughout. June 9/96. Restless & noisy, each day: noisy also, by night & sleeps very poorly: talks very irrationally & possesses delusions. "Thinks he is going to be killed". Is continually moaning & crying for help. June 13/96. no change noticed in any respect: was calling for his brother". Is apparently becoming somewhat emaciated: out in chair, a short while, this afternoon.

" 16 Still sleeps very poorly, and, on some nights, none at all. June 16/96. Some quieter, to day, but began

" 18 his moaning, towards night: "Wants to see his wife, before he dies". June 18/96 Moaning, groaning & crying, all day. June 20/96. No change in behavior or conduct. "Wants to see his wife & son."

" 27 June 27/96. Can see no special change: Still shows many delusions: "he does not seem to improve any": "Wants to go home & see his family": very restless. Sup & out, some days, in chair.

" 30 Eats lightly. June 30/96. No change specially noticeable.

July 9 Moans & cries most all the time & wants to go home: Has all kinds of delusions

" 15 No change. Bowels irregular. Eats & sleeps well. Is up & out in chair daily

" 21 Visited by friends. July 22 Visited by son - no change mentally or physically.

Aug 1 Is very despondent: Thinks he cannot live long. Is noisy at times: Cries a good deal: Sept 1 No change since last note. Appetite usually good, tho has to be fed by nurse occasionally: Cries & sobs a good deal: Noisy at times. Sept 2 Appetite fair: Sleeps quite well. Is very weak & feels cold most of the time: Sept. 6 Is growing quieter: Moved to a warmer room.

Sept 9 Visited by wife & son: No change in condition: Sept 11 Taken home on trial by wife & son. Summary by Dr Phelps. Father & mother both died insane. A poor prognosis was given to wife but she insisted on the trial: He is usually very quiet & melancholy - not exactly stuporous but tending in that way.

Discharged.

Personal and Medical History of Peter Peterson #2

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 14407.
Residence, Grove City, Minn.
Date Admission, 28th May 1896
Admitted by Dr. C. B. Eby Hour, 6th P.M.
How Sent, G. Wilbrick, Jo. P. Ramsey County
Sex, Male
Age, 43
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Farm Laborer
Degree Education, a little. Common school.
Profession Religion, "has been Salvationist"
Habits, not intemperate
Nativity, Norway: (Parents also born there).
Physicians Committing, J. Ohage and Olof Schlberg.
Correspondents, none given in papers
Andrew Peterson (bro.) Long Lake, Minn.

No. for Year, 235.
Insane Relatives, not known
Cause Exciting, Religious excitement.
Cause Predisposing, not stated
Form, Mania acute
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, not
Date of this Attack, a Day or two ago
Duration, a day or two
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 43
Time of Leaving, June 29 1897
Time in Hospital, 1 yr. 1 mo. 1 d.
Result, Transferred to Fergus Falls.

Ok. pm

EXAMINATION ON ADMISSION.

Exam. by P. M. Pulkes M.D. 9/23/96

MENTAL CHARACTERISTICS.

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

MEMORY:
Past Events,
Recent Events, } Good now.
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Fairly alert
Correct or Illusive, Correct on ordinary subjects

REASONING POWER:
Ordinary Subjects,
Own Mental State, } Slightly poor
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient now suffers simple depression - No delusions noted but likes to read Bible & talk on religion. Brother don't like that so he don't want to go to brother - Admits preaching, taking & being noisy on streets & that was crazy, then - Seven years ago was sick

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓ slightly.

DELUSIONS:
Systematized or Not, None definite.
Special Subjects, Religious ideas.
Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Salvation army 3 years - in old Country.

Personal and Medical History of Peter Peterson #2

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 11½ WEIGHT, 153 ½ lbs. NUTRITION, Good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, None. Coatings, Normal. Promptness Movement, prompt
PUPILS, Equality, Equal. Size,
Response Light, Accommodation,
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, " General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Was insane in old Country 6 years ago but says he was not.
LENGTH OF INVASION, 7 years. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies insanity in family.
Mother or Mat. Relations, Died Consumption. Mothers sister insane.
Father or Pat. Relations, Died lung trouble.
Brothers or Sisters, 3 sisters.

Personal and Medical History of Peter Peterson #2

1896

This patient was brought here by Deputy-Sheriff H.W. Chapel, with following history. Patient is in fair condition. No history of consanguinity: as to heredity, not known. This is 1st attack: symptoms manifested a day or two ago: found in the streets dancing & singing in a maniacal way. Whether disease is increasing, decreasing or stationary, don't know: if variable at rational intervals don't know. Derangement now shown on religion. Thinks he's sent by God to convert everybody &c. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. Patient was a Salvationist, in Norway. No history of intemperance in parents or self: nor of any severe disease or head-injury. He has not been restrained or confined. Supposed cause of the disease is religious excitement. Patient wandered away from home in order to convert the world. Thinks he is persecuted by enemies of God.

May 28 On admission, was put on B3 (G.S.N. P.P.H. Complexion dark: hair light: eyes blue: condition of skin good; second finger off of left hand. Is dirty: behavior good). May 29/96. Slept only 1 hour: very restless, all night. Ate very little, today: was quite noisy: singing & praying: behavior restless: at
" 30 6:30 P.M. Transferred to B1. May 30/96. Slept only 2 hours, last night. Refused breakfast: ate fair dinner, but refused supper. Bowels regular: was restless & noisy most all day. In the evening was extra noisy: hallooing & singing. Has delusions: "thinks the food is poisoned". 7 P.M. Given hot bath 105°, with cold application.
" 31 May 31/96. Slept 6 hours. Appetite good: bowels regular: is much quieter, today. Was out, with the crowd. Behavior good. Does not speak English. June 1/96. Was restless 6 hours & slept only 2 hours, last night.
June 1 Is much quieter, this morning. While out with crowd, attempted to run away: refused to talk: Again given a
" 2 hot bath (105°). Wt 151 lbs. June 2/96. Was restless all night & slept none. Behavior very changeable:
" 3 by spells, Quite noisy & restless: praying & singing. 7:30 P.M. Given hot bath as before. June 3/96. Slept only 3 hours, last night. Apparently the same. Still restless & noisy, by spells: has delusions in religion.
" 4 Refuses to have Temp. taken. Force had to be used. June 4/96. Slept 6 hours. Is restless & noisy: usually
" 5 worst, in afternoon. Refused to sleep in room: "afraid roof fall on him". Slept on hall. June 5/96. Restless 4 hours: praying & talking to self: Slept 4 hours. Noisy & restless: praying & preaching: Says servants
" 6 to go home: Talks incoherently. Habits clean. June 6/96. Slept only 4 hours. Behavior, apparently little better.
" 7 Talking less: quieter when out: also same on hall. Urinates regularly: bowels regular. June 7/96. Slept 5 hours.
" 8 Was good, all day, being quiet & well behaved. Eats well. June 8/96. Slept 7 hours. Apparently, some better, mentally: has a better expression. Is quiet & will do what he's told. Reads newspapers, a little. —
" 9/10 June 9/96. Slept 4 hours. Appetite good: bowels regular. otherwise, no change noticed. June 10/96. Slept 6 hours. Behavior much better, of late, in actions & speech. Talks quite rationally with anyone, who speaks his
" 11 language. Is now sleeping in room. June 11/96. Slept 8 hours. Condition, apparently, the same. Is quiet and
" 12 obedient. Still has delusions as to religion. Habits neat & clean. June 11/96. Slept 8 hours, last night. -

Summary: Appetite has been fairly good, most of the time: the first few days onward, refused meals occasionally, saying "that the food was poisoned". From June 1st to 10th, ate very heartily. Bowels regular. Behavior changeable. During 1st week, was extremely noisy & restless, by spells: singing & praying; of late, has been good. Was very restless at night, & the first week, slept but little. Has given Combination baths & hypo. occasionally. (average sleep, during the 14 days, 4 hours & a fraction). Has delusions as to religion; does not speak English, but can understand fairly well.

27 Appetite good. Bowels regular. Behavior very good of late. Talks & acts quite rationally.

Personal and Medical History of Peter Peterson #2

Habits neat & clean. Works in dining room & will do willingly what is asked of him.
July Wt. 171 lbs. P. 72. Has gained over 20 lbs. in last month - no change in mental condition:
Aug 1 Wt. 166 lbs. P. 74. Aug 28. Talks & acts rationally. Has no delusions. Is a good worker.
Sept Wt. 174 lbs. P. 62. Stays in room a good deal of late reading Bible. Nov. 26 No change
whatever in behavior or mental state during past two months. Physical condition good.
Jan Wt 169 lbs. Jan 7 Went to work in laundry. Jan 12 Worked in laundry about 2½ days
then became restless on ward: Yesterday refused dinner & tea: Has delusions
of poisoning etc. Jan 13 Slept 1 hr. last night. Moved bed into hall - refused to
sleep in room. Refused breakfast & dinner - ate slice of bread for tea. Jan 14 No Change.
20 No improvement mentally - Has lost in weight since this attack came on.
Has scar on hip as if burned on heater. Has to be watched closely to keep
clothing on. Jan 26 Patient much better today - Appetite somewhat better:
went walking with crowd. Jan 31 Appetite good: Bowels regular. Is much better
of late. Works in dining room again. Feb 10 Is much better: Still in dining room.
Mch 1 Wt. 175½ lbs. P 80. Mch 8 Refused dinner. Appears as if going into spell. Mch 9 Very
restless: walking floor & gesticulating. Put in Bag Mch 25 Behaves fairly well again
& working in dining room. Trans to B2. Apr 1 Wt. 182½ lbs. Apr 10 Talks
freely & rationally: Works every day on ward. Apr 24 Had spell during afternoon
Talked to himself & destroyed bedding. Apr 25 Seems to be growing worse: Trans to B1.
27 Still in spell. Restless when out & requires constant watching.
May 11 Talks quite rationally at present. Says he would like to work outside in open
air. May 12 Trans to B2. May 14 Is working on farm. Trans. to C2. May 25 Refused to
go to work: Talks to himself. Eloped at 5 P.M. while outside. May 29 Patient re-
turned to B1. Feet sore, caused by walking so much. Appetite good. Bowels
regular. Habits clean. June 29 Behavior has been quite good of late: Habits neat &
clean. Bowels regular. Transferred today to Fergus Falls Hospital.

Personal and Medical History of August Schultz

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4411.

Residence, Stokay. Minnesota

Date Admission, 5th June 1896.

Admitted by D. Phelps Hour, 4 00 PM

How Sent, Thos Ryan. Jof P. Houston County

Sex, - Male -

Age, - 37

Civil Condition, married

Children, five (5).

Age Youngest Child,

Occupation, Laborer

Degree Education, None: cannot read.

Profession Religion, Yes: Catholic

Habits, not intemperate

Nativity, Germany: (parents also born there) -

Physicians Committing, W. W. Freeman and E. B. Johnston

Correspondents, none given in Papers

T. N. Blewett & J. J. Stohl of County of Houston, Minn. appointed Guardians by P. Court. Two petitions as to insanity given, signed by the Physicians

No. for Year, 239.

Insane Relatives, none

Cause Exciting, Typhoid fever

Cause Predisposing, - previous attack -

Form, Paranoia

Accompanying Bodily Disorder, Nervousness &c.

Suicidal or Not, Yes. by shooting: propensity active

Date of this Attack, 8 months ago

Duration, - 8 months -

No. of Attack, Not 1st -

No. of Admissions, 1st

Age First Attack, 36 +

Time of Leaving, June 23 - 1901.

Time in Hospital, 5 yrs 18 ds

Result, Died: Phthisis pulmonalis

St. Hosp & Kalendar Return & Minn. family Phys.

Ed by Dr Herzog 6/6/96.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Slight impairment

Recent Events, - do -

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Quite slow

Own Mental State, realizes something is wrong

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Had Typhoid. July '95. Patient has probably been of low mentality: Heart's attacks, at which times he is much confused: these pass off in a few moments: Had an attack during Examination: veins of forehead became very full & curtain simulates "petit-mal". When at his best, was slightly demented.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Somewhat depressed

DELUSIONS:

Systematized or Not, Unregulated

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, somewhat reticent

action is not good: Says he is subject to vertiginous

Notice of hearing petition for appointment of Margaret Schultz as guardian for August Schultz (insane). Served upon A. J. Kilbourn, Supt. Sept - - 1898.

Wm.

Paper placed on file under No. 4411.

August Schultz

ION, CONTINUED.

ERISTICS.

Wt 175 NUTRITION, Considerably impaired: slight anaemia

condition of skin: Skin somewhat greasy

Promptness Movement, Responds promptly

Slightly Contracted -

Accommodation, Normal

SIGHT, Seems good

HEARING, Good

COORDINATION, Arms,

Legs,

TREMORS, Hands, Slight

Facial Muscles, No

Tongue, Some

General, No

REFLEXES, Patellar, R - L. Equal: Sluggish

Other

ARTICULATION,

Slurred,

Hesitating, Yes

FACIAL EXPRESSION,

SENSIBILITY,

EXAM. URINE,

TAKEN,

HEART, Systolic aortic murmur soft & blowing: Strength Sounds somewhat weak: Pulse normal: Apex beat feeble 5th interspace 1/2 inch to right of nipple: Slightly irregular: apex impulse somewhat tortuous: not stiff: pulse full-

LUNGS, Respiration normal: 7 breath sounds good -

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, rather Poor,

SLEEP, Good, Poor, Irregular, as a rule, has been broken

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

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

HERBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4411.

Residence, Stokah. Minnesota

Date Admission, 5th June 1896.

Admitted by D. Phelps Hour, 4.00 PM

How Sent, Thos Ryan. Jof P. Houston County

Sex, - Male -

Age, - 37 -

Civil Condition, married

Children, five (5).

Age Youngest Child,

Occupation, Laborer

Degree Education, None: cannot read.

Profession Religion, Yes. Catholic.

Habits, not intemperate.

Nativity, Germany: (parents also born there) -

Physicians Committing, W. W. Freeman and E. B. Johnston

Correspondents, None given in Papers

G. N. Blexrud & J. Stohl of County of Houston, Minn. appointed Guardians by P. Court this present day of Inquiry first Examined by the Physicians

Ex'd by Dr. Herzog 6/6/96.

Cause Prec...

Form, Paran...

Accompanying Bodily Disorder, Nervousness ...

Suicidal or Not, Yes. by shooting: propensity active

Date of this Attack, 8 months ago

Duration, - 8 months -

No. of Attack, Not 1st -

No. of Admissions, 1st

Age First Attack, 36 +

Time of Leaving, June 23 - 1901.

Time in Hospital, 5 yrs 18 ds

Result, Died: Phthisis pulmonalis

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Slight impairment

Recent Events, - do -

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Quite slow

Own Mental State, realizes something is wrong

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Somewhat depressed

DELUSIONS:

Systematized or Not,

Special Subjects, Unelicited

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, somewhat reticent

GENERAL DESCRIPTIVE REMARKS: Had Typhoid Fever. Patient has probably been of low mentality: heart's action is not good. Says he is subject to vertiginous attacks, at which times he is much confused: these pass off in a few moments. Had an attack during Examination: veins of forehead became very full & cyanotic. Simulates "petit-mal". When at his best, was slightly demented.

Personal and Medical History of August Schultz

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 9in WEIGHT, 161 lbs (usual Wt 175) NUTRITION, Considerably impaired; slight anaemia

WOUNDS OR ABNORMALITIES, condition of skin: Skin somewhat greasy

TONGUE, Tremors, Coatings, White coating in centre broad Promptness Movement, Responds promptly

PUPILS, Equality, Equal Size, Slightly contracted -

Response Light, Normal Accommodation, Normal

SIGHT, Seems good

HEARING, Good

COORDINATION, Arms, ✓

Legs, ✓

TREMORS, Hands, Slight Tongue, None

Facial Muscles, No General, No

REFLEXES, Patellar, R. & L. equal: sluggish EXAM. URINE,

Other ✓

ARTICULATION,

Slurred,

Hesitating, Yes

FACIAL EXPRESSION,

SENSIBILITY, ✓

HEART, systolic aortic murmur soft & blowing. Strength sounds somewhat weak: size normal. Apex beat feeble 5th interspace 1/2 in. to right of nipple. Slight irregular apex pulsation. Pulse 96 Temperature normal Tortuous: no stiff: pulse full-

LUNGS, Breath sounds good -

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium, rather	Poor,
SLEEP, Good,	Poor,	Irregular, as a rule, has been broken
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

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 *August Schultz*.

This patient was brought here by Sheriff's Deputy George Blessed attended by J.J. Hole, with following history. Patient is in fair physical condition. There is no history of Consanguinity or heredity. This is not 1st attack: it began 8 months ago & growing worse since; Symptoms Manifested by incoherent Constant talking & crying. Disease appears to be increasing: there are rational intervals, which occur regularly. Derangement now shown on the subject of religion & he is very hostile towards his wife. He has not shown any disposition to injure others: sometimes pushing his wife around. He has attempted Suicide, by shooting & propensity now active. He also of filthy and destructive habits. No peculiarities had been previously shown. There is no history of intemperance in self or parents. He had Typhoid fever a year ago, last January. Restraint & confinement has not been employed, but he kept himself close home. Supposed cause of the disease is Typhoid Fever. He has had no treatment. There is nothing unusual in the appearance of the patient. He said but little of indifferent matter, (on personal examination); seemed restless & excitable: appearance & manner were excitable, nervous & restless: moving around the house constantly & fighting his wife. The patient is Committed here because he is a dangerous person to be at large, from his behavia towards his wife or some members of his family or others. —

June 5 On admission, was put on B3 (G.A.N. R&P. Complexion dark: hair black: eyebrows: Condition of skin good: scars on back, about 2 ft sq. Caused by burn: is clean: behavia good). June 6/96. Slept 6 hours, last night. Behavia good. Patient is quite restless, watching for a chance to escape: is under close surveillance while on on grounds. June 7/96. Slept 7 hours, last night. Tried to escape, today. Was caught by nurses Dorr & Schmatz. Says he has frequent "spells" when his mind is blurred & he cannot realize his surroundings". Is on medicine, 3 times, daily. June 8/96. Slept 6 hours. Is restless & uneasy. Says "he must go home". Talks foolishly. Says "he was insane, but is all right now & feel first rate". June 9/96. Slept 6 hours. Still restless. Tries doors & screens, in hall, frequently. Appetite good. bowels in good condition. Physical condition good. June 10/96. Slept 7 hours. Goes out on ground, daily. Is continually watching for a chance to escape. June 11/96 Slept 6 hours. Tried to pick a screen-lock, with a safety pin, which was taken from him. June 12/96. Slept 8 hours, last night. Behavia restless & uneasy. Says "he will go home, today": "that he does not have the "spells" mentioned above. and "that he is all right now". June 13/96. Slept 7 hours: tried to escape, today: was caught & returned. Still restless & uneasy & apparently thinks of nothing but to escape. June 14/96 Slept 8 hours. No change in behavior. June 15/96. Slept 6 hours: refused medicine, today. June 16/96. Slept 8 hours. Is quite stubborn: will do nothing that is asked of him. June 17/96. Slept 8 hours. No change in behavior. Talks very little & scarcely above a whisper. June 18/96. Slept 7 hours. Appetite fair: bowels in good Condition. Goes out on grounds, daily. Tried to escape, by crawling through the oat field, today, but was seen & brought back. June 19/96. Slept 7 hours. While out walking, escaped from guard, but was caught by a farm employé & returned. Summary: Behavia has been aggressive, and uneasy during past 2 weeks; as above stated, continually trying to escape. Says "he must go home, as they need him there". Physical condition fair: is emaciated some and in poor flesh. No delusions noticed but he talks foolishly. Says "he had "spells" of a few minutes' duration, when he was confused & could not think, but is all over them now. He is well enough to go home". Says "we can't keep him here". Is stubborn & will do nothing asked of him, unless force is used,

Personal and Medical History of *August Schultz*.

July 6/96. Patient escaped but was brought back during same day by nurses with Team. Is continually trying to escape and is very stubborn & ugly. Aug. 28/96 Escaped. Sept 2 Returned with feet sore & wrists swollen. Jan 28 Patient as having become very quiet: walks up & down hall talking to himself at times. At times tries to escape. May 31 '97 Wt. 175 lbs. July 1 Rather talkative talk, however, mostly in german: is usually quiet: occasionally laughs to himself: Seems to have exalted delusions. Jan 31 '99 Patient rather more noisy of late & very untidy, otherwise no marked change Feb 1 - July 31 '99. (Dr Manons) Wt. 165. Patient is simple in actions & speech. No change in condition. July 31. Appetite good. Habits fairly clean.

Aug 1900 Jan 31 1900 (Dr Manons) Wt. 159. Sept 16. Mans & Annex. No change nor improvement during period. Has been in good health: behavior good. Habits untidy. Is very inactive
Feb 1 Wt 155 lbs. P 78. July 20 Vaccinated: result negative. July 31. No change, in any way: Quite cleanly
July 20 in habits, but very inactive: never does any work. Appetite, sleep & behavior good. Has had an occasional
" 31 "noisy spell". Seldom talks and seems very much demented. Aug 1. Wt 156 lbs. Sept 10. To Dr.
Sept 15 1900 visited by friends. Jany 31/1901. But little change noticed: sits in one place, nearly all the time:
Jan 31 will not converse, though he talks to himself, at times. Health fairly good. Feby 2. Wt 159 lbs
June 8/01 To Tw. Failing Physically: Coughs & expectorates. T 100 2/5. P 96. (Has tuberculosis). June 15. Is
23 failing quite rapidly. June 23. Died. 5:30 P.M. (Diagnosis: Tuberculosis pulmonalis)

Died —

Personal and Medical History of Jeremiah Murnane

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4415

Residence, Rosemount, Minn.

Date Admission, 8th June 1896.

Admitted by D. Phelps Hour, 2.15 P.M.

How Sent, Thos P. Moran. Jof P. Dakota County

Sex, Male

Age, 69 years

Civil Condition, widower

Children, 7

Age Youngest Child,

Occupation, Farmer

Degree Education, Some: limited: can read.

Profession Religion, Catholic

Habits, Is addicted to intemperance.

Nativity, Ireland: (Parents also born there).

Physicians Committing, G. C. Fitch and A. VanBeeck

Correspondents, address of Kin } Jeremiah Murnane Jr. Rosemount. Dakota Co. Minn

No. for Year, 243

Insane Relatives, Dont Know.

Cause Exciting, Poor health

Cause Predisposing,

Form, Dementia senilis

Accompanying Bodily Disorder, Gen. poor health.

Suicidal or Not, Suicidal: Drowning & threatening to cut throat

Date of this Attack, 2 Years ago

Duration, 2 years

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, — 67 —

Time of Leaving, Nov. 16. 1897

Time in Hospital, 1 yr. 5 mo. 8 d.

Result, Discharged under Peterson Law. Unimproved. 11/16/97

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Ex. by Dr. F. H. Heyse.

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 Jeremiah Murnane

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, 112 lbs NUTRITION, Poor

WOUNDS OR ABNORMALITIES, Ears sessile - projecting palate - Light, narrow arched.

TONGUE, Tremors, Coatings, Yellowish Promptness Movement, Slow

PUPILS, Equality, Yes. Left somewhat oval. Size, Normal

Response Light, Excessive Accommodation, Excessive

SIGHT, Impaired - Beginning cataract on right eye.

HEARING, Impaired

COORDINATION, Arms, } Impaired
Legs, }

TREMORS, Hands, Yes Tongue, Yes

Facial Muscles, Some General, On standing

REFLEXES, Patellar, 6-7 Equal EXAM. URINE,

Other

ARTICULATION,

Slurred, Yes. marked "brogue".

Hesitating,

FACIAL EXPRESSION, —

SENSIBILITY, —

HEART, Soft 1st mitral sound. Weak. Slight enlarged. Apex beat feeble. Circulation poor. Hands cold - Puffy eye-lids.

LUNGS, —

Arteries - Stiff.

TAKEN,

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 *Jeremiah Murnane.*

1896

This patient was brought here by Deputy Sheriff Jno. Wasser & attended by Philip Kearns, with the following history. Patient is in fair condition. As to consanguinity or heredity, don't know. This is 1st attack: first symptoms manifested two years ago, by periods of violent temper & incoherency of action and thought. Disease seems increasing: variable & with rational intervals, but these, not at regular intervals. Derangement now shown by undue excitement & he uses profane language: he states he has catarrh of the stomach. Patient is disposed to injure others & he has attempted to suicide by drowning & threatening to cut his throat: propensity now active. No filthy or destructive habits. The patient always had a violent temper. Is addicted to intemperance. He has not been subject to any severe disease &c or had any head-injury. He has not been restrained or confined. Supposed cause of the disease is Poor health. Has had no medical treatment. On personal examination, there are noted Evidences of poor health: marked pulse 110. Temp. 99 2/5. Tongue coated: tip red; excitable & incoherent. = On admission, was put on B3 (G.S.H.N.R.P.) Complexion light, Hair gray: eyes brown: condition of skin fair: no marks, scars, or bruises noticed: is clean: behavior good. (Is rather feeble). Patient has a Cough & raises Phlegm. Says he has catarrh of the stomach.

June 9/96. Transferred to IW. appearing weak. Given bath & put to bed. Talks quite rationally, on most subjects.

" 9 Says his only ailment is a disorded stomach. Is on regular & extra diet. June 10/96. Slept 7 hours last

" 10 night. Quiet & well-behaved, today. T. about normal. Eats fairly well. Coughs & expectorates considerably: throat sprayed. June 11/96. Slept only 4 hours: No change in behavior. Cough continues.

" 11 Throat sprayed. (-9-3). June 12/96. Slept 8 hours, last night: has not coughed so much as usual,

" 12 today: throat again sprayed. (-9-3). June 13/96. Slept 6 hours. Says he feels stronger. Coughed

" 13 very little during night. Throat still sprayed: was out in Pm. June 14/96. Slept 7 hours, last night.

" 14 Eats fairly well. Behavior good. Seems contented. Talks quite rationally. Says he feels strong enough

" 15 to get up. June 15/96. Slept 7 hours: Can see no change: out this Pm. Throat sprayed (9-3)

" 16 June 16/96. Seems to improve, physically: does not expectorate as much as of late. Throat still

" 17 sprayed. Out this Pm. June 17/96. Slept only 4 hours: no marked Change, though he seems stronger.

" 18 Wishes to get up. Is quiet & well-behaved. Out in Pm. June 18/96. Slept 6 hours. Continues in about the

" 19 same condition, apparently. Throat sprayed, twice a day, is much improved. June 19/96. Slept 6 hours

" 20 Seems to be doing well. Temp. & Dressed. June 20/96. Slept 6 hours. Can go onward. Appears to improve

" 21 steadily. Out for short walk, in afternoon. June 21/96. Slept well, last night. Still has slight Cough,

" 22 with Some expectoration. June 22/96. No marked change: physical improvement noticed. Throat sprayed, twice a day. He sleeps well, at night. Summary. Has been quiet and well-behaved: Cough at first, was quite bad & he expectorated Considerably: treatment given throat by spraying, & cough is much better. He claims he has catarrh of stomach. He has talked quite rationally. Says that after turning all his property over to his sons, they sent him here to get rid of him. Patient was rather weak, when received, but gained strength steadily; on 11th day was allowed up & Dressed. Showed no inclination to elope, while at present, he coughs very little, with slight expectoration. Temp. about normal, throughout. Pulse was somewhat above normal mark & respiration quick. June 23/96. Up onward: appears improving

" 23

" 30 physically. June 30/96. Behavior good: Sleeps well: Appetite good: bowels regular: nose & throat are still treated: Gets out into grounds. Condition about same, from day to day.

Personal and Medical History of *Jeremiah Murnane*

July 1 Appetite good: Bowels regular: Walks half a good deal: Goes out daily with Comp: Wt. 114 lbs. July 31 No change since 1st of month. Appetite good: Habits clean: Reads some: Makes no complaints. Aug 3 Wt. 117#. Aug 15 Patient appears about same: Seems perfectly contented: Talks very little unless spoken to. Talks rationally on all subjects: Aug 31 No change from day to day: Never speaks of going home - seems perfectly contented here. Sept 11 Trans. to A2. No change. Oct 1 Wt. 117 lbs: Eats & sleeps well: Bowels regular. Nov 1 Physical condition poor: Mental powers fairly good: hearing defective. Dec Appetite poor: Sleeps well: Has slight cough. Wt. 117 lbs. P. 84

Dec 1 coughs a good deal: Complains of being cold: Breathes with difficulty

" 6 Complained of not feeling well & asked to be allowed to go to bed. Temp. 102°. Trans. to Infirmary. Notes by Drs Phelps & Coy." Respiration markedly increased: Expectorates large quantities of frothy mucous. Left side of chest all right. Lower lobes of right consolidated. Had a severe coughing spell during night. Groans at times and complains of pain in chest. Physical condition not very good."

" 8 A little better today: Visited by Father Reardon. Dec 31 Apparently no change in physical condition: Sits up in bed most of time. Temp 100.

Jan 1 97 Very restless most of time: Breathing labored: Wt. 105# Temp 99°-100°.

" 5 Is improving slightly: Breathing not so labored: Is restless at night.

" 11 Very little change in Patient from day to day. Today complains of pain in stomach: Appetite fair: Bowels fairly regular. Temperature about normal.

" 17 Talks incoherently: Breathing labored at times: Coughs a good deal: Complains of severe pain in stomach at times: Expectorates greenish mucus.

" 31 No change since last note. Feb 5 Patient seems to be improving some: Does not expectorate quite so much: Talks to himself. Feb 7 Up on ward this Pm.

" 9 Walks about ward some & appears quite strong: Talks quite rationally. Reads a good deal Feb 28 Patient has been up on ward since 21st Seems to be improving gradually: Still expectorates greenish, frothy mucus: has slight cough. Is very quiet on ward: Pulse & Respiration good. Trans. to A4. March 1 Wt. 110½ P. 88 Patient on regular & extra diet: Appetite fair: Bowels quite regular: Sleeps fairly well: Talks quite rationally but is childish on some points: Has very nervous disposition. Does not go out. March 29 Went for walk today. Apr 13 Trans. to A2. No change.

May 1 Wt. 110½ lbs P. 86. Physical condition poor. No change mentally: Is on parole.

June July & August No change. Sept 1 On regular & extra diet. Seems gradually failing physically. Is very childish at times Sept 2 Visited by friend. Oct 1 Wt. 119#. Is gaining slightly physically. No other change. Nov 1 Wt. 118½ lbs. P. 80. Patient is on parole. Coughs & expectorates a good deal - especially in morning: Talks rationally on any subject. Nov 16 Sent home today under Peterson Law.

Discharged.

Personal and Medical History of Mathias Peterson #1

ROBERT, FIELAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4416
Residence, Manchester, Minn.
Date Admission, 8th June 1896.
Admitted by Dr. Phelps Hour, 7 45/60 PM.
How Sent, Herman Blackmer, Jeff. Freeborn County
Sex, Male
Age, 32
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farmer
Degree Education, Slightly educated; Can read or write
Profession Religion, Yes: Lutheran
Habits, not intemperate
Nativity, Freeborn County Minn: (Parents born in Norway).
Physicians Committing, H. Von Berg and J. A. Blackmer.
Correspondents, None given in papers

No. for Year, 2414
Insane Relatives, None (father intemperate)
Cause Exciting, Supposed due sunstroke (in 1888).
Cause Predisposing, Previous attacks
Form, Mania acute
Accompanying Bodily Disorder, some insomnia
Suicidal or Not, Not
Date of this Attack, One week ago
Duration, — one week —
No. of Attack, Many
No. of Admissions, 5th
Age First Attack, about 18
Time of Leaving, Nov. 24. 1897
Time in Hospital, 1 yr. 5 mo. 16 d.
Result, Discharged May 4. 1898
Much improved.

EXAMINATION ON ADMISSION.

Ex. By Dr. R. M. Phelps. **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: Patient has been here several times, now in an attack of violent resistive mania. Masturbates extremely.

Acute mania - Confirmed

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 Mathias Peterson #1

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not Taken WEIGHT, Not Taken NUTRITION,
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, — Size,
Response Light, — Accommodation,
SIGHT, —
HEARING, Slightly deaf
COORDINATION, Arms, —
Legs, —
TREMORS, Hands, — Tongue,
Facial Muscles, — General,
REFLEXES, Patellar, —
Other
ARTICULATION, —
Slurred,
Hesitating,
FACIAL EXPRESSION, —
SENSIBILITY, —
HEART, —
Arteries good.
LUNGS, —

EXAM. URINE,

TAKEN,

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.) 59. (v.m.) 68. Naso oc. a. 35.5. Bin. a 35. Aur. p. d. 19.4. Ocanov. d. 18.6. Bimd. 14.3. Sec. l. 13.1
HISTORICAL, Had fever 12 yrs. ago - Rheumatism 4 yrs. ago. quite severe. Says first attack was slashing and got sunstroke.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Sudden.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any insanity in family - are some nervous.
Mother or Mat. Relations, Living and healthy.
Father or Pat. Relations, Died of fever at about 70.
Brothers or Sisters, Four Brothers - no Sisters - Two died.

Personal and Medical History of Mathias Peterson #1

This patient was brought here by Deputy-Sheriff T. L. Torgerson, with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is not 1st attack. (about '80 or '81, first): and he has been in asylum 4 times since; at this (Rochester) hospital: some beneficial effect. First symptoms of this attack manifested one week ago: began laughing and acting silly. Disease appears to be increasing: not variable: no rational interwals. Derangement now shown on no particular subject. Not disposed to injure others, during this attack. Is not suicidal: no filthy or destructive habits. — Before the accession of the disease, no peculiarities &c had been shown. Patient not addicted to intemperance: father was intemperate; There is no history of any severe disease &c whatever. Has not been restrained or confined, this time. Supposed cause of the disease is Sunstroke (in 1880). Has only had treatment in asylum. He now appears silly restless and is suffering from insomnia.

Note. June 8 — As stated, Patient has been here 4 times before. (last time, from Jany 8/94 to Sept 10/94: for particulars see vol 27 page 17 No 3618). On admission, was put on C. (G.H.R.Rpt. Complexion light: hair light: eyes blue. Condition of skin good. has a deformed ear; also scars: 5 on head: 1 on back: 3 on arm: 2 on left side: 3 on right side: 2 eruptions on right side below ribs: 2 bruises on chest. Is clean. behavior stubborn: could not be induced to come out of the hack: had to be handcuffed & then carried to the ward). June 9/96. Restless 9 hours, during night. (had been given Cathartic: bowels then moved 3 times): Was inclined to be obstreperous. Eats well: has delusions: no complaints. June 10/96. Was noisy & destructive 9 hours, during night. Makes no complaints: physical condition emaciated. Bowels move. Patient, while running up the hall, was tripped up by a fellow-patient, causing Peterson to fall & bruise his forehead. June 11/96. Slept 8 hours, during night. (was given hyos): no improvement in behavior: troublesome to fellow-patients: appetite poor. June 12/96. Restless 8 hours, during night. Given Cathartic: bowels moved freely: Eats well: behavior not good: no physical complaints. June 13/96. Restless 8 hours, during night. behavior improving. rational all day. June 14/96. Quiet, all night: behavior still improving: rational, all day. Eats well: no complaints: habits untidy. June 15/96. Eats & sleeps well: behavior quiet: Makes no complaints: no delusions or illusions noticed. June 22/96. During this, the 2d week, patient has kept on improving: behavior quiet: he eats & sleeps well: making no complaints. no delusions noticeable. Walks in hall, every day: habits neat: bowels regular. Physical condition improved. Is rational.

Summary: Patient, on arrival here, was very stubborn: could not be got out of the hack, so he had to be taken out by force & was carried up to the ward. On the 13th behavior began to improve and he became more rational: no delusions were noticeable: physical condition also began to improve. This improvement kept up, and behavior is now good & mental condition seems much improved.

July 1/96 — Summary Nurses Notes by Dr Phelps. Wt. 185#. Is noted as being childish in behavior but able to work some & not especially troublesome. July 14 Trans. to T3. July 17 Getting uneasy. Threw himself in the water while out walking: Trans. to C. Aug 1 Rather more quiet again. Wt. 149 lbs. Sept 1 Has been for last three or four days uneasy: Seems to be getting rapidly worse.

Oct. 1 — Patient has been quite violent and very troublesome to take care of all of month.

May 1/97 — Nurses records show an almost continual period of noise & destructiveness. In restraint nearly all the time. Very maniacal & troublesome. Oct 1 '97 Patient was quite restless

Personal and Medical History of

all summer but is noted as much quieter during last few weeks: Is neat & clean in habits. Oct 17 Trans. to T3. Nov 24 Went home. Weighed about 200#. Had been down to 180#. Was again quiet & rational, altho, of course, silly at times in his talk and behavior.

Discharged.

Personal and Medical History of Orramel Gould

BUDGET, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4417
Residence, Spring Valley, Minn.
Date Admission, 7th June 1896
Admitted by Dr Phelps Hour, 3.30 P.M.
How Sent, E.V. Farrington. Jof. Fillmore County.
Sex, Male
Age, 60 years
Civil Condition, widower. (by divorce)
Children, two
Age Youngest Child, ——
Occupation, (formerly) Farmer
Degree Education, Common School
Profession Religion, United Brethren (Has been a member formerly. Quit longer ago than he can remember)
Habits, Extravagate
Nativity, Franklin Co. New York. (Parents born in Vermont)
Physicians Committing, J.P. Phillips MD. Henry Jones
Correspondents, None given in papers

No. for Year, 245
Insane Relatives, None: Parents were Cousins.
Cause Exciting, Intemperance in alcoholic liquors
Cause Predisposing, previous attack
Form, Paranoia
Accompanying Bodily Disorder, had Sunstroke in 1863.
Suicidal or Not, Not: but will injure others
Date of this Attack, about a month ago
Duration, — about a month —
No. of Attack, 2nd (occurred in 1891)
No. of Admissions, 2nd
Age First Attack, about 55.
Time of Leaving, Apr. 7. 1898
Time in Hospital, 1 yr. 9 mos. 29 d.
Result, Discharged Apr. 7. 1898 Recovered.

EXAMINATION ON ADMISSION.

Ex. by Dr. P.M. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Slightly Confused
Quick or Sluggish, Quick
MEMORY:
Past Events,
Recent Events, Some, not much.
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Not very good.
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: A gradually invading mental impairment, a garrulous, eccentric demented. Some like Alcoholic dem. Cause not known, though he denies heredity. Patient says he was wrongfully charged with assault. Don't think himself he was quite right mentally.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Slightly Exalted
Depressed,
DELUSIONS:
Systematized or Not, Secret Police - Belonged to
Special Subjects, it for years.
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Orramel Gould

EXAMINATION ON ADMISSION, CONTINUED.

Re. Orramel Gould

Notice of hearing petition on 10th Aug 1896 at Preston, Minn for the appointment (on petition of N. E. Molstad Jof T. J. Dneghon of Fillmore County as Guardian of person & estate of said Orramel Gould. Dated at Preston 18 July 1896. and Service accepted by D.K. 26 July 1896. and service made on Orramel Gould by reading over to him original as copy & service was "Hawk".

RISTICS.

NUTRITION, Impaired some.
Promptness Movement, Prompt
mmodation,
ined.
ladder trouble
ue,
Facial Muscles, General,
REFLEXES, Patellar, Normal.
Other
ARTICULATION, Fairly normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Faint. Impulse strong and irritable.
LUNGS, Seem good.
Arteries - probably slight impairment.
EXAM. URINE,
TAKEN,

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.) 57½ - (v.m.) 65½ Naso-oc. a 37½. Bin. a. 25½. Ant. p. d. 10.4 Trans. d. 15.7 Bin. D. 13.2 Jac. b. 11.6
HISTORICAL, T. Fever in 1858 - 1863 heat stroke - Bladder trouble since '67. Uses Catheter. Headaches quite scarce - only occasional. Has had trouble with Cataract
LENGTH OF INVASION, 7 years ONSET GRADUAL OR SUDDEN, Slow.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Died at 65 - Old Age.
Father or Pat. Relations, Died at 69 - Old age and Rheumatic
Brothers or Sisters, Two Brothers & Sister all dead - Knows no insane relations.

Personal and Medical History of [illegible]

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4417

Residence, Spring Valley. Minn

Date Admission, 7th June 1898

Admitted by Dr. Phelps Hour, 3.30 P.M.

How Sent, E.V. Farrington. Jail. Fillmore County.

Sex, Male.

Age, 60 years

Civil Condition, Widower. (by divorce)

Children, Two

Age Youngest Child, ——

Occupation, (Formerly) Farmer

Degree Education, Common School

Profession Religion, United Brethren (Has been a member for many years. Quit taking part when dropped from church)

Habits, Intemperate

Nativity, Franklin Co. New York. (Parents born in Vermont)

Physicians Committing, J.F. Phillips. M.D. Henry Jones

Correspondents, None given in papers

C.

Cause P.

Form,

Accompanying Bodily

Suicidal or Not, Not: N

Date of this Attack, about a

Duration, — about a

No. of Attack, 2nd (as occurre

No. of Admissions, 2nd

Age First Attack, about 55.

Time of Leaving, Apr. 7. 1898

Time in Hospital, 1 yr. 9 mos. 7 d.

Result, Discharged Apr 7. 1898 Recovered.

EXAMINATION ON ADMISSION.

Ex. by Dr. P.M. Phelps.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Slightly Confused

Quick or Sluggish, Quick

MEMORY:

Past Events,

Recent Events, Some, not much.

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Not very good.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: A gradually invading mental impairment, a garrulous, eccentric demented. Some like Alcoholic dem. Cause not known, though he denies heredity. Patient says he was wrongfully charged with assault. Don't think himself he was quite right mentally.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Slightly Exalted

Depressed,

DELUSIONS:

Systematized or Not, Secret Police - Belonged to it for years.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Orramel Gould

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7½ WEIGHT, 134 lbs. NUTRITION, Impaired some.

WOUNDS OR ABNORMALITIES,

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

PUPILS, Equality, Equal. Size,

Response Light, Yes. Accommodation,

SIGHT, Poor - Left eye impaired - Cornea impaired.

HEARING, Fairly.

COORDINATION, Arms, Says is now weak from bladder Trouble

Legs,

TREMORS, Hands, Some tremors Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal. EXAM. URINE,

Other

ARTICULATION, Fairly normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Faint - Impulse Strong and irritable.

LUNGS, Seem good.

Arteries - probably slight impairment.

TAKEN,

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.) 57½ - (v.m.) 65½ Nas. to a 37½. Bin. a. 25½ Ant. f. d. 20.4 Trans. d. 15.7 Bin. D. 13.2 Jac. b. 11.6

HISTORICAL, To Iowa in 1858 - 1863, heat stroke - Bladder Trouble since '67 - Uses Catheter. Headaches quite severe, only occasional. Has had trouble with Cataract

LENGTH OF INVASION, 7 years ONSET GRADUAL OR SUDDEN, Slow.

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

Mother or Mat. Relations, Died at 65 - Old Age.

Father or Pat. Relations, Died at 69 - Old age and Rheumatic

Brothers or Sisters, Two Brothers & Sisters all dead - Knows no insane relatives.

Personal and Medical History of *Orramel Gould*

1896

This patient was brought here by Sheriff's deputy W. Nupson, with following history. The patient is in fair physical condition. Parents were cousins. No insane relatives. This is not 1st attack: he had one in 1891: when he was sent to this (Rochester) Hospital: afterward discharged. First symptoms of this attack were manifested about a month ago: he became very quarrelsome & made threats and assaults. The disease seems increasing: variable & with rational intervals, but these irregular & occur at any time. Derangement now shown in that he is quarrelsome; suspicious of people, without cause. Attempts to injure people for fancied wrongs. Has not attempted suicide. Prosperity not a cause. No filthy or destructive habits. Patient has been eccentric for years: he has been addicted to & intemperance. He had a sunstroke in 1863. Was confined in Rochester from Sept 1891 to April 1893. (?) Supposed cause of the disease is intemperance in alcoholic liquors. The only treatment given has been confinement at Rochester. He, on personal examination, talks a great deal, in an incoherent manner.

Note. Our records (Vol 18 page 112 No 2876), show that patient was here before, from Nov 17/91 to Feb 21/93: — On then coming, he claimed to have catarrh of bladder & kidney trouble: had pains & had to be catheterized: was dizzy and sick to stomach, in morning, on rising. Was inclined to be over-communicative. Did not seem depressed or much exalted. Was continually telling the story of his troubles to anyone who would listen to them: repeating the story, over & over: was a tireasome talker: wrote many letters, to his wife & others; some very abusive & vulgar: (copies of same on file). Eloped from kitchen April 16/92: brought back May 17/92. Was, from time to time, troubled with his bladder & catarrh. Letters show his faultfinding ways &c. Later, bladder trouble became less, & he also was less complaining, and faultfinding, & was more pleasant and agreeable.

June 9 On admission, was put on B^3 (G.H.N.Rift). Complexion light: hair dark: eyes blue: condition of skin
" 10 clean: has Double hernia: bed clean: behavior good). Given bath on admission. June 10/96. Slept only 1 hour,
" 11 last night: Complains of trouble with urine & pain in bladder. Passed catheter, Am + Plus. June 11/96. Slept
6 hours. Eats well: behavior good. Passed catheter several times, today. Bowels in good condition. He is cheerful
" 12 & contented. June 12/96. Slept 7 hours. On no medicine: Passed catheter, several times, today. He talks
rationally, but in an egotistical manner. Talks a great deal. Complains, more than usual, of pain
" 13 in urethra. June 13/96. Slept only 4 hours, last night. Again passed catheter, several times. 7 Bm Could
" 14 not pass catheter. June 14/96. Complained of severe pain in urethra & bladder, is quite weak: lying
" 15 down, most of day. Felt better, toward evening. Slept only 5 hours, last night. June 15/96. Slept only 4 hours,
bowels in good condition. Patient much better, today: passed urine, several times. Talks much &
" 16 plays games, a great deal. June 16/96. Slept 5 hours. Says he feels first rate, today: passed urine,
" 17 several times. June 17/96. Slept only 3 hours, last night. Appetite fair. (Is on regular & extra Diet).
also takes medicine, 4 times a day: passed urine several times, today: has to use catheter occasionally
" 18 June 18/96. Slept 6 hours. Behavior good. No change noted, otherwise. Passed catheter several times,
" 19 June 19/96. Slept 6 hours: "feeling quite well today". Talks much about himself, in a bragging manner.
" 20/21 June 20/96 No change noticed. June 21/96. appetite good: bowels regular. Passes urine of late, with
" 22 using catheter. June 22/96. Still talks much: says that the lady & whom he was engaged has a
" 23 bad character & he will not marry her, when he leaves". June 23/96. Sleeps 5 to 6 hours, each night.
Talks much of people from his home, & flatters none of them. Now passes urine without catheter.

Summary: Patient has been quiet & contented, & apparently, quite cheerful, during last 2 weeks.

Personal and Medical History of *Orramel Gould*

Summary cont'd Physical Condition not good: has retention of urine & some trouble with bladder. Is not in good flesh. Patient talks a great deal. He either has delusions or is trying to lie more than is necessary. Says the hotel at Spring Valley is a house of ill fame" & also says that most every lady there has a bad character".

June 30/96 Summary Nurses Notes by Dr Phelps. Appetite good: Sleeps well. Talks in a bragging manner. Has bladder trouble which he has had for several years. July 13 Complains of hernia. Apr. 1/97 Patient during months past has lived along quietly & well & has been quite quiet & rational. Of late has complained of passing blood & more of pain & constitutional trouble: Apr 7 Trans. to Infirmary on account of this trouble. Apr 8 Operated upon by an opening made into bladder. Apr 30 Patient's condition has, of course, needed constant watching during month. Has done fairly well however. Urine discharging at first thro' open wound.

May 1897. Patient has been troubled somewhat by bedsores. Still, however, seems to have no especially serious trouble at present. Able to help himself, still has considerable pain in back. May 21 Patient up & about ward most for several days. Is gaining strength & getting along very well. Nov. 22 wt. 149 lbs. Has a double hernia which, however is easily reduced. Dec. 2 Wt. 151. Dec 28 Complains of a feeling of numbness in 3rd & 4th fingers of right hand, extending to forearm. Given electrical treatment. Jan 26'98 Right cheek swollen & inflamed. Complains of arm. Jan 31'98 Swelling in face broke & discharged. Feb 1 Wt. 150. General condition fairly good. Apr. 7'98 Went home, wt. 153. Fairly rational in talk & manner & well-behaved in every way.

Discharged.

Personal and Medical History of John Kirchner

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4418

Residence, Dakota Co. Minn

Date Admission, 9th June 1896. —

Admitted by Dr. Phelps Hour, 6 Hrs PM.

How Sent, Thos. P. Moran. Jo. P. Dakota County.

Sex, Male

Age, 59 Years

Civil Condition, married

Children, 8

Age Youngest Child,

Occupation, Farmer

Degree Education, Grammar School

Profession Religion, Yes: Lutheran.

Habits, not Intemperate.

Nativity, Germany: (Parents also born there) —

Physicians Committing, O.A. Beal and V. J. Hawkins

Correspondents, Wm Kaus Maier St Paul P.O. Minn
Mrs John Kirchner } St Paul P.O. General Delivery.
Edward Kirchner }

Family Phys. St Paul Minn 408 So Wabasha St

No. for Year, 246

Insane Relatives, One brother, in Germany, insane.

Cause Exciting, Money

Cause Predisposing, probably heredity

Form, Melancholia acute agitated

Accompanying Bodily Disorder, None mentioned —

Suicidal or Not, Will Ingive his Grandchildren — suicidal, by drowning & Propensity active.

Date of this Attack, March 1896.

Duration, about 3 months.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, — 59 (about)

Time of Leaving, Dec. 9th - 1896.

Time in Hospital, Six months.

Result, Discharged May 5: 97. Improved

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 John Kirchner

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in WEIGHT, 118 lbs NUTRITION, Fair

WOUNDS OR ABNORMALITIES, Skin - Good

TONGUE, Tremors, Good Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Normal

Response Light, Normal Accommodation, normal

SIGHT, normal

HEARING, normal

COORDINATION, Arms, } normal
Legs, }

TREMORS, Hands, } normal Tongue, } normal
Facial Muscles, } General, }

REFLEXES, Patellar, Normal EXAM. URINE,

Other

ARTICULATION, normal

Slurred,

Hesitating,

FACIAL EXPRESSION, —



SENSIBILITY, —

HEART, —

LUNGS, —

TAKEN,

Arteries - Some radial Sclerosis notable

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Cir (R) 57 (com) 63½ Nas v.a. 37½ Bim. a. 32 Ant p. l. 18.4 Trans v. d. 15.2 Bim. d. 11.7. Ine length 11.7.

HISTORICAL, No headaches -

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 John Kirchner.

1896

This patient was brought here by Edward Kirchner, attended by Fanny Meyer & patient's wife. Patient is in fair physical condition. As to consanguinity, nothing stated. A brother, in Germany, is insane. This is 1st attack. Symptoms manifested in March 1896: he thought his friends had all turned against him. The disease seems increasing: variable & with rational intervals, but his rational moments occur at irregular times, now. Derangement now shown in religion; fear of personal injury: i.e. thinks he will be cut up & burned". Is disposed to injure his friend Chelcrew. He has attempted suicide, by drowning: prosperity now active: "asked for a rope". 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 & or head-injury. He has not been restrained or confined. Supposed cause of the disease is worry. Has been treated by Cathartics & bromidia, as needed: good at first. On personal examination, there are noted expressions of fear. Patient said "his church brethren have combined against him" and he thinks they have made a devil out of him. He cried & appeared in great distress, because his wife & children were to be killed & burned - Appearance & manner were wild. He ran away from home. Commitment recommended because he has perpetrated acts dangerous to himself & family.

June 9 On admission was put on B3 (G.H.N.Hpt. Complexion dark: hair dark: eyes blue: condition of skin fair: no marks scars or bruises noticed. Is clean: behavior good). June 10/96. Slept only 3 hours, last night: very restless & scared; crying & talking about his troubles. 7 P.M. Transferred to Infirmary.
" 11 Was excited & noisy. Given bath & put to bed. T. 99.2. Urinates & bowels move. June 11/96. Quite noisy, during night & slept only 3 hours. Eats fairly well: Is on regular & extra diet. Very noisy all day: "believes he & his family have been unjustly accused of some misdeed". Has various other delusions. Bowels move.
" 12 June 12/96. Very restless & disturbed & slept only 2 hours, last night. Behavior unchanged today. Imagines he
" 13 is going to be harmed by those around him". June 13/96. Noisy during night: slept only 1 hour. Is about as usual today. Is continually talking of his troubles. Temp (Axn). 99.4 - Rx 99.6 (F.B.H., today).
" 14 June 14/96. Slept only 2 hours. Noisy all day: out of bed frequently: Refused food: Could not be persuaded
" 15 to eat. June 15/96. Slept only 2 hours last night. Very noisy & restless, all day. Bowels constipated: given
" 16 Enema: bowels then moved. June 16/96. Slept only 2 hours. Still very noisy: 5.30 P.M. Given Shower-Bath.
" 17 Still fed by tube. June 17/96. Slept 4 hours: behavior unchanged: very noisy all day. Fed by nurse
" 18 June 18/96. Slept only 2 hours. Continues very noisy: "talking of his troubles". 8.00 P.M. Was visited by Son.
" 19 June 19/96. Slept only 1 hour, last night. No apparent change. 11.00 AM. Fed, with tube, 1 qt. Eggnog.
" 20 June 20/96. Slept 5 hours, last night. 8.00 AM. Bowels moved: Quite noisy, up to 10.30 AM: was taken out alone for a walk ½ hour; was well-behaved: Was quiet on return for a time, but became noisy
" 21 again - at times quiet, at others noisy, during afternoon. June 21/96. Noisy in night & slept only 1 hour.
" 22 Noisy all day: out of bed & walking floor, most of time. Fed by nurse still. June 22/96. Slept 5 hours
Comparatively quiet, at times: at others, noisy. Objected to taking medicine. Mental condition
" 23 seems unchanged. June 23/96. Slept only 3 hours, last night: no change in behavior. Was given Salts, with tube: bowels moved twice, then. Still has to be fed. Same medicine.

Summary: when received, was very restless & appeared scared. Behavior has not changed up to last day. It has been difficult to get him to take nourishment & he has had to be fed, with tube. No cough has been noted. Bowels costive throughout. Still fears that he will be harmed by those around him. Cries a great deal. Has averaged about 2½ hours sleep, nightly. ——

Personal and Medical History of John Kirchner

Summary (by D.H.): Is an average agitated melancholiac. There has been considerable impairment of nutrition, in addition to the costiveness & slight rise of temperature (99° to 100°). Delusions are fixed & unsystematized. "Fears that he will be buried alive". "begs to be killed". Continually insists that he has received no money from the German Government - "Fears for safety of family" - Treatment has been directed toward improving nutrition and small doses of chloral bromide have been given. Improvement slight. Is rather quieter, when at above with nurse & occasionally drops whining tone of voice.

June 24 June 24/96. Slightly noisy, all day & part of night: had delusions. June 25/96. Got his bed against door & the
" 28 night nurse had to force open. Slept only 3 hours. June 26/96. Very noisy. Part of day: it required
" 30 three D. feed Iris. June 30/96. At times, is Quiet: at others, noisy & restless & out of bed, every little while.
Is taken out walking, some days. Bowels constipated: is given Hunyadi water. Sleeps very poorly.

Dec 8/96 Summary Nurses Notes by Dr. Phelps: Patient's behavior during stay here presented very little variation: was kept upon sick ward most of time: Continually crying in a loud manner. This was his condition with little change, up to time of being taken home, Although somewhat thinner, no notable symptoms of disease.

Discharged

Personal and Medical History of Charles Dodds

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4420
No. for Year, 248
Residence, Dakota Co
Insane Relatives, — not known —
Date Admission, 11th June 1896. 4:30 PM
Cause Exciting, Don't know
Admitted by Dr. Phelps Hour, 3:00 PM.
Cause Predisposing, previous attack
How Sent, Thos P. Moran, Jr. Dakota County
Form, Dementia organic
Sex, Male
Accompanying Bodily Disorder, some feet - soreness
Age, 36
Suicidal or Not, — not —
Civil Condition, single
Date of this Attack, about June 1st
Children,
Duration, — about 10 Days —
Age Youngest Child,
No. of Attack, not 1st —
Occupation, Laborer
No. of Admissions, — 1st —
Degree Education, None
Age First Attack, — ? —
Profession Religion, not a church member
Time of Leaving,
Habits, — not intemperate —
Time in Hospital,
Nativity, England: Parents born in Russia
Result,
Physicians Committing, J. P. Caldwell and W. M. Dodge
Correspondents, Thomas Dodds, Taunton Street, Peter England
no family Physcn.

EXAMINATION ON ADMISSION.

Ex. by Dr. A. M. Phelps.

MENTAL CHARACTERISTICS.

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

MEMORY:
Past Events, Confused
Recent Events, mixed up.
Special Subjects,

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

REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,

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

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Delusive Ideas so mixed with real events as not to be distinguished.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: 1½ yrs in poor house - 16 mo's in May '96. Physically has incoordination of legs quite extreme and absent Pat. reflex. Has a Hernia. Mentally has a queer dementia. By some tests memory seems good, though usually can't depend on answers. Tells most preposterous stories. Has ideas of grandeur, tho' they can at times be argued away. Exaggerates everything. Talks in a silly, self-satisfied, wandering way - a little more like imbecility than Paresis. Facial expression slightly passive - Tongue slightly to right. Was picked up + sent here - made trouble on a train + was thrown off according to his account.

Personal and Medical History of Charles Dodds

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5½ WEIGHT, 155 lbs. NUTRITION, Good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Point deviates to right Coatings, Normal Promptness Movement,
PUPILS, Equality, Eq. Size, Normal
Response Light, Resp. Accommodation,
SIGHT, ?
HEARING, Good
COORDINATION, Arms, Fair
Legs, Poor
TREMORS, Hands, None of note Tongue,
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION, Good
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. At base first sound ends with snapping sound. Somewhat weak
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ. (R.) 54 (cm) 63. Nas. oc. a 33.5. Bin. a. 33 Ant. p. d. 19 - Trans. d. 15.3 - Bin. d. 13. - Fac. d. 12.
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations, Dead - Crazy - when died.
Brothers or Sisters,

Personal and Medical History of *Charles Dodds*

1896

This patient was brought here by Deputy Sheriff W. H. Brownell, with following history. The patient is in rather poor physical condition. As to consanguinity, nothing states: as to heredity, not known. This is not 1st attack. First symptoms of this attack was manifested about June 1st by wandering away. Disease seems increasing: variable & with rational intervals but these irregular. Derangement now shown by property hallucinations; (money & harness). Patient is not disposed to injure others, no suicidal, nor filthy nor destructive in habits. Previously he showed kleptomania. There is no history of intemperance in parents or self, nor of any severe disease or head-injury. He has not been restrained or confined. Don't know cause of disease: no treatment, at present. On personal examination, there is incoherent talk; general rambling talk, as money matters &c. Uneasy conversation: incoherent. Appearance & manner were incident. Was found in the highway, several miles from usual place of abode, without clothing. Commitment recommended because he wanders about & is exposed to want of food & shelter & to accidents.

June 11 On admission, was put on T.W. (Gen. N. & Ph.). Complexion light; hair light; eyes blue: condition of skin good: 2 or 3 slight scars at back: legs & feet badly bruised: has double hernia: dirty: behavior good. On being received on ward, appeared somewhat excited. Was quite talkative & very irrational. Legs scratched & bruised. Given bath & put to bed: has large hernia. T 100.2 June 12/96. Slightly noisy, at times, during night; slept 4 hours. Ate better well, today. T. 99.3. Behavior unchanged. Converses freely but very irrationally. Says he owns the world & everything in it: has various other delusions. Legs & feet treated.

" 13 June 13/96. Slept 6 hours. No change in behavior; talk still incoherent & irrational. Makes no trouble.

" 14/15 June 14/96. Slept 4 hours, last night. Eats well: bowels moved: behavior quiet. June 15/96. Slept 4 hours. Very quiet all day. Gait very unsteady: seems to have partially lost power of legs: soreness in legs about gone. June 16/96. Slept 4 hours: Can see no change in condition, mentally or physically.

" 17/18 June 17/96. Examined urine for albumen: acid & find no trace. June 18/96. About as usual. Was out in chair, this afternoon. June 19/96. Quiet, all day: (Slept 5 hours, last night). Out in afternoon.

" 20 June 20/96. Slept only 3 hours, last night. Still has delusions. Otherwise, no change noticeable.

" 21/22 Habits clean. June 21/96. No change noted: was out in afternoon. June 22/96. Slept 6 hours, last night.

" 23 Behavior unchanged: talks very irrationally. Out in P.M. June 23/96. Slept 4 hours. No change noted.

" 24/25 June 24/96. Slept 4 hours: out this afternoon. Is given baths. June 25/96. Slept 5 hours: Condition and behavior remain about the same. Has been eating well, but bowels irregular.

Summary: On Coming onward, was excited, talkative & very irrational. Gait unsteady. Slept rather poorly; (averaged about 4½ hours, nights). Temp. up to June 17th, somewhat above normal. Highest 100.2 (Noted by D.H.: Rise of temperature, during first few days, probably due to the inflamed condition of legs, which were also quite oedematous. Gait has been very ataxic: delusions were sensational, of grandeur and similar to paretic delusions. Articulation & Coordination of arms rather better than in paresis. Was kept abed up to June 18th on account of rise of temperature, and the ataxia. Afterwards, was out in afternoons, when weather permitted.)

May 1/97 Summary Nurses Notes by Dr. Phelps. Patient at present suffering from an attack of erysipelas. During year past, while he has shown somewhat of gradual failure yet it has been rather slight. The signs have been chiefly of locomotor ataxia altho some paresis undoubtedly coexists. On the whole a quiet case: During early part of day he was full of bragging talk & exalted, grandiose ideas, but

Personal and Medical History of *Charles Dodds.*

during latter part of year was more quiet & dull. May 3/97 Patient sits around in a dull quiet way. Talks incoherently. Has hallucinations of talking with spirits & occasionally noisy. Wt. 156th Nov. 1 166th Patient has been considered as having locomotor ataxia. Is settling down in a quiet, chronic condition. Jan 31/99 Very unsteady on feet. About same in every way. General health fairly good.

Feb 1 - July 31/99. Wt. 167th Mental condition does not change. Is very unsteady on feet. April 8 Struck by Mr McGroaty. Fell to floor striking & bruising himself. April 11 Suddenly taken with chills followed by fever. Up & dressed on the 15th & is apparently quite well. July 31 Condition unchanged.

Aug 1 1900 - July 31/1900 (Dr Warnock) Sept 7. Had severe convulsion which left him very weak. Remained in bed for several days. May 3 Right thumb badly bruised - cause unknown.

May 16. Trans. to Annex. Noisy & incoherent. July 20. Vaccinated - result unsuccessful.

Aug 1 1901 - Jan 31 Does no work. Augs. Wt 163th. Sept 10. To D.C. - Jany 31/1901. Very little change during the period: does no work: is inactive; eyesight very poor. Sits & laughs to himself frequently. Speech very irrational & incoherent, but will answer ordinary questions quite sensibly. Is rather feeble & subject to peculiar "sinking spells," which pass off in a few hours. Aug 31. Wt 159th: Feb 1/02. Has diarrhoea: complains of abdominal pain. Transferred to T.W. Feb 18. To D.C. Feb 19. Again complains of bowels: To T.W. Feb 19. Vomiting. March 31 Has been in bed, during March. Apl 1/15 - May 1/15 no change of importance. Apl 7. Is up, onward. Apl 15 To A.C. - May 1. Wt 151th & T.W. had a "sinking spell" while at stool. Is normal - May 11 To A.C. June. To T.W.

July 15/17 - Aug 1 To A.C. July 31. No change mentally: has had several peculiar attacks, in which he is prostrated (suspected of being hepatic-colic). Augs. Wt 154th - Nov 30. Patient has had several attacks of sudden unconsciousness, without, as far as known, any convulsive movements. Dec 8. Patient complains of pain in abdomen: weak: dizzy: vomiting.

Nov 30 - Dec 8 - 10/11/16 Moved to T.W, where he vomited, during day. Dec 11. Temp. 102.2 - Dec 16. Appears as well as usual, again. The Temp. runs from normal to 100° - Dec 18. Moved back to A.C.

18 1902 - Jan 31/03 Condition about as usual.

Jan. 31/03 During past year patient has had several spells (so called): - Feb. 6/02 a sinking spell, with chilly feelings, resembled shock, was in bed for three days. Mar. 10, Convulsion at 4.45 P.M. Apr. 4 A sinking spell at 7 P.M. June 7. Sinking spell in P.M. Oct. 6 Severe convulsion in the morning. This was a quite typical convulsion - noted for the first time; fell & struck his head on the floor. Oct. 16 Severe convulsion. Jan. 18/03 Convulsion at 3 P.M. Jan 31/03. Patient's condition between convulsions about as before. Does not seem to affect his general health. Very demented; but quiet.

Personal and Medical History of Guy Sackett.

EGBERT, FULLAM & CHAMBERS, DAVENPORT, IOWA.

Whole No. 44421

Residence, Janesville, Minnesota.

Date Admission, 11th June 1896.

Admitted by D. Kilbourne Hour, 7.35 P.M.

How Sent, Geo. H. Wilson, Jo. P. Wasica County.

Sex, Male

Age, — 18 —

Civil Condition, single

Children,

Age Youngest Child,

Occupation, No occupation

Degree Education, Common School

Profession Religion, Not a church member

Habits, Not intemperate —

Nativity, Janesville, Minnesota: fathers Minnesota: Mother, Wisconsin

Physicians Committing, M. J. Taylor and D. S. Cummings.

Correspondents, — None given in papers —

No. for Year, 2429.

Insane Relatives, Mother's two Sisters are insane

Cause Exciting, Inherited

Cause Predisposing, — Heredity —

Form,

Accompanying Bodily Disorder, has lost flesh.

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 15

Time of Leaving, Apr. 26. 1897.

Time in Hospital, 10 mos. 15 da.

Result, Discharged Aug. 11th 1897 Improved.

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 Guy Sackett

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, 137½ lbs 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, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

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 Guy Sackett.

1896

This Patient was brought here by Deputy Sheriff George H. Goodspeed, with following history. There is no history of consanguinity, but there is of heredity; mothers two Sisters are insane. This is the 1st attack. symptoms manifested 3 years ago: afraid of contaminating himself by touching doors & furniture. - The disease appears to be increasing: not variable: no rational interval: Derangement now & lately being afraid of contracting disease by touching furniture, or food that his relatives or friends have touched, or prepared. Patient is not disposed to injure others, nor suicidal: is of filthy & 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. He has not been restrained or confined. Supposed cause of the disease is inherited. No treatment has been given. Patient has lost flesh because he would take but little food.

June 11 On admission was put on C3 (G.H.M. Rpt). Complexion light: hair light: eyes blue: Condition of skin good:
" 12 very slight eruptions on breast. Slight bruise on right leg. Is clean: behavior good. June 12/96. Slept 7 hours: restless 2 hours, last night. Mental condition seems good; no cough noticed: very quiet: is rational
" 13 June 13/96. Restless 1 hour, but slept 7 hours. Appetite fair: bowels move. Still quiet & rational. No
" 14 work. June 14/96. Behavior good: Talks rationally, but has some very peculiar ideas. Bowels move
" 15 June 15/96. Slept 6 hours, restless 2 hours: no change noticeable, from day to day. June 16/96. Restless
16 2 hours, but slept 6 hours: Appetite fair: no medicine. Appears to be contented: behavior good.
" 17 quiet: Shows delusions. June 17/96. Slept 7 hours, restless 1 hour. Patient is very peculiar
" 18 about some things. "Fears catching Some disease": Talks quite rationally. June 18/96. Slept 5 hours, last night; no change noticed from day to day: appetite fair: bowels seem regular. Habit normal.
" 19 June 19/96. Restless 3 hours, but slept 5 hours, last night. Patient still has delusions, but does not say
" 20 much about things pertaining to them. Is quiet, neat & tidy. June 20/96. Slept 7 hours.
" 21 No change to note. Takes exercise. June 21/96. Very melancholy, today: laments being sent here:
" 22 Otherwise, about as usual. June 22/96 Very sad & melancholy: Crying & lamenting his position.
" 23 "Wants to go home". June 23/96. More cheerful today: plays ball & other games. Talks rationally
" 24 No delusions noticeable. June 24/96. Good patient: quiet, orderly, neat. More cheerful today.
" 25 June 25/96 Sleeps well, of late. Mental condition seems good: No complaints: claims to have catarrh in head & a cold. (Summary by D.H: Pulse rate & Temperature have been normal, during 14 days: Slight impairment of nutrition: Heart's impulse rather forcible: has no melancholiac delusions, beyond the fear of acquiring "Leprosy", but has had a few spells of depression, on account of his confinement. Neat & tidy & converses readily on ordinary subjects. Reticent concerning his psychosis. The rest treatment was explained to him, but he refused to take it & it was deemed inadvisable to attempt it, without his consent).-

Aug/96 Summary Nurses Notes by Dr. Phelps. Patient during month of July was quiet & well-behaved. July 29 Commenced to work in dining room: probably for sake of more freedom. Talked quite freely of his ideas talked of at home: July 31 Quite rational in manner & in every way. Talks none of his delusions.

Apr 6/97 During year has been quiet & well-behaved. Has come to demand & ask complete parole, however, & to be rather assumed to have all the privileges of an employé. Apr 26'97 Went home.

Discharged.

Personal and Medical History of

Personal and Medical History of Jonas G. McCloud.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4424

Residence, Steele County, Minn.

Date Admission, 17th June 1896

Admitted by Dr. Herzog — Hour, 10 oo Am.

How Sent, W. B. Chadwick, J of P. Steele County.

Sex, Male

Age, 78

Civil Condition, married

Children, 8

Age Youngest Child,

Occupation, Farmer

Degree Education, Common School

Profession Religion, Not a church-member

Habits, Intemperate

Nativity, Burlington Vt. (father's Burlington Vt.: Mothers, Vermont).

Physicians Committing, Theo. L. Hatch and J. H. Adair

Correspondents, None given in papers

No. for Year, 252.

Insane Relatives, None

Cause Exciting, Old age + intemperance.

Cause Predisposing, Chronic

Form, Dementia senilis

Accompanying Bodily Disorder, Weakness

Suicidal or Not, Suicidal

Date of this Attack, 5 or 6 years ago

Duration, 5 or 6 Years

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, about 72

Time of Leaving, January 3d 1901.

Time in Hospital, 4 years. 8 mos. 17 days

Result, Unimproved. Died May 1st 1901

EXAMINATION ON ADMISSION.

Exam. by R. M. Phelps 9/23/96 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Not very good.

Recent Events, Blank or nearly so

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

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,

GENERAL DESCRIPTIVE REMARKS: Says mind is all gone - Says Andersonville did it. Was There 5 months - 36000 men on 27 acres. To an old man - Drinks drinking much But history states differently - Is in a quiet symmetrical dementia, apparently quite intelligent but really cant remember anything over night. Dont Know that he ever saw me before.

Jan. 10 1899.

C. M. Finch, Clinton Falls, Minn.

Guardian J. G. McCloud.

Can telephone from Owatonna to Clinton Falls Creamery.

M.E.D.

Service admitted by W. B. Chadwick

Jan. 7th 1898

J. G. McCloud

ON, CONTINUED.

RISTICS.

NUTRITION, Good

Skin - good -

Promptness Movement, Prompt

Small

mmodation,

TREMORS, Hands, Normal

Facial Muscles, "

REFLEXES, Patellar, Normal.

Other

ARTICULATION,

Slurred, Fair.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Sounds weak.

Arteries. Some atheroma

LUNGS,

Normal.

Tongue, Normal

General, "

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, C.(h) 54½ (rm) 66 N.o.a. 35 Bi.a. 33 Aut.p.d. 19.2 Sag.a.d. 14.1 Bi.d. 12.7 Fl. 2.5

HISTORICAL,

LENGTH OF INVASION, Gradual ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies insanity but cant tell

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Jonas G. McCloud

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4424

Residence, Steele County, Minn.

Date Admission, 17th June 1896

Admitted by Dr. Herzog — Hour, 10:00 AM.

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

Sex, Male

Age, 78

Civil Condition, married

Children, 8

Age Youngest Child,

Occupation, Farmer

Degree Education, Common School

Profession Religion, Not a church member

Habits, Intemperate

Nativity, Burlington Vt. (father's Burlington Vt. mothers, Vermont).

Physicians Committing, Theo. L. Hatch and J. H. Adair

Correspondents, None given in papers

No. for Year, 252.

Insane Relatives, None

Cause Exciting, old age + intemperance.

Cause Predisposing, Chronic

Form, Dementia senilis

Accompanying Bodily Disorder, weakness

Suicidal or Not, Suicidal

Date of this Attack, 5 or 6 years ago

Duration, 5 or 6 years

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, about 72

Time of Leaving, January 3d 1901.

Time in Hospital, 4 years, 6 mos. 17 days

Result, Unimproved. Discd May 1st 1901

EXAMINATION ON ADMISSION.

Exam. by R. M. Phelps 9/23/96 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Not very good.

Recent Events, Blank or nearly so

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Says mind is all gone - Says Andersonville did it. Has been 5 months - 36000 men on 27 acres. But history states differently - Is in a quiet intelligent but really cant remember anything over night. Dont know that he ever saw me before. Is an old man - Drinks drinking much symmetrical dementia, apparently quite

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 Jonas G. McCloud

Notice of hearing Petition for appointment of Phila P. Reynolds as Guardian for Jonas G. McCloud received.

Service admitted by Dr. A. F. Kilbourne

Jan. 7th 1898

...ION, CONTINUED.

...ERISTICS.

NUTRITION, Good

Skin - good -

Promptness Movement, Prompt

..., Small.

...ommodation,

TREMORS, Hands, Normal

Facial Muscles, "

REFLEXES, Patellar, Normal.

Other

ARTICULATION, Fair.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Sounds mat. Arteries, some atheroma

LUNGS, Normal.

Tongue, Normal

General, "

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, C.(h) 54½ (r.m) 66 N.o.a. 35 Bi.a. 33 Aut.p.d. 19.2 Sag.a.d. 14.1 Bi.d. 12.7 H. 12.5

HISTORICAL,

LENGTH OF INVASION, Gradual ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies insanity, but can't tell

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Jon[illegible]

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4424

Residence, Steele County, Minn.

Date Admission, 17th June 1896

Admitted by Dr. Herzog — Hour, 10:00 AM.

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

Sex, Male

Age, 78

Civil Condition, married

Children, 8

Age Youngest Child,

Occupation, Farmer

Degree Education, Common School

Profession Religion, Not a church member

Habits, Intemperate

Nativity, Burlington Vt. (Father's Burlington Vt.: Mothers, Vermont).

Physicians Committing, Theo. L. Flatch and J. H. Adair

Correspondents, None given in papers

No. for

Insane Relative

Cause Exciting, Old

Cause Predisposing,

Form, Dementia

Accompanying Bodily Disorder, None

Suicidal or Not, Suicidal

Date of this Attack, 5 or 6 years ago

Duration, 5 or 6 years

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, about 72

Time of Leaving, January 3d 1901.

Time in Hospital, 4 years, 6 mos 17 days

Result, Unimproved. Discd May 1/1901

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps 9/23/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Not very good.

Recent Events, Blank or nearly so

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Says mind is all gone - Says Andersonville did it. Was There 5 months - 36000 men on 27 acres. To an old man - Drinks drinking much but history states differently - To in a quiet symmetrical dementia, apparently quite intelligent but really cant remember anything over night. Dont Know that he ever saw me before.

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 Jonas G. McCloud

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7½ WEIGHT, 135 lbs NUTRITION, Good

WOUNDS OR ABNORMALITIES, Skin - good -

TONGUE, Tremors, Coatings, Promptness Movement, Prompt

PUPILS, Equality, Equal. Size, Small.

Response Light, Yes. Accommodation,

SIGHT, Says getting blind -

HEARING, Fair

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Normal Tongue, Normal

Facial Muscles, " General, "

REFLEXES, Patellar, Normal. EXAM. URINE,

Other

ARTICULATION,

Slurred, Fair.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Sounds mat - Arteries. Some atheroma

LUNGS, Normal -

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, C.(h) 54½ (c.m) 66 N.o.a. 35 Bi.a. 33 Aut.p.d. 19.2 Fr.au.d. 14.1 Bi.d. 12.7 F.l. 12.5

HISTORICAL,

LENGTH OF INVASION, Gradual ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies insanity but can't tell

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Jonas G. McCloud

1896

This patient was brought here by Sheriff J. Z. Barnard 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 of this attack manifested 5 or 6 years ago, hyperactiveness, disposition to wander. Disease seems increasing: variable & with patches intervals, but these are not regular. Derangement now shown by failure of memory, with tendency to melancholia. Patient is not disposed to injure others. He has attempted suicide, & also threatened to cut his throat while at "Soldiers' Home", Minneapolis. Not filthy or destructive in habits. Before accession of the disease, he dissipated with intoxicants, for number of years; also inveterate Drinker & very intemperate. There is no history of any severe disease or head injury. He was confined as an inmate of "Soldiers' Home" during 1895. Supposed cause of the disease is old age & intemperance. No medical treatment has been given him. Patient bears usual evidences of beginning senile dementia.

June 17 On admission, was put on B3 (G.H.N.D.H.). Complexion light: hair gray; eyes blue: Condition of skin good: no marks, scars or bruises noticed: is clean: behavior good). June 18/96. Slept 6 hours, last night. Behavior, today, restless, confused. Thinks he is at the "Soldiers' Home" & has been here several months.
" 19 June 19/96. Slept 6 hours, last night. Is out on grounds, daily: wanders around much: is restless & has to be closely watched, to keep him from wandering away. June 20/96. Slept 6 hours.
" 20 Was found smoking, in wash-room today. Says "he must smoke in-doors". Memory is very poor.
" 21 June 21/96. Slept 5 hours, last night: Patient frequently ask to go out of doors & gets very
" 22 indignant because he cannot be allowed to smoke in-doors. June 22/96. Slept 5 hours. Behavior fairly good. Complains of being exhausted during day, & wants to lie in bed: lies down, during day,
" 23 1 or two hours. June 23/96. Slept 5 hours, last night. Wants to wear hat in doors; says "head gets cold":
" 24 memory very poor: Cannot remember his seat at table, or his bed &c. June 24/96. Slept 6 hours, last night &
" 25 about as usual, today. June 25/96. Slept 6 hours: becomes very indignant, at times, because he cannot
" 26 smoke in doors, or go out when he pleases. June 26/96. Slept 6 hours. Says "the management have
" 27 have stolen 1844 dollars (seven) in money from him": Still thinks he is at the "Soldiers' home". June 27/96 Slept 5 hours, last night. Physical condition fair: is rather feeble (due to old age): Is some contented, of late.
" 30 June 30/96. Sleeps 5 to 6 hours, nightly. No change in condition. Out on grounds, every day: behavior
July 1 good: habits neat & clean. Bowels regular. Appetite good. July 1/96. Slept 5 hours, last night. No change.

Summary: Behavior fairly good, during last 2 weeks. Was quite restless & uneasy, during first 2 or 3 days, asking for hat, wanting to smoke, to go out &c, & becoming very indignant if not humored. Is feeble & easily exhausted; is in fairly good flesh. Seems to have no memory: Power of concentration fair: attention fair: holds to the idea that he is at the "Soldiers' Home" & also that he is persecuted. (D. H. notes: Fairly typical senile dementia, particularly in loss of memory of recent events: There has been slight physical improvement & he has become better accustomed to his surroundings).

May 1/97 Summary Minus Notes by Dr. Phelps. Patient an aged man with very little memory at the
with a quiet manner & good behavior. Has considerable ability to talk,
especially on subject of his past life. Has shown little if any failure during
last year. May 3/97 Wt. 139#. July 31/97 Has a most complete lack of memory for recent
events. Can, however, give a very fair account of his experiences during the war.
Is quite demented but has appearance of fair intelligence. Behavior good. June 31/99

Personal and Medical History of Jonas G. McCloud

1899

Jan 31/99 No change of any kind in behavior or condition during period.

Feb 1 - July 31 To July 31/99. (Dr Watmough) Wt. 141#. Apr 11 Complained of pain in abdomen: Is constipated: given salts
improved. Mental condition very dull & shows loss of memory. Apl 30. no noticeable change.
Sep 29/99 - Oct 27 Patient complained: put to bed & put on light diet: condition worse. Sep 30. Transferred to I.W. Patient treated &
improved & was then Got out of bed Oct 27 - He has some trouble walking around Nov 14 Transferred to A4
Dec 30 1900 - Apl 4/1900 Visited by Daughter. Apl 4/1900 Visited by daughter. June 19. Sick in bed: has severe cold: put on treatment
and improved July 6/1900. Urinalysis made: condition normal. July 17. Again complained of backache. Transferred
July 17 - Aug 21 to I.W. Aug 3. Is on extra diet: seems badly constipated. Aug 18. Is up, around: Patient expectorates a
great deal. Augus: Transferred to A4. Sep 20. Fell on floor: bruised left side: given paracta: patient improved.
Oct 31 1901 - Jan 3 Patient seems very feeble: fell over rug. Dec 1. Visited by daughter. Jany 3/1901. Was visited by
Daughter & taken home.

Discharged

Personal and Medical History of Franklin E. Clason. (Frank)

GUDGET, FIGLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4427.
Residence, New Haven Tp. Olmsted Co. Minn.
Date Admission, 24th June 1896. —
Admitted by D. Phelps Hour, 3:00 PM
How Sent, Thomas Fraser, Jo. Co. Olmsted County
Sex, Male
Age, — 44 —
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Farmer
Degree Education, Educated
Profession Religion, Not a church member
Habits, Not intemperate
Nativity, Wisconsin, Dodge Co. (Father born Newport, Steuben Co. N.Y. Mother " " Madison Co.)
Physicians Committing, J. R. Morse and Chas. T. Granger
Correspondents, none given in papers -

No. for Year, 255.
Insane Relatives, (Brother here now)
Cause Exciting, La Grippe
Cause Predisposing, previous attack & heredity
Form, Mania subacute
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, — not —
Date of this Attack, June 22nd 1896
Duration, — 2 Days —
No. of Attack, 2nd
No. of Admissions, 2nd
Age First Attack, about 20 -
Time of Leaving, July 29 - 1896
Time in Hospital, 1 mo 5 da.
Result, Improved. Discharged Nov. 10'96.

EXAMINATION ON ADMISSION.

Early Dr. Herzog 6/25/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, slightly confused and
Quick or Sluggish, sluggish
MEMORY:
Past Events, fair, but not very fact
Recent Events, " so -
Special Subjects,
PERCEPTIVITY:
Alert or Dull, somewhat dull
Correct or Illusive, correct
REASONING POWER:
Ordinary Subjects, slow
Own Mental State, does not realize
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Patient neither drinks nor smokes: occupation farmer. Physical condition is considerably impaired: has lost sleep: is a confessed masturbator: has recently been of low mental grade: not perfectly right at times, since last attack & now restlessness increased. Says "the Spirit moves him" & he talks in a most mystical manner: says "all his doings are controlled by the Spirit". —

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, slightly exalted
Depressed,
DELUSIONS:
Systematized or Not, unsystematized
Special Subjects,
Transitory or Not, fixed
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Franklin E. Clason

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4½ WEIGHT, 127 lbs. NUTRITION, somewhat impaired
WOUNDS OR ABNORMALITIES, (See Sketch)
TONGUE, Tremors, — Coatings, heavy fr. thick fine Fr. coat Promptness Movement, prompt
PUPILS, Equality, Yes Size, slightly contracted
Response Light, excessive Accommodation, excessive
SIGHT, Good
HEARING, — Do —
COORDINATION, Arms, fair: usual test
Legs, fair " "
TREMORS, Hands, Yes Tongue, quite marked
Facial Muscles, Tight about mouth General, no
REFLEXES, Patellar, ½ : equal
Other
ARTICULATION,
Slurred,
Hesitating, Yes, with a "Yankee Drawl"
FACIAL EXPRESSION,
SENSIBILITY,
HEART, slight mitral murmur 1st sound 2nd pulmonic sound sharp: strength sound somewhat weak.
LUNGS, apex beat 6th interspace ¼ in. to right of nipple marked epigastric pulsation rapid & somewhat irregular
Lungs & pansion good.
OPHTHALMOSCOPIC EXAM.,
EXAM. URINE,
TAKEN,

HABITS, Dirty, Recent Past Clean, Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, ~~Good~~, has been fair Medium, Poor,
SLEEP, Good, Poor, Irregular, has been broken
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Probably long ONSET GRADUAL OR SUDDEN, gradual
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or ~~Pat.~~ Relations, patient says not intemperate
Brothers or Sisters, one brother here

Personal and Medical History of *Franklin E. Elason*

1896

This patient was brought here by Sheriff C. Stewart & attended by C. Nye & C. Stevens, with following history. Patient is in fair physical condition. There is no history of consanguinity. C. brother is here now, insane. This is not 1st attack: he had one attack about 4 years ago, of 3 months duration, when he was at this (Rochester) Hospital: treatment was beneficial. First Symptoms of this attack were manifested June 22/96 by irrational acts: wandering about at night. Disease seems increasing; variable & with rational intervals: but these not regular. Derangement now shown by religious delusions. Patient is not dirty & injures others: nor suicidal nor filthy nor destructive in habit. No peculiarities had been previously shown. There is no history of intemperance in parents or self, nor of any severe disease or head injury. Supposed cause of the Disease is "La Grippe". Got any treatment from this time.

Note× On personal Examination, he refuses to answer questions. Complains of a "bad feeling" in the top of the head. ×Note — The records here (Vol 18 Page 316 No. 2944) show that Patient was here before, from Feb 17/92 to June 5/92: at then coming, denied his name: assumed a name: had a restless, frightened manner: denuded himself: showed delusions on religious subjects & a tendency to acute delirious mania: would not talk much: was quite wild, at times & sometimes destructive: lay in bed, the greater part of time. Was got up & dressed about March 14th, but, subsequently, was up & down from his bed, for a week or so: still held various & strange delusions. During April he commenced to improve: During May, he made steady gain in physical health & a corresponding improvement in mental condition: more coherent & rational: talked freely, & pleasantly: and was, apparently, free from delusions & in this condition was taken home, by father.

June 24 On admission, was put on P.3 (G.St.N.R.Ft.) Complexion light: hair sandy: eyes blue: condition of
" 25 skin good: no marks, scars or bruises noticed: is clean: behavior good). June 25/96. Slept only 1 hour,
last night: was restless & uneasy. Has delusions: Says he can live without food: stares in a stupid
" 26 manner, at different things. June 26/96. Slept 3 hours, last night. Made several attempts to elope, while
" 27 out of doors: says "it is God's will that he should run away". June 27/96. Slept 4 hours, last night.
Is restless & nervous: tries to escape quite frequently, while out of doors: appears to grow stupid, of late.
" 28 Talks a little. June 28/96. Slept only 3 hours, last night. Bowels in good condition. Eats fairly well:
Is very restless. Stares into space, a great deal, while out doors: says "he is studying the universe".
" 29 June 29/96. Slept only 4 hours. Habits are neat & clean. Tries doors on hall, frequently, to see if
" 30 he can get out. Appears to perspire quite freely. June 30/96. Slept only 4 hours: no change noted.
says "he must get out of here". Needs constant attendance, while out of doors. Is dull & stupid.
July 1 July 1/96. Slept only 4 hours last night. Behavior more quiet & contented, today: is restless. Quite
" 4 dull & stupid. July 4/96. Sleeps only 4 to 5 hours, nightly: appetite fair: will, occasionally, skip a meal:
bowels in good condition: Physical condition good: patient talks occasionally, in a slow
precise manner, when any questions are asked of him. Remembers any friend, who may happen
to speak to him: is quite easy & restful: while out of doors, sits down by side of nurse & remains
" 5 there, until he returns toward. July 5/96. Behavior good: Patient is stupid & dull, most of the
time: while on ward, stares in a dazed way, at some object, for an hour at a time. (Slept 8 hours
" 7 last night. July 7/96. Slept 6 hours: appears brighter, today: talks rationally: is quiet & more contented.

Personal and Medical History of *Franklin E. Elason*

1896

July 8 July 8/96. Slept 6 hours last night: patient considerably improved, during past 2 days: is a little stupid,
but talks rationally. Summary: During first week, patient was very restless & uneasy; tryed to elope,
at every opportunity: of late, became more quiet & during past several days, has seemed to improve much: Phy-
-sical condition good, though is not in very good flesh. Patient's Mental Condition improved much, of late:
N.H. Notes July Sub-acute mania, combined with considerable defectiveness: ideas of a sexual & religious nature:
mystical: Considerable improvement in behavior, as well as physically:
29/97 Notes by Dr Phelps (Summary Nurses Notes.) Notes during Month of July show patient
visited by father: Improved steadily & was taken home today in quite good
condition: Forward last was cheerful & rational & willing in every way.

Discharged.

Personal and Medical History of John Brown

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4428.
Residence, St Paul. Minn.
Date Admission, 24th June 1896.
Admitted by Dr Phelps Hour, 7 P.M.
How Sent, G. Willrich, Jail. Ramsey County
Sex, Male
Age, 37.
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Baker
Degree Education, Common School
Profession Religion, Yes: Roman Catholic.
Habits, Not intemperate
Nativity, Germany: (Parents also born there).
Physicians Committing, J. O'Hage & J. A. Quinn
Correspondents, M. Hollenitsch (Bro-in-law)
1448 La Fond St. St Paul

No. for Year, 256.
Insane Relatives, None
Cause Exciting, not given
Cause Predisposing, Chronic
Form, Dementia primary.
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not
Date of this Attack, when 14 years old
Duration, about 23 years
No. of Attack, not 1st: at times, for 10 years.
No. of Admissions, 1st
Age First Attack, about 14
Time of Leaving, Aug. 7. 1896.
Time in Hospital, 1 mo. 14 d.
Result, Discharged Feb. 3 '97. Unimproved.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exd by Dr Herzog June 25/96.

MENTAL ACTIVITY:
Clear or Confused, Clear
Quick or Sluggish, Quick
MEMORY:
Past Events, Good
Recent Events, — do —
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert.
Correct or Illusive, Correct
REASONING POWER:
Ordinary Subjects, Fairly good
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm, Normal
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects, None noted
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:
Has been treated by injections for Syphilis & salivated: Diagnosis based on the tinea versicola - He a cook patient is a fairly well-nourished man: undersized & prematurely bald, with a decidedly Hebraic cast of Countenance. He is fairly bright & has made good wages as a cook. He speaks freely & shamelessly of his perverted sexual life. He is an active & passive Sodomist: has practised solitary & mutual masturbation & both active & passive oral masturbation. Says he has desire for women but has not had intercourse for many years. Has desire for men since 15 years of age. Is unable to give any reason for his arrest. Says he was accosted by an officer who led him into a position & then arrested him —

Personal and Medical History of John Brown

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2 in WEIGHT, 125 pds. NUTRITION,
WOUNDS OR ABNORMALITIES, Tinea versicolor on chest: deformity from Colle's fracture right wrist.
TONGUE, Tremors, Condition of skin somewhat greasy Coatings, Dirty white coat Promptness Movement, Prompt —
PUPILS, Equality, Yes Size, Slightly Contracted.
Response Light, Excessive Accommodation, Excessive
SIGHT, Good
HEARING, Impaired
COORDINATION, Arms, Good — by usual tests
Legs, — Do — " " "
TREMORS, Hands, Slight Tongue, Slight
Facial Muscles, No General, No
REFLEXES, Patellar, 10 - Equal EXAM. URINE,
Other
ARTICULATION,
Slurred, Yes & Lisps
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Murmurs, None
Strength Sounds Good - regular
Arteries Good
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,	Yes & Regular	Constipated,	Irregular,
APPETITE, Good,		Medium,	Poor,
SLEEP, Good,		Poor, Has always been 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,
None brought out

Personal and Medical History of John Brown.

Personal and Medical History of

1896

This patient was received here at the hands of Sheriff's Deputy, Mr. Liberson, with the following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is not 1st attack. He has had them, at times, for 10 years. Duration of each, not given. When 14 years old, was fond of boys & men, adverse to society of females. Is a sexual pervert. Is now, addicted to unnatural sexual crimes with other men. Is not disposed to injure others. Not suicidal. Not destructive in habits. No penitentiaries & has been previously known. There is no history of intemperance in patient or self, nor of any severe disease &c or head injury. He has served a Work-house term. Cause of disease not given. Has had no treatment.

June 24 On admission, was put on B³ (G.H.N. Rpt. Complexion dark: hair black: eyes brown: condition of skin good: large number of dark spots on skin, over chest. Is clean. Behavior is good)

" 25 June 25/96. Slept 7 hours last night. Is on regular diet: appetite good: bowels in good condition: behavior

" 26 good: patient seems rational: no delusions noticed: apparently in quite sane. June 26/96 Slept 7 hours.

" 30 Behavior good: out on grounds: appears perfectly rational. June 30/96. Sleeps 6 to 7 hours nightly. Patient is quiet & apparently cheerful & contented: works in dining-room: habits neat & clean: makes

July 1 no complaints as to physical condition: talks rationally: July 1/96. No change noticeable. -

" 8 July 8/96 During this the 2nd week, patient has been sleeping 6 to 8 hours each night. Takes considerable interest in his surroundings. Is quiet & contented. Behavior good. Talks rationally: mental condition apparently sound. Summary: Patient, as stated, has been quiet, cheerful & contented, during past 2 weeks: working on ward & appearing interested in his surroundings. Physical condition good: no delusions or hallucinations noticed. (Dr. H. notes: aside from sexual perversion there is little noticeable, beyond a slight dullness).

Aug 7/96 Summary Nurses Notes by Dr Phelps. Patient went home today. Was a quiet retired man, rather dull in appearance. Did not read or seem to take any interest in current events. Seemed slightly feeble-minded. No active delusions or ideas noted. Behavior had been quiet during all of stay.

Discharged

Personal and Medical History of Petur Pegachunk / Pegatchnick

HERBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No.	4430.	No. for Year,	258.
Residence,	St Joseph, Stearns Co. Minn	Insane Relatives,	Unknown
Date Admission,	26th June 1896.	Cause Exciting,	Epilepsy "Chronic"
Admitted by	Dr. Herzog Hour, 6:45 PM	Cause Predisposing,	
How Sent,	G Willrich, Jail Ramsey County	Form,	Dementia epileptic.
Sex,	Male	Accompanying Bodily Disorder,	Epilepsy following injury to head.
Age,	- 53 -	Suicidal or Not,	Not suicidal, but homicidal.
Civil Condition,	Widower	Date of this Attack,	Sudden attack of mania, June 8th
Children,	3	Duration,	about 8 days
Age Youngest Child,		No. of Attack,	1st
Occupation,	Farmer	No. of Admissions,	1st (has been in 6th. Hosp. St Paul)
Degree Education,	Common School	Age First Attack,	63 (?)
Profession Religion,	Yes. Catholic	Time of Leaving,	Mar. 25. 1898
Habits,	Unknown	Time in Hospital,	1 yr. 8 mo. 29 da.
Nativity,	Illyria, Austria. (Parents Same).	Result,	Discharged Mar. 25. 1898 Improved.
Physicians Committing,	John B. Brimhall & G Sweeny		
Correspondents,	John (Joseph) Notsch, St Joseph Minn Brother in Law		

EXAMINATION ON ADMISSION.

Exd by Dr. Herzog 6/27/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:		EMOTIONAL STATE:	
Clear or Confused,	Confused	Normal, Calm,	
Quick or Sluggish,	Sluggish	Indifferent,	
MEMORY:		Exalted,	
Past Events,		Depressed,	Depressed: stupid
Recent Events,	None	DELUSIONS:	
Special Subjects,		Systematized or Not,	None noted.
PERCEPTIVITY:		Special Subjects,	
Alert or Dull,	Dazed: Dull: extreme dullness	Transitory or Not,	
Correct or Illusive,	Does not understand.	HALLUCINATIONS:	
REASONING POWER:	None	ILLUSIONS:	
Ordinary Subjects,		CONVERSATION:	
Own Mental State,		Coherent or Incoherent,	
Special Subjects,		Voluble or Reticent,	

GENERAL DESCRIPTIVE REMARKS:

Am unable to find depression in skull, mentioned in Commitment. Evidently history of epilepsy is correct, with mania following & present confusion. Confusion is quite marked. Understands slightly, when asked to do something but only speaks single irrelevant words.

John. Pegatchnick

June 30/96

Joseph Notsch (brother in law)
St. Joseph
Correspondent Stearns Co
Minn

St Cloud, June 1/96

Ven. Sr. Superioress:

Mr. John Pogatschnik told me about his adventure down there in the home of the poor. He was requested to leave your place by his brother. He feels sorry he did so. He humbly asks to be readmitted. Will you please have the kindness to receive him once more? If you do, you will greatly oblige

Your friend in Christ
Rev. Ildefonsus Stolz OSB
Rector
of the Im. Conc. Church

PITAL, Reg. No.

Interne H.P.R.
p.m. June 1 1896
Height Weight
apps & whiskey
Skin Eruptions, Oedema, Deformities,

tution. No evidence
on forehead and upon
Metatarsal & index finger
brought to hospital
rs. Came from St. Joe Minn

epileptic attacks since 1882, every
ometimes lasts only two hrs but generally
k. at a time. Gives history of accident
of horses. Had injury to head but
termine depression or left middle

apoplexy
d Epilepsy. F. dead 16 yrs.
ving previously good health.

ded to go to "Little Sisters of Poor" in
going to St. Cloud. From St. Joe
s not remember getting on train
he suddenly dashed head through
do. Glass taken off train at
ed, but immediately tore off
whole trip to St Paul and when
ditim all day and night.

Born Rathmansdorf, Illyria, Austria (Bohemia) in 1833. - Came to America in 1854
Married in 18 at St Joseph Minn - Had 12 children, 9 dead. Three children here

Nurse
Interne
Remarks
Service
Transfer
Died
Eloped
Discharged
Born
Admitted
Operation
Diagnosis
Name
Reg.

Brothers or Sisters,

Personal and Medical History of Johan Pegac... Pogat...

BORGERT, FICKLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No.	4430.
Residence,	St Joseph, Stearns Co. Minn
Date Admission,	26th June 1896
Admitted by	Dr. Herzog Hour, 6.45 PM
How Sent,	G Willrich, Jof P. Ramsey County
Sex,	Male
Age,	- 63 -
Civil Condition,	Widower
Children,	3
Age Youngest Child,	
Occupation,	Farmer
Degree Education,	Common School
Profession Religion,	Yes: Catholic
Habits,	Tobacco
Nativity,	Illyria, Austria (Parents Same)
Physicians Committing,	John B Brimhall & J Sweeney
Correspondents,	John (Joseph) Rotsch, St Joseph Minn
Brother in Law	

No. for Year,	258.
Insane Relatives,	
Cause Exciting,	6
Cause Predisposing,	Hereditary
Form,	Dementia epileptic
Accompanying Bodily Disorder,	Epilepsy following injury to head.
Suicidal or Not,	Not suicidal; but homicidal.
Date of this Attack,	Sudden attack Illness, June 15th
Duration,	about 8 Days
No. of Attack,	1st
No. of Admissions,	1st (has been in 686. Hosp. St Paul)
Age First Attack,	63 (?)
Time of Leaving,	Mar. 25. 1898
Time in Hospital,	1 yr 8 mos. 29 da.
Result,	Discharged Mar. 25. 1898 Improved.

EXAMINATION ON ADMISSION.

Exd by Dr. Herzog 6/27/96.

MENTAL CHARACTERISTICS.

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

MEMORY:
- Past Events,
- Recent Events, None
- Special Subjects,

PERCEPTIVITY:
- Alert or Dull, Dazed: Dull: extreme dullness
- Correct or Illusive, Does not understand

REASONING POWER:
- Ordinary Subjects, None
- Own Mental State,
- Special Subjects,

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

DELUSIONS:
- Systematized or Not,
- Special Subjects,
- Transitory or Not, None noted.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
- Coherent or Incoherent,
- Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:

Am unable to find depression in Skull, mentioned in Commitment. Evidently, history of epilepsy is correct, with mania following & present confusion. Confusion is quite marked. Understands slowly, when asked to do something but only speaks single irrelevant words.

THE CITY AND COUNTY HOSPITAL,

Reg. No.....

ST. PAUL, MINN.

CLINICAL HISTORY SHEET.

Service of Dr. Sweeney Pogatschnick Dept. Neurological Interne H.P.R.

Name John Pegachnick Admitted, Born, Hour 7.45 a. m. p. m. June 19 1896

Age 64 Sex Male Color W. Nativity Polander Illyria Austria Height Weight

Occupation Farmer Habits Drinks some schnapps & whiskey

...ime of admission—Mental and Physical—Alcoholism, Injuries, Scars, Skin Eruptions, Oedema, Deformities,

Ven. Sisters of the Poor

St. Cloud, June 17-96

Ven. Sr. Superioress:

Mr. John Pogatschnick told me about his adventure down there in the home of the poor. He was induced to leave your place by his brother. He feels sorry he did so. He humbly asks to be readmitted. Will you please have the kindness to receive him once more. If you do, you will greatly oblige

Your friend in Christ
Rev. Ignatius Stahl OSB
Rector
of the Im. Conc. Church

bodily good nutrition. No evidence cial cuts upon forehead and upper oedema or. Mutilations of underexplorer dition. When brought to hospital this state 40 yrs. Came from St. Joe Minn.

epileptic attacks since 1882. every sometimes lasts only two hrs but generally k. at a time. Gives history of accident horses. Had injury to head but termine depression on left middle

apoplexy
d Epilepsy. F. dead 16 yrs.
ving pt would good health.

ded to go to "Little Sisters of Poor" in going to St. Cloud. from St. Joe s not remember getting on train he suddenly dashed head through do. Was taken off train at ed. put immediately into ff whole trip to St Paul and when ition all day and night.

Born Rathmansdorf, Illyria, Austeria (Befet) in 1833. - Came to America in 185
Married in 18 at St Joseph Minn - Had 12 children, 9 dead. The three children live

Nurse
Interne
Remarks
Service
Transfer
Died
Eloped
Discharged
Born
Admitted
Operation
Diagnosis
Name
Reg. No.

Father or Pat. Relations,

Brothers or Sisters,

Unknown

245

Personal and Medical History of Pot

EGBERT, PIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4430.
Residence, St Joseph, Stearns Co. Minn
Date Admission, 26th June 1895.
Admitted by Dr. Herzog Hour, 6 45 PM
How Sent, G Wilbrich, Jof P Rann
Sex, Male
Age, 53
Civil Condition, Widow
Children,
Age Youngest Child,
Occupation,
Degree Education,
Profession Religion
Habits,
Nativity,
Physicians
Correspondents,
Brother in Law

(St. Paul)

8
ay da.
e. 45. 1898

Exd by Dr. Herzog 6/27/4

MENTAL ACTIVITY:

Clear or Confused, Confused
Quick or Sluggish, Sluggish

MEMORY:

Past Events,
Recent Events, None
Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dazed: Dull: extreme dullness
Correct or Illusive, Does not understand

REASONING POWER:

Ordinary Subjects, None
Own Mental State,
Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

Am unable to find depression in Skull, mentioned in Commitment. Evidently history of epilepsy is correct, with mania following & present confusion. Confusion is quite marked. Understands slowly, when asked to do something but only speaks single irrelevant words.

SION.

AL STATE:

mal, Calm,
Indifferent,
Exalted,
Depressed, Depressed: Stupid

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
None noted.

HALLUCINATIONS:
ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Sheet No.....

THE CITY AND COUNTY HOSPITAL, Reg. No.....

ST. PAUL, MINN.

CLINICAL HISTORY SHEET.

Service of Dr. Surgery Pagatchnick Dept. Neurological Interne H.P.R.
Name John Pagachuck Admitted, Born, Hour 7 45 a. m. p. m. June 19 1896
Age 64 Sex Male Color W. Nativity Polander Illyria Austria Height Weight
Occupation Farmer Habits Drinks some schnapps & whiskey

Condition at time of admission—Mental and Physical—Alcoholism, Injuries, Scars, Skin Eruptions, Oedema, Deformities, Previous Illness, Family History, Etc., Etc.

(A) General Remark: In general bodily good nutrition. No evidence of alcoholism. Has some superficial cuts upon forehead and upon dorsum of right hand. No oedema or. Metatarsal of index finger & middle finger of right hand dislocated. Mental condition when brought to hospital bad raving & delirious. Has been in this state 40 yrs. Came from St. Joe Minn.

(B). Previous Illness. 1. Has had Epileptic attacks since 1882. every week but only twice in daytime. Sometimes lasts only two hrs but generally much longer. Does not sleep for a wk. at a time. Gives history of accident when was knocked down by team of horses. Had injury to head but would not describe it. Palpating, determine depression on left middle parietal bone.

(C). Social History: Says father had Epilepsy apoplexy. F. dead 16 yrs. Mother died two yrs ago, enjoying periods of good health.

(D). Evolution of Symptoms: Intended to go to "Little Sisters of Poor" in St. Paul to get work. Remembers going to St. Cloud from St. Joe & St. Paul. to get work. Remembers getting on train & cured his knee in St. Paul but does not remember getting off train. His said, that while on train, he suddenly dashed head through window, inflicting scalp wounds. Was taken off train at Clearwater and had head dressed. Put immediately bore off bandages. Was maniacal during whole trip to St Paul and when brought to hospital was in that condition all day and night.

Born Rathmansdorf Illyria, Austria (Bohet) in 1833. - Came to America in 1855 Married in 18 at St Joseph Minn - Had 12 children, 9 dead. Three children live near St Joseph -

Personal and Medical History of John Pegactuick

Personal and Medical History of John Pegactuick

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 11½ WEIGHT, 159 lbs. NUTRITION, fairly good

WOUNDS OR ABNORMALITIES, 3 cuts on forehead: sutured: skin somewhat greasy:

TONGUE, Tremors, — Coatings, clean Promptness Movement, slow

PUPILS, Equality, Yes Size, slightly dilated

Response Light, slow Accommodation, slow

SIGHT, seems fair.

HEARING, seems impaired

COORDINATION, Arms, some impairment: } usual tests fail: uncertain gait -

Legs, — " — }

TREMORS, Hands, none Tongue, Yes

Facial Muscles, no General, no

REFLEXES, Patellar, 2 - 3: slow EXAM. URINE,

Other —

ARTICULATION,

Slurred, slow

Hesitating, Yes

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Murmurs, none - strength sound good: regular: arteries somewhat stiff

LUNGS,

Expansion Good

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,	Recent Kept	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, Unknown

Brothers or Sisters,

J. Pogatchnick

Joseph Notch, St Joseph Minn } brother in law

Register No.

Diagnosis and Complications,

Personal and Medical History of John Pegachuck

1896

This patient was brought here by Deputy Sheriff Charles Reichow with following history. Patient is in fair physical condition. There is no history of consanguinity. This is 1st attack: he has been in C & C Hospital, St Paul, for a week, strapped to bed & wound of head treated there. First symptoms were manifested by a sudden attack of mania June 18th. The Disease appear to be stationary; variable & with rational intervals, but how these occur is unknown. Derangement now shown by General violence and mania. Has threatened to kill nurse, but has not attempted suicide. No any filthy or destructive habits, insane relatives, previous peculiarities, if addicted to intemperance &c, also unknown. Patient has had epilepsy since 1882, following injury to head. Has been confined restrained as above. Supposed cause of the Disease is Epilepsy. Patient has had no treatment. —
(See letter to Little Pieters & the Poor & Clinical History Sheet, both attached)

June 26 On admission, was put on B3 (G.H.N.P.P.). Complexion dark: hair gray: eyes blue: condition of skin good: scars on forehead with 4 stitches in it: bruises on right leg above ankle.
" 27 In Dority: behavior good). June 27/96. Slept 7 hours, restless 2 hours, last night. Mental condition appears stupid & dull: he talks some & quite rationally: behavior good. On regular diet: appetite good.
" 28 June 28/96 Slept 8 hours, last night: bowels in good condition: out on grounds daily: Does not like to behave, says "he wants to do some work outside". June 29/96. Slept only 4 hours, last night. Talks rationally. Makes no complaints as to physical condition. Ordered Bromides, 3 times daily: says "he does not want the Bromide, as he never took any fit before". June 30/96. Slept only 4 hours. Mental activity slow. It is quite difficult for him to understand: is stubborn at times: says "he does not belong here".
July 1/2 July/96. Slept only 4 hours, last night. Behavior stubborn & cranky. Refuses medicine. July 2/96. Slept 4
" 3 hours. Still rather stupid: Mental faculties slow & sluggish: Physical condition good. July 3/96. Slept 8 hours.
" 4 No change noted. July 4/96. Slept 5 hours: about as usual: no complaints as to physical condition.
" 10 July 10/96. Since last noted, has been sleeping 4 to 6 hours, nightly. Appetite good: bowels in good condition. Seems doing well. Summary: Patient is quiet: physical condition good, apparently. He is
Aug 1/96 quite stubborn, at times. Is subject to epileptic fits, but has had no attack since he has been
to here. Mental condition is stupid, though not to a great extent: mental activity sluggish.
May 1/97 Summary Nurses Notes by Dr Phelps Patient is an epileptic having fits rather infrequently but being quite dull mentally & having frequently ideas of being imposed upon, at times amounting to delusions of persecution thinks especially that he is kept from sleeping. Has grown somewhat more fleshy during year & is in fairly good health.
May 1/97 Patient continually complaining of inability to sleep. Very cranky in complaints
Wt. 180 June 1/97 Patient noted as taking everything he can lay his hands on.
in a kleptomaniac sort of way. Aug 31/97 Noted as having been
at times quite ill-tempered & obstinate & somewhat troublesome in
this way. Oct 15 Patient still the same. Has occasional convulsions:
Complains a good deal of being unable to sleep. Has been recently
transferred to B1. on account of having struck nurse with chair.
Nov. 4 Noted as having convulsions quite frequently & as being quite forgetful

Personal and Medical History of

afterward. Mch 25 Visited by brother who took him home. Patient has been quite disturbed ward of late & at times had to be held on account of stubbornness & irritability, especially after convulsions.
May 31/97 Wt. 180 Oct 31/97 Has numerous convulsions; at times very irritable and complaining. Mch 25/98 Visited by brother who took him home. Patient has a fair degree of intelligence but is quite feeble in all his judgments and full of delusions ideas and complaints: is rather obstinate & hard to care for

Discharged.

Personal and Medical History of William A. Colby

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 44431.
Residence, Afton, Minn.
Date Admission, 26th June 1896.
Admitted by Dr. Herzog Hour, 7:30 P.M.
How Sent, Herman Blackmer, Jo P. Redwood County
Sex, Male
Age, 32.
Civil Condition, Married
Children, 3
Age Youngest Child,
Occupation, Baker
Degree Education, Moderately educated
Profession Religion, Not a church member.
Habits, Not intemperate.
Nativity, Denmark: (Parents also born there)
Physicians Committing, G. W. Earck and J. M. Todd.
Correspondents, Charles Jurgenson (bro-in-law) Albert Lea Minn

No. for Year, 259.
Insane Relatives, None
Cause Exciting, Nothing discoverable, except overwork
Cause Predisposing, not given
Form, Mania acute
Accompanying Bodily Disorder, Stricture, & cystitis & consequent weak.
Suicidal or Not, — Not —
Date of this Attack, about 4 weeks ago
Duration, — about 4 weeks —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 32 —
Time of Leaving, Aug. 20 96.
Time in Hospital, 1 mo. 25 days
Result, Died. Exhaustion in Acute Mania

Ed by D. H. Herzog 6/27

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused (very).
Quick or Sluggish, sluggish & wandering.

MEMORY:
Past Events, Recent Events, Special Subjects, — mostly obliterated, to all events rarely answers questions: wanders in mind: occasionally mentioning pat: nothing reliable

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

REASONING POWER:
Ordinary Subjects, Can do no logical reasoning.
Own Mental State, Sense "well-being" — vague.
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, slightly exalted.
Depressed,

DELUSIONS:
Systematized or Not, Unsystematized.
Special Subjects, and
Transitory or Not, Transitory.

HALLUCINATIONS: ? — none of any
ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:
Patient is seemingly by some good evidence a dissipated man. Quite probably had syphilis: Seems to have been ordinarily able, but with some prodromal motor Symptoms, during the past months an outbreak, quite sudden 2 weeks ago. One week ago, said he fell — a suggestion of pneumonia at this time — Evidence now indicates the excited Stage of General paralysis. Beside the stricture no history of bodily illness is yet obtained.

Personal and Medical History of William A. Colby

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, 117 pds. NUTRITION, Very Considerably impaired.
WOUNDS OR ABNORMALITIES, None noted: Pubic lice: 2 abrasions on right knee: slight: Slight hernia on L Side.
TONGUE, Tremors, — Coatings, Slight black-yellow (right) - Skin fairly clean: Some dryness, Promptness Movement, Slow in response
PUPILS, Equality, Rt. slightly larger Size, — Dilated - lids droop -
Response Light, respond slowly Accommodation, respond slowly -
SIGHT, —
HEARING, —
COORDINATION, Arms, Gross
Legs, gross: Standing on one foot, can't do it: Turning quickly, Staggers always about.
TREMORS, Hands, Semulous Tongue, Coarse tremors
Facial Muscles, No General, only in standing.
REFLEXES, Patellar, O. in ordinary test. EXAM. URINE,
Other Doubtful on reinforcement.
ARTICULATION,
Slurred, slightly, at times.
Hesitating, Jerky - sluggish, hesitating
FACIAL EXPRESSION, Same, usually. Slow. Rt & Lt sides at times then action

Cranial measurements (including hair & scalp).

Circumference (horizontal)	57
Circumference (vertex - mental)	64½
Naso, occipital arc	35½
Bicauricular arc	33½
Ant - post diameter	18.6
Transverse diameter	15.1
Bicauricular diameter	13.
Facial length	11.6

SENSIBILITY,
HEART, No Murmurs Detected
Strength Loud, fairly strong - apex beat in 5th Inter Space - ½ in. to L of Nipple line Sounds feeble - Arteries apparently good
LUNGS, Resp. Rapid & Slight -
Struggled during examination of lungs & heart
TAKEN,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless, Was drinking man. One of the boys.
BOWELS, Normal, Constipated, Habitually. Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, ~~Good,~~ (For 2 weeks) very Poor, by of late Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, 2 weeks ago, though some prodromal symptoms: history accompanying States & appearance suddenly sudden: had prodromal symptoms — The Beard in front was noted - No trouble in walking was noted.
ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters, Brother Denied.
Prominent Diseases &c none noted.

Personal and Medical History of William C. Colby.

This patient was brought here by Deputy Sheriff E. H. Ellickson, attended by Victor Colby, with following history. Patient is in fair physical condition. No history of any Consanguinity. This is 1st attack: symptoms manifested about 4 weeks ago: began to have aberrations: the disease appears to be increasing: is fairly rational, at times: but these not at regular intervals. Derangement now shown in that he imagines himself immensely wealthy: During last 48 hours, fears attack or harm. Is not disposed to injure others: no suicidal: very little disposition to filthy or destructive habits. No insane relatives: he has been somewhat peculiar for some few months: There is no history of intemperance in parents or self: no of any severe disease &c or head-injury. Has been in hospital 2 weeks: As to cause of the disease, nothing discernable, except overwork. Has been treated by nerve sedatives & tonics. Patient now is Emaciated, weak: has stricture and cystetis: _____

June 26 On admission, was put on T.W. (G.H.N.Pt. Complexion fair: hair dark brown: eyes brown: Condition of skin good: has a few pimples on back: is clean: Excited and noisy). Was given bath & put to bed. Talks irrationally & incoherently: delusions are innumerable. Pulse 120 R 28 T 101.4

" 27 June 27/96. Restless & noisy, all night: slept none. On regular & extra diet: refused breakfast: took a fair dinner: was fed, at supper time. (Is troubled with Crabs: blue ointment applied) Behavior unchanged, today: had trouble in keeping him in bed. 7.00 Pm. Enema: bowels then moved twice.

" 28 8.30 became unmanageable: was placed in restraint-Sheet. June 28/96. Slept only 3 hours, last night. Restless & noisy all day (Out of restraint at 8 Am). Refused meals: was fed by tube: had trouble in keeping him in bed: says he is King of Denmark, & President of the U.S. & has a right to do as he pleases.

" 29 June 29/96. Slept 6 hours, last night. Refused breakfast: ate fair dinner & light supper (was fed).

" 30 Very restless & talkative, all day: out of bed & out in hall, a number of times. June 30/96. Noisy, all night: behavior the same as during day: slept none. Very restless, & noisy, all day: Continually out of bed & inclined to be pugnacious. Bowels move. Refuses some meals & has to be fed by tube.

July 1 July 1/96. Slept 6 hours, last night: very restless, all day & night: out for a walk, a little while, this Pm. Appears very weak. July 2/96. Slept none, last night. Very restless & noisy, greater part of day & night & still inclined to be pugnacious, at times. Again, out for a walk this Pm

" 3 (Slept 4 hours, 3.00 to 7.00 Pm): was given bath. July 3/96. Slept only 2 hours, last night. —

" 4 Slightly noisy, part of night: has been slightly noisy, all day: out for a walk, this Pm. July 4/96. Slept none, last night. Is somewhat quieter, today. Eats fairly well. Still talks irrationally, & has all kinds of delusions. Physical condition about the same. July 5/96. Slept 7 hours, last night. Slightly

" 6 noisy, all day. Out for a walk, this Pm. July 6/96. Noisy part of night, but slept 8 hours. Patient

" 7 does not seem to improve any, physically or mentally. July 7/96. Noisy part of night: slept 8 hours. very restless, part of night. Very restless, all day. Talks most of time & very irrationally. Out for walk this Pm. Bowell moved. July 8/96. Slept 3 hours: slightly noisy most all day (& part of night): there appears

" 8 to be no change. Out for a walk, a little while, this afternoon. Ate a fair breakfast & fed): took good dinner & good supper. July 9/96. Slept only 2 hours, last night. Still very restless & continually talking to self-

" 9 Talks very irrationally. Inclined to be pugnacious. Given bath. July 10/96. Slept only 3 hours, last night.

" 10 restless, most of night. Very restless, all Day. Appears about same, from day to day. July 11/96. Slept only

" 11 3 hours, last night. Summary. Was received on ward, in a very excited condition: was

Personal and Medical History of William C. Colby.

July 11 Summary (Cont'd) quiet both & put to bed. Shows all kinds of delusions: has talked very irrationally & incoherently: as above stated, was placed in restraint Sheet, for a time: he talks most all the time & is inclined to be pugnacious, at times. Has to be fed by nurse & at times, requires 3 to feed him & also to take Temperature. (Temp. usually under 100°). Bowels very irregular. Is taken out for a walk nearly every afternoon. Sleeps, on an average, 3 hours. Physical & mental condition appear about the same, as at first.

July 13/96 Summary Nurses Notes by Dr. Phelps. Patient a very restless case. Was taken out for a walk but was quite troublesome: Talk is incoherent & irrational & is rather maniacal in behavior. July 21 Temperature has been taken regularly - it was once as high as 100°, but is usually normal. Patient is restless & maniacal & inclined to fight. Talks in a rambling way. July 31 Temp. has been about normal all of the time. Was visited by Mrs yesterday: Has been usually quite restless: Is kept in bed most of time, as he has been exercised some. Sleeps very poorly & yet it is hard to keep him in bed. Aug 7 Patient has improved some: Temp. 2 to 3 subnormal. Very restless & disturbed & it is hard to control him. Has been up on ward some: Has been on special diet, baths, exercise, etc. Aug 10 More quiet but is growing rather more weak. Aug 14 Patient can be taken up & out of doors every day. Appears, however, to be growing weaker. Temperature has been as low as 96°. Aug 15 Kept in bed all day: Quiet & quite weak. Temp. 96° Am. 96 Pm. Aug 16 Am. Temp. 97 Pm. 96°. Seems to be steadily failing. Aug 17 Was catheterized. about 3 qts. Taken away: very weak. Aug 18 Patient again very much bloated: egg nog given in small quantities. Aug 20 Died. Notes in this case show steady physical failure without rise of temperature. There was an exhaustion somewhat like that of General Paresis on our first examination. Paresis seemed possible. Later, however, it was rejected. Sub-normal temp. shows possible trouble with kidneys.

Died

Personal and Medical History of Isadore Lehman

EBBERT, FIDLAR & SHAWCROS, DAVENPORT, IOWA.

Whole No. 4432.
Residence, Austin, Minnesota
Date Admission, 27th June 1896 —
Admitted by D. L. P. Eby Hour, 7 30 P.M.
How Sent, E. S. Washburn, Jo P. Mower County
Sex, Male
Age, 40 years
Civil Condition, Married
Children, — None —
Age Youngest Child,
Occupation, Travelling - Salesman
Degree Education, Educated for the Ministry —
Profession Religion, Not a church member
Habits, Intemperate in use of Tobacco —
Nativity, Race :— (Father's, Jewish Mother's, Germany).
Physicians Committing, E. S. Washburn and O. A. Legge
Correspondents, none given in Papers.

Family Phys. O. A. Legge

No. for Year, 260
Insane Relatives, Yes : Cousin
Cause Exciting, Overwork
Cause Predisposing, probably heredity
Form, Dementia Paretic
Accompanying Bodily Disorder, general Physical Derangement
Suicidal or Not, — Not —
Date of this Attack, July 1893.
Duration, about 3 years
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 37 —
Time of Leaving, 15th July 1896
Time in Hospital, — 18 Days —
Result, Died : Congestive attack in Gen. Paresis.

EXAMINATION ON ADMISSION.

Eddy D. Herzog 6/22/96.

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Exalted
Depressed,
DELUSIONS:
Systematized or Not, unsystematized
Special Subjects,
Transitory or Not, Transitory
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:
Patient is in 3° Stage of General Paresis: Extreme incoordination: grandiose ideas: much demention no definite delusions of grandeur: appears average of Convulsion: considerable prostration. No history obtainable of Syphilis: no history of Convulsion: is quite excited and noisy. Previous mental state alleged to be good. No history obtainable from patient. (Examined chest, with some difficulty).

Personal and Medical History of Isadore Lehman

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, quite good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, bright yellow coat Promptness Movement, Skin greasy Slow
PUPILS, Equality, left larger Size, both dilated
Response Light, sluggish Accommodation, sluggish
SIGHT, impaired
HEARING, — Do —
COORDINATION, Arms, much impaired: } not usual tests —
Legs, — Do — : } Can scarcely walk &c
TREMORS, Hands, Yes Tongue, Coarse & fine
Facial Muscles, twitchings about lips General, Yes: with muscular twitchings.
REFLEXES, Patellar, 10 = equal EXAM. URINE,
Other ankle clonus
ARTICULATION,
Slurred, Yes
Hesitating, Yes & slow
FACIAL EXPRESSION,
SENSIBILITY, Impaired
HEART, Murmurs: nothing definite Heart sounds weak: Imp. normal apex beat feeble: rapid: slightly irregular —
LUNGS, large moist rales over both bases —
TAKEN,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Kept 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 Isadore Lehman

1896

This patient was received here at the hands of John L. Johnson and J. E. Flood, attended by M. Arnold, with the following history. Patient is in fair condition. There is no history of consanguinity, but some, seemingly, of heredity: a cousin has been insane. This is 1st attack: first symptoms manifested in July 1893, by eye trouble. The disease appears to be increasing: is not variable: no rational intervals. Derangement now shown by general mental & physical derangement. Patient is disposed to injure others, but is not suicidal. Is filthy & destructive in habits. Has been intemperate in use of tobacco. Has not been subject to any severe disease &c or had any head-injury. Has been confined & restrained for one week. Supposed cause of disease is overwork: he has been treated by general nursing & tonics. On personal examination, we find him suffering from General Paresis & recommend the commitment because his disease is of such a nature as to require care & treatment, under restraint.

June 27 On admission was put on I.W. (Order #96). Complexion dark: hair black: eyes brown: has large blister on left heel. Is clean: Behavior excited). After being received inward, was slightly noisy & in a very nervous condition. Given bath & put to bed. Pulse 130 R 30 T 102⅘. Was put on restraint sheet at 8.30 Pm. June 28/96. Slightly noisy, most of night & slept only 2 hours. Taken out of restraint at 6 Am. appears somewhat easier. Bowels moved. Visited by friends, twice during day. Ate well, today. Heel bathed in alcohol, twice a day. Gets to bed. June 29/96. Slightly noisy, most all night. Slept only 2 hours: has been somewhat quieter during day, but slightly noisy, at times. June 30/96 Was slightly noisy 2 hours, at night & slept only 2 hours. Patient does not seem to change any. Slightly noisy during day: talks very irrationally. Eats well, as a rule: heel bathed in alcohol, twice a day.

July 1 July 1/96. Slightly noisy, part of night, but slept 5 hours. Appears some better, today: was out in chair-wagon
" 2 was given Cold-Sponge-bath at 8.20 Pm. July 2/96. Slept only 2 hours, last night. Appears lame & sore, all over body. Talks most of the day: Gets bed. Given cold Sponge-bath at 7.45. July 3/96. Slept 4 hours
" 3 last night. somewhat quieter, today. Bruised heel treated twice a day, but does not seem to improve much. (Wt, today, 142 lbs). July 4/96 Slept only 1 hour, last night. Can notice no change in patient.
" 4 Is talking in his usual manner: talks very irrationally. Still wets bed. July 5/96 Slept 6 hours, last night: slightly noisy, part of night. Slightly noisy, all day, today. Was given a cold Sponge bath
" 5 twice, today. July 6/96. Slept 4 hours, last night. Very restless, all day: seems to be losing control of
" 6 limbs, somewhat, and physical condition failing. July 7/96 Slept only 2 hours, last night. No
" 7 Change noticeable: very restless & talks irrationally. July 8/96 Slept only 2 hours, last night. Very
" 8 restless in bed & continually tearing it to pieces. July 9/96. Slept some, last night. Is in a very
" 9 restless condition: talks most of time. Seems to be failing: habits dirty. Gets bed. July 10/96. Slept
" 10 none, last night. No change, today: given cold Sponge-baths: heel treated, every day. July 11/96. Slept
" 11 4 hours, last night: slightly noisy, most of night: very restless all day. heel bathed, but does not
" 12 seem to improve much. Gets bed. Always trying to get up. Use bed-board to keep him in bed.
July 12/96. Slept only 1 hour, last night. Talks very irrationally, all day & appears to be failing.
Gets bed. Still give Cold Sponge-Baths &c. Summary. When received inward, was slightly noisy & in a very nervous condition. Put to bed: was in restraint for a while: talking most all the time & very irrationally: has delusions: has very poor control of limbs & of voice. Appetite good, but has to be fed by nurse: bowels very irregular. Temp. Pulse & Resp. mostly always

Personal and Medical History of Isadore Lehman

1896

July 12 (cont'd) Keep high. Was at times in a chair-wagon: has been given 4 cold Sponge-baths to reduce Temp.
July 13 Patient appears to be failing physically. Stools & urinates in bed. July 13/96. Slightly noisy 5 hours, slept
" 14 only 2 hours. Perspiring freely all day, & very restless. Given cold-Sponge at 7.00 Am and 9.00 Pm. Temp 104.3
July 14/96. Slightly noisy, most all night. Slept none: very restless, all day & appears to be getting weaker.
Given 3 cold sponges, today. Refused supper. 5 Pm. Temp 104. Pulse 174. Resp. Is failing fast.
" 15 July 15/96. Continued to fail rapidly & died at 12.00 o'clock, last night. (See attached record).

— Died —

Personal and Medical History of Pierre Marchand

EGBERT, FIELD & CHAMBERS, DAVENPORT, IOWA

Whole No. 4434.
Residence, St Paul Minn.
Date Admission, 1st July 1896
Admitted by Dr. P. Relf (3rd) Hour, 3.30 PM
How Sent, G. Willrich, Jr. Ramsey County
Sex, - Male -
Age, about 52.
Civil Condition, married
Children, none
Age Youngest Child,
Occupation, Physician and Surgeon
Degree Education, Classical
Profession Religion, Catholic
Habits, Intemperate & has opium habit
Nativity, Canada: (parents also born there).
Physicians Committing, J. F. Baker and A. W. Running
Correspondents, Albert P. Quesnel
Son-in-law } 93 - E 6th St St Paul

No. for Year, 262.
Insane Relatives, none
Cause Exciting, Intemperance
Cause Predisposing, Intemperance
Form, Dementia alcoholic acute
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, — not —
Date of this Attack, 2 or 3 months ago.
Duration, 2 or 3 months
No. of Attack, 1st —
No. of Admissions, 1st
Age First Attack, about 52
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Ex'd by Dr Henzog July 3/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, somewhat confused
Quick or Sluggish, sluggish

MEMORY:
Past Events, poor
Recent Events, — do —
Special Subjects,

PERCEPTIVITY:
Alert or Dull, slightly dull
Correct or Illusive, Illusive —

REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
} slow & confused

GENERAL DESCRIPTIVE REMARKS:
Patient has some fatty heart: apparently, dropsical effusion in abdomen: knee joints somewhat deformed. says has had articular rheumatism: previous mental grade probably good: now, quiet dementia, with no fixed delusions, but talking about his patents, in a random fashion. Probably alcoholic —

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

DELUSIONS:
Systematized or Not, unsystematized
Special Subjects,
Transitory or Not, Transitory. Yes.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Pierre Marchand

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken (usual weight 205) NUTRITION, fleshy; plethoric.
WOUNDS OR ABNORMALITIES, See G.H.R. Kept — acne rosacea.
TONGUE, Tremors, Coatings, clean. Glossy Promptness Movement, prompt
PUPILS, Equality, ✓ Size, ✓
Response Light, ✓ Accommodation, ✓
SIGHT, Slight impairment
HEARING, Good
COORDINATION, Arms, ✓ ✓
Legs, ✓
TREMORS, Hands, slight Tongue, none
Facial Muscles, no General, no
REFLEXES, Patellar, O.K. (test unsatisfactory) EXAM. URINE,
Other ✓
ARTICULATION,
Slurred, slightly
Hesitating,
FACIAL EXPRESSION, ✓
SENSIBILITY, ✓



TAKEN,

HEART, no murmurs: strength sounds weak: apex larger apex beat displaced L. left nipple line — regular. Arteries seem good
LUNGS, Breath sounds asthmatic.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless, probably hard drinker
BOWELS, Normal, left Constipated, Irregular,
APPETITE, Good, poor Medium, Poor, Yes.
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,
} history from patient inaccurate

Personal and Medical History of *Pierre Marchand.*

1896

This patient was brought here by Ex-Judge Olivier & attended by Mr Defoe, with the following history. Patient is in fair physical condition. No history of consanguinity or heredity. This is 1st attack: symptoms manifested 2 or 3 months ago. Disease seems increasing: variable & with rational interval, but these not regular. Derangement now shown by insane delusions & imaginary cases in his practice. Is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. No peculiarities had been previously shown: No patient is addicted to intemperance. He has not been subject to any severe disease &c nor had any head-injury: he has not been restrained or confined. Supposed cause of the disease is intemperance. Has been given treatment at home, for intemperance & the opium habit. He now has insane delusions.

July 1 **On admission**, was put on T.W. (G.H.N. 29th) Hair gray: eyes blue: condition of skin good; has a mole on left shoulder: some scars on right knee: sprinkles on breast: is clean: restless.

" 2 Re coming inward, was in a very restless & nervous condition. Given bath & put to bed at 7pm July 2/96. Slept none, last night. Eats very lightly: very restless, all day & continually out of bed: Complains of pains in abdomen (given 1/40 gr. Strych): Thinks he is in some St Paul Hotel & want to go home.

" 3 July 3/96. Slept only 1 hour, last night: very restless, all day & Continually getting out of bed. Still Complains of pains in abdomen & again given 1/40 gr. Strych. (at 8 – 2 – 8). Bowels move: urinates.

" 4 July 4/96 Slept none, last night: very nervous all night: very nervous, all day. Complains of pains in abdomen & wants liquor. Says "he has lots of business on hand". Eats very light meals:

" 5 was given some eggnog, with whisky: also strychnia, at intervals. July 5/96. Slept 8 hours, last night. Appetite about normal. Bowels move. Out of room, every little while, during day. "Wants his clothes & horse, & go home". Slept 1 hour, during day. July 6/96.

" 6 Slept 3 hours, last night: has been very noisy,

" 7 all day & hard to keep in bed: always has something that he wants to explain. July 7/96. Noisy, part of night; slept none. Very restless, today. "Wants to go to see to his business, or a good deal of whisky. Talk very irrationally. Eats fairly well: occasionally refuses meal: Bowels move. Is

" 8 also given Eggnog with whisky: also strychnia, at intervals. July 8/96. Slept 6 hours, last night. Carrying on, in his usual way, all day. Can see no change: still complains of pains in abdomen,

" 9 and wants liquor. July 9/96. Slept 6 hours: very restless, all day, & cannot be kept in bed. Inclined,

" 10 at times, to be pugnacious. July 10/96. Slightly noisy & slept only 5 hours, last night: very

" 11 restless, all day: complains still of pains in abdomen. Bowels move. July 11/96. Noisy, most all

" 12 night: slept none. Very restless. Was up & out with Crowd. July 12/96. Slightly noisy, part of night, and out of room often: slept only 4 hours. very restless, today. Eats fairly well: receives Eggnog with whisky.

" 13 also hyps. of strychnia: & hyps. morph. July 13/96. Noisy part of night: out of his bed, all the time: slept none: Complains of pains in side & says "he cannot lay down": up & out this afternoon.

" 14 sleeps some in daytime. July 14/96. Slept none, last night. Can see no change in patient. Has delu-

" 15 sions & talks irrationally. July 15/96. Slightly noisy, part of night & slept only 3 hours.

Summary: Was very restless & nervous, when received inward. It has been very hard to keep patient in room: Thinks he is in some St Paul Hotel & is continually asking to go home. Has delusions & talks very irrationally. Complains of pains in abdomen & wants liquor. Sleeps some during daytime, but very poorly at night: habits clean: Memory very poor.

Personal and Medical History of *Pierre Marchand.*

1896

Summary Nurses Notes by Dr. Phelps. During months of July & August patient was upon sick ward, not, however, especially sick except for occasional asthmatic symptoms. At times he had a rise of temperature but without any prominent symptoms. Patient has little memory altho in appearance is quite intelligent.

Oct 31 Patient at first thought he was here to see a patient, but during the last month it has been noted that he knows he is here as insane, he is, however, quite childish in all that he says or does, altho to superficial observation quite intelligent. Mch 24/98 Trans. to A. About as for months past. May 29 Patient seems to have rather less asthma than before. He lies along very quietly in a rather dull mental state. May 31/97 Wt. 187 lbs.

July 31/97 Patient has changed little in physical condition since coming here: Has a great deal of asthma, not however spasmodic asthma but from organic trouble. Has considerable intelligence but is very quiet and demented: Memory very poor.

Jan 31/99 Wt. 209 lbs. So about the same in every way. Feb 1 – July 31 '99 (Dr. Warnock) Wt. 214 lbs. Has

July 31 delusions of persecution. No change from time to time: Physical condition very good

Oct 1 1900 Wt 220 lbs. Appetite good: bowels regular: patient has severe attacks of asthma, at times: very delusional.

Feby 1 Condition good: memory much impaired. July 1/1900 Wt 218 lbs July 19. Severe attack of asthma 3 day.

July 31 No change in general condition of patient. Aug 31. Is on treatment for asthma; also on extra diet.

Oct 1/ 1900 30 Wt 217 lbs. Oct 30. No change to note. Nov 21. Complains of severe headache; also of back-ache:

Jan 31 urine examined, but nothing ascertained. Jany 31/1901. Physical condition better: patient medicine

Feby 28 Wt 214 lbs. Feby 6. Generally well-behaved. Has spells of depression and Cyanosis.

" Visited by friend. Does not like to go out walking. Sleeps on bench, on hall, because

July 31 of his asthma. July 31. Condition remains about same. Still subject to asthmatic attacks.

Aug 1 Wt 212 lbs. Dec 31. Is somewhat easily irritated; General health usually poor: suffers a good

Dec 31 deal from asthma &c. Jany 1902. Is rather stupid & has been vomiting. Moved to 1 W.

1902 Jan 15 Up, dressed & about: (sickness was evidently temporary, from his heart weakness & asthmatic Condition). Jany 31. Is about as usual.

Jan. 31. (Dr. Phelps) No change during whole period. Always quiet. Demented; tho able to answer many questions well. Cardias Asthma quite bad at times. Will not sleep inside the room. Otherwise his general health does not seem to have failed.

Personal and Medical History of Christ Katke

BERRY, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4435.
Residence, St. Paul: Minn
Date Admission, 1st July 1896.
Admitted by Dr. Herzog Hour, 6.45 P.M.
How Sent, G. Wilbrick, Jof P. Ramsey County.
Sex, Male.
Age, — 40 —
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Brick-maker.
Degree Education, very little
Profession Religion, Yes: Lutheran
Habits, not known
Nativity, Germany: (Parents also born there)
Physicians Committing, J. F. Baker & Chas. J. Meade
Correspondents, not given in papers

No. for Year, 263.
Insane Relatives, none
Cause Exciting, not given
Cause Predisposing, previous attack
Form, Paranoia
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, Not
Date of this Attack, June 30th 1896 (?)
Duration, one Day (?)
No. of Attack, 2nd
No. of Admissions, 1st
Age First Attack, abt 39.
Time of Leaving, 11th December 1901
Time in Hospital, 5 yrs 5 mos 10 ds
Result, Transferred to Hastings asylum

Ed by Dr. Herzog 7/2/96.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, slightly confused
Quick or Sluggish, quick

MEMORY:
Past Events, fairly good
Recent Events, — Do —
Special Subjects,

PERCEPTIVITY:
Alert or Dull, alert
Correct or Illusive, in ordinary subjects, correct

REASONING POWER:
Ordinary Subjects, fair
Own Mental State,
Special Subjects, — Do —

GENERAL DESCRIPTIVE REMARKS: Syphilis fever, 10 yrs. ago: foot crushed in mill: 15 yrs ago: moderate drink (Drinking & Smoking): brickmaker. Plate Iron job work. Patient has never been very successful in life: has had Delusions "of persecution" for years, People are after him trying to kill him: he can hear them talking saying "there he is now". Hesitation in speech: talks in a very angry tone, giving short answers. Occasionally, curses his persecutors: seems a well advanced paranoiac.

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

DELUSIONS:
Systematized ~~or Not~~, somewhat
Special Subjects, "persecution"
Transitory or Not, fixed
HALLUCINATIONS: "of hearing"
ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Christ Katke

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6in WEIGHT, not taken NUTRITION, Considerably impaired — skin greasy —
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, — Coatings, dirty yellowish coat Promptness Movement, prompt.
PUPILS, Equality, Yes Size, contracted: left pupil irregular in shape —
Response Light, excessive Accommodation, excessive
SIGHT, of left eye impaired
HEARING, good
COORDINATION, Arms, fairly good: usual tests
Legs, fairly good: " "
TREMORS, Hands, Yes: quite marked Tongue, some
Facial Muscles, of eyelids & lips General, slight on standing.
REFLEXES, Patellar, 7-8 equal
Other
ARTICULATION, ✓
Slurred,
Hesitating,
FACIAL EXPRESSION, ✓
SENSIBILITY, ✓
HEART, murmurs - none ~~strong~~ sounds, somewhat muffled apex beat forcible: slightly irregular pulse full
LUNGS, good

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Kept Neat	Clean,	Careless,
BOWELS, Normal,		Constipated,	Irregular,
APPETITE, Good,		Medium,	Poor,
SLEEP, Good,		Poor,	Irregular, Says sleeps 3-4 hours
PULSE,		Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, probably long ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, mother died: no recollection.
Father or Pat. Relations, father died: accident
Brothers or Sisters, Claims healthy: one nephew epileptic

Personal and Medical History of *Christ Katke*

1896

This patient was brought here by Deputy Sheriff Emanuel Johnson, with following history. Patient is in fair physical condition. No history of consanguinity or heredity. This is not 1st attack: one occurred in Oct 8th 1895: duration not stated. First symptoms of this attack manifested, when he was arrested on street, June 30th 1896. Condition or state of the disease not mentioned. Derangement now shown in that he claims he is always followed by some Frenchmen, who run to the country & back again: robbed him of his money. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. As to any previous peculiarities &c or Intemperance &c, don't know, nor as to any Severe Illness &c. He has not been restrained or confined. Causes of the Disease not known. He has had no treatment, to our knowledge. He is irritable & answers questions in angry voice, especially when he speaks of people who follow him.

July 1 On admission, was put on T.D.[3] (G.N.R. 12th Pt. Complexion dark: hair black: eyes brown: left foot has been broken. Is dirty: behaves stubborn). July 2/96. Slept 4 hours, last night. Patient is restless & uneasy: talks much & is very indignant, because he is here: says "he will shoot all of us & that "the Empress of Germany is coming with Soldiers, to annihilate us". July 3/96. Slept 4 hours, last night. Is quite cranky: will not mind without being forced: talks German, a great deal. July 4/96. Slept 4 hours, last night: appetite good: bowels in good condition: health considerable. Has delusions of persecution: says "certain parties want to do him". July 5/96. Slept 6 hours: Is more quiet, today. Talks some. Is saucy & stubborn, when asked any questions. Says "he will have us all hung for keeping him here": July 6/96. Slept 5 hours. Was quite noisy, this morning - Transferred to B[2]. Is now quiet, but is inclined to be stubborn. Eats well; bowels regular. July 7/96. Slept 5 hours: has been fairly good, today: Inclined to be restless, when sat with crowd: when spoken to, answers very gruffly. July 8/96. Slept 7 hours, last night. Behavior unchanged. Was given bath: at first refused: also refused to work at hall: July 9/96. Slept 7 hours. Is on regular diet: behavior quite good: still stubborn: when spoken to, answers gruffly: plays cards with other patients. July 15/96. No special Change noticeable, since last note: habits neat & clean: Eats in dining room: is a very hearty Eater: very regular in his habits as to movements of bowels": still very stubborn & sulky in his speech & actions: Well behaved & quiet, when left alone, but, when Crossed, is stubborn & sulky: refused to be shaved; said "was going home & did not need it". Is well behaved, when out. Refuses to work & says "they have no right to keep him here". Has been sleeping 7 hours, nightly.

Summary: Behavior, from 2nd to 6th, was restless & inclined to be noisy & somewhat stubborn. From 6th to 15th, more quiet: but still sulky & stubborn, in his sayings & actions: has talked but little sense as B[2]; only when spoken to: Answers questions fairly well. Appetite has been very good, all the time & eats heartily: Bowels regular: medicine, none. From 2nd to 6th, was somewhat restless, nights: but from 6th to 15th slept good. (Average 6 hrs per night).

May 1/97 Summary Nurses Notes by Dr. Phelps. Patients record from July '96 to May '97 shows quite steady & uniform behavior & talk. Is irritable & complains some: Restless in manner. Has been always quite healthy & has had no physical sickness Wt. 174-178#. May 31 '97 Wt. 180#. July 1 '97 Wt. 184#. Rather surly & quarrelsome

Personal and Medical History of *Christ Katke*

Does no work. Quite neat in habits but rather demented. Jany 31/99 Now at Annex: Wt. about 230#. Behavior unchanged. Feb 1 - July 31/99 (Dr. Wanous) Wt. 206. Appetite good. Behavior fair. Has delusions & is incoherent in speech.

Aug 1 1900 - July 1 - July 29 - 31 - Aug 1 - Jan 31 1901 - Feb - Nov 1 - Dec 11

Jan 31 1900. (Dr. Schaffle) Wt. 197. No change during period. Health & behavior very good. Is very demented. Seldom speaks. Habits cleanly. Does nothing. July 1900. Wt 196#. 180. age 11. Struck by a car, knocking him down. July 20. Vaccinated, result negative. July 31. No change noted: health good: is inactive: does no work: is surly and contrary: habits neat: never speaks civilly. Wt 200#. Age 10. Transferred to D[2]. Jany 31/1901. No change: Eats & sleeps well: in excellent physical health: does no work: very surly in manner. "Thinks that he owns the buildings and pays for his board". Also has other delusions. Delusions. Wt. 191#. May 1. 189#. Aug 1. 192#. 190#. Dec 11. No change whatever, during year: Good health: inactive: stubborn. Surly: Today, Transferred to Hastings State Asylum.

Personal and Medical History of Dominick Schultz

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4436.
Residence, Steele County, Minn
Date Admission, 2nd July 1896 –
Admitted by Dr. Kilbourne Hour, 10:00 am
How Sent, C. J. O'Brien, Court Comm. Steele County
Sex, – Male –
Age, – 58 –
Civil Condition, Married
Children, – 8 –
Age Youngest Child, ———
Occupation, Farm-laborer.
Degree Education, None
Profession Religion, Not church member: (R.C.)
Habits, Intemperate.
Nativity, Bohemia: (Parents also born there).
Physicians Committing, A.K. Stewart and F.M. Smersh
Correspondents, – none given in papers.

No. for Year, 264.
Insane Relatives, Brother, in 1st Commitment
Father in East
Cause Exciting, not known: (Rheumatism, neuralgia, vertigo, appetit-ital - previous causes) —
Cause Predisposing, Heredity + previous attack
Form, Dementia terminal
Accompanying Bodily Disorder, none mentioned –
Suicidal or Not, not attempted but has threatened. (making threats since return home)
Date of this Attack, worse since June 27/96.
Duration, — some time —
No. of Attack, — 3rd (probably more).
No. of Admissions, 3rd
Age First Attack, 40 + —
Time of Leaving, Aug. 4th. 1896.
Time in Hospital, 1 mo. 2 da.
Result, Discharged Feb. 3 '97
Unimproved.

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 Dominick Schultz

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in WEIGHT, Not taken 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, EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,

TAKEN,

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 Dominick Schultz

1896

This patient was brought here by Sheriff Barnard with following history. Patient is in fair physical condition. No history of consanguinity; this is not 1st attack (3d or probably more); Others occurred Apl 30th 1887, and Oct. 29th 1890. Duration of 1st 6 months; of 2d, 9 months: was at this (Rochester) Hospital & discharged, as stated above. First symptoms of this attack manifested in that he has been making threats since home from the Asylum, but is worse since June 29th 1896. Disease seems to be increasing; variable; rational interval not regular. Derangement now shown, as follows: leaves home for several days to several weeks, at a time, without family knowing of his whereabouts: also restless at night & has threatened to kill family, on many occasions & injure others: has not attempted suicide, but has threatened & propensity now active: has destructive habits. There is heredity in case. (Brother, stated Rheinsane, in 1st Commitment and father, in last;) as to any previous peculiarities, don't know. Patient drinks: no severe disease or head-injury, as known: as stated, has been Confined in Rochester Asylum, twice. Don't know cause of disease. (In 1st Commitment it was stated to be Rheumatism, neuralgia, vertigo & petit-mal as previous causes.) The only treatment mentioned is that at Rochester. Is now, easily excited & talkative.

Note. Was here, 1st time, (Vol 8 of Pt. St. No 1344,) from Apl 30/87 to June 29/87. On 1st Coming, Complained frequently of pain in head & face: a piece of necrosed bone removed gave immediate relief; also caused the "nervousness" to disappear. He quickly improved, became coherent & rational & was sent home. (Was probably a case of mild Dementia).

Was here, 2d time, (Vol 14 of 189 No 2529), from Oct 30/90 to Jany 5/91. During this stay, he was highly emotional: Easily depressed: frequently crying, but was not noisy or excited, apparently. Subsequently, became more cheerful. Worked some & took an interest in his work but this continued until he was taken home.

July 2 On admission, was put on B3 (G.H.N. Kft. Complexion dark: hair brown: eyes blue: Condition
" 3 of skin good: no marks, scars or bruises noticed: tongue clean: behavior good). July 3/96. Slept 8 hours, last night. Behavior good - patient feels despondent: cried some, today: talks very little English.
" 4 says "his wife wanted to get rid of him & sent him here": July 4/96. Slept 8 hours. behavior good:
Is now quiet & contented: habits neat: he makes no complaints as to his Physical condition.
" 5 July 5/96. Slept 7 hours: appetite good: bowels in good condition: Goes out on grounds, every day.
" 6 behavior good: is still a little despondent. July 6/96. Slept 6 hours: patient talks scarcely
" 7 any English. Seems more contented: Is quiet. July 7/96. Slept 8 hours: behavior good: no change
" 8 noticed, otherwise. July 8/96. Slept 8 hours: Is about as usual. July 9/96. Slept 9 hours:
" 13 Appetite good: bowels in good condition: July 16/96 During this, the 2d week, patient has been sleeping 8 to 9 hours, nightly. Behavior Good: has been quiet & contented: working in dining-room & on ward: is inoffensive: Physical condition, good: out on grounds, daily.

Summary: Patient has been quiet & well behaved, during past 2 weeks. Is a little foolish & fickle-minded, but has no marked indications of a disordered mind. Talks very little English & cannot understand it. Appears quite content with his surroundings. Works on ward: Physical condition good.

Personal and Medical History of D. Schultz

1896

Summary Nurses Notes by Dr Phelps. Patients record commencing July 17 shows him as quite quiet: sleeps well: works some on ward: & is fairly contented.
July 25 Trans. to A' Aug' Went home - No special change noted in state while here.

Discharged

Personal and Medical History of Wm. S. Brainerd

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4437.
Residence, "Transient"
Date Admission, 3rd July 1896.
Admitted by Dr. Phelps Hour, 4:00 PM
How Sent, Thomas Fraser, Jeff. Olmsted County
Sex, Male
Age, 44
Civil Condition, Married
Children, Two
Age Youngest Child,
Occupation, Horse-trainer
Degree Education, College
Profession Religion, Not a church member
Habits, not intemperate.
Nativity, New York State. (Parents also born there)
Physicians Committing, A. L. Baker and Chas T. Gauger
Correspondents, (Is a brother-in-law of Dr. Filgum of State Board — "Rep")

No. for Year, 265
Insane Relatives, Father was insane
Cause Exciting, Do not know
Cause Predisposing, Heredity & previous attacks
Form, Paranoia.
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, — not —
Date of this Attack, 29th June 1896.
Duration, — 4 Days —
No. of Attack, Several (at intervals during past 8 yrs).
No. of Admissions, 1st time
Age First Attack, about 39.
Time of Leaving, Dec. 2. 1896.
Time in Hospital, 5 mo. 1 day
Result, Discharged May 5-97. Improved.

EXAMINATION ON ADMISSION.

Ex'd by Dr Herzog July 29 96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Slightly Confused.
Quick or Sluggish, Quick
MEMORY:
Past Events, Good
Recent Events, — Do —
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, Correct
REASONING POWER:
Ordinary Subjects, quick: fairly clear.
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Exalted
Depressed,
DELUSIONS:
Systematized or Not, somewhat systematized
Special Subjects, "of grandeur"
Transitory or Not, fixed
HALLUCINATIONS: ✓
ILLUSIONS: ✓
CONVERSATION:
Coherent or Incoherent, Slightly incoherent
Voluble or Reticent, very voluble

GENERAL DESCRIPTIVE REMARKS:
Articular rheumatism, 9 years of age & at 17 & 8 years ago. 4 years ago. says has had syphilis: history doubtful. Does not drink or smoke, at present: has been handling horses, to some extent: became excitable 3 years ago for 2 months. Patient seems to have always been somewhat eccentric. Has had great ideas of training the Western horse, buying them cheap & selling at a profit. Hard work combined with a bad heredity & excitable nature seem to have precipitated a sub-acute mania. Has had some dissipation, but not much. Patient looks worn & tired. His talk is at random & slightly grandiose.

Personal and Medical History of Wm. S. Brainerd

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7in WEIGHT, 158 lbs (usual wt 165) NUTRITION, fairly good.
WOUNDS OR ABNORMALITIES, 3 scars on head: lost one once, each time. Has healed
TONGUE, Tremors, — Coatings, slight white coating. Promptness Movement, prompt
PUPILS, Equality, yes Size, Dil. slightly Contracted
Response Light, slow Accommodation, slow
SIGHT, fairly good
HEARING, good
COORDINATION, Arms, good: usual tests
Legs, — do — : " "
TREMORS, Hands, slight Tongue, none
Facial Muscles, no General, no
REFLEXES, Patellar, O. test unsatisfactory EXAM. URINE,
Other
ARTICULATION, Good
Slurred, —
Hesitating, —
FACIAL EXPRESSION,
SENSIBILITY,
HEART, slight murmurs 1 sound at apex, 2 pulmonic sound sharp - strength & rhythm good. hypertrophy. apex beat 6th interspace - slightly inside - regular
LUNGS, TAKEN,
Chest symmetry good
Breath sounds seem good
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, ~~Good,~~ has been Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, long ONSET GRADUAL OR SUDDEN, gradual
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, mother healthy
Father or Pat. Relations, father insane: at meadville for a time: father's brother, asylum short time.
Brothers or Sisters, brother, successful man, patient says: he is excitable.

Personal and Medical History of Wm. S. Brainerd.

1896

This patient was brought here by Sheriff Stewart with following history. Patient is in fair physical condition: no history of consanguinity, but father was insane: this is not 1st attack: they have occurred at intervals during past 5 yrs: duration variable: First symptoms of this attack were manifested June 29th 1896: hysterical, writing incoherent letters and telegrams. Disease appears to be stationary: variable with rational intervals, but these not regular. Derangement now shown by writing incoherent telegrams and letters: delusions: various ways of money-making. Patient is not dispos'd to injure others nor suicidal, nor filthy nor destructive in habits. Previously, he showed a predominant passion for horse-training. There is no history of intemperance in parents or self, nor of any severe disease &c or head-injury: has not been restrained or confined. Do not know cause of disease: has been treated by nerve sedatives: effects beneficial. He is now excited: shows delusions: has schemes to make large amounts of money.—

"Note by Dr Phelps. Father was insane: living at 76 in Wisconsin: never very bad. Used to occasionally think was Emperor or something: confined several times for a short period: for 25 years or so, all right." On admission, was put on B3 (G.H.N. Rft. Complexion dark: hair dark: eyebrows: condition of skin good: no marks, scars or bruises noticed: Sec'ban: behavior good).

July 3/96. Slept only 3 hours last night. Patient is very restless and uneasy: almost continually talking & telling of his "schemes". Writing numerous telegrams, which he desires to have sent to almost everyone of note, in the whole Country.

" 4 July 4/96. Slept only 1 hour last night: was talking part of night. Is very nervous: very troublesome all day, calling nurses insulting names, & in every way, trying to irritate them.

" 5 July 5/96. Slept same, last night. Transferred to "Infirmary Ward", at 1.00 PM: was given hot bath & put to bed. Very restless & troublesome, all afternoon & could not keep patient in bed: was given cold Sponge-bath at 8.00 & 8.30.

" 6 July 6/96. Slightly noisy, 1 hour during night, but slept 7 hours. Urinates often: he talks, most all the time & incoherently: has hand delusions: lovelessness.

" 7 July 7/96. Out of his bed, most all the time: slept only 4 hours: very noisy, greater part of day: & inclined to be pugnacious, at times: kicked tray, from nurse, at supper time & broke dishes & said "he would not eat supper". Still urinates often.

" 8 July 8/96. Again, slightly noisy part of night: slept 5 hours. Very restless, all day: out of bed & walking from room.

" 9 July 9/96. Struck night-nurse, on head, with Lumber & was inclined to be pugnacious, at different times. Slightly noisy 7 hours during night & slept only 1 hour. Urinates often & talks irrationally. Very restless all day: out of bed: talking. Out for a walk this Am.

" 10 July 10/96. Since last note, patient has been, at times, slightly noisy at night & sleeping only 4 to 5 hours, in each: has been restless & nervous, by day: continually talking: talks all the time of his "horse-hoes-training": has been taken out for walks, daily: has been given shower-baths.

" 15 July 15/96. Since last note, patient has been rather maniacal, restless & irritable all month. Talks incessantly & has vague transitory delusions. Sept 1 Has continued irritable & maniacal all of month: Is rather more irrational in talk & behavior than in July & August. Oct 1 Dirty & untidy at times: In restraint. Oct 30 Considerably improved of late. Thinks himself a great inventor but is more rational. Trans. to B3. Dec 1 Mut. Improving considerably during last month. Quite rational in talk & behavior.

" 16 Urinates very often. Appetite good: bowels move freely.

" 17 July 17/96. Behavior now good & he seems to be improving some. There is a slight breaking out on body. Up out this Am & onward the rest of day. Appears very much better, today. Still has some delusions: talking most all the time: wants to send telegrams & write letters to all of his relatives. Summary: above notes show patient have

Personal and Medical History of Wm. S. Brainerd

Summary Cont'd

been very restless & uneasy, on admission & for some time afterward: Continually talking: holding delusions & full of "schemes": wanting to send numerous telegrams & letters: talks very irrationally & incoherently: was insulting to nurses: inclined to be pugnacious. Would not stay in bed: was up frequently & walking floor. Says "he is going to bring suit against the State, when he goes home" & "not a fool, in the hospital". Has been taken out, daily, for walks & he now appears some better: habits clean: behavior changeable.

July 20/96. Up, onward: looks some: talks most all the time & very irrationally. Does not with the crowd: appears somewhat better: tells his story to everyone: talks religion, at times. Still has some delusions: very restless: sending telegrams & writing letters to the Drs. about every half hour": "has considerable trouble to eat".

" 21 July 21/96. Still up on ward: Condition about the same: behavior changeable. Transferred to B3.—

Summary Nurses Notes by Dr Phelps. Patient works some on ward: Talks in a rambling, irrational way most of time. Writes notes & telegrams frequently

30 Patient has been rather maniacal, restless & irritable all month. Talks incessantly & has vague transitory delusions. Sept 1 Has continued irritable & maniacal all of month: Is rather more irrational in talk & behavior than in July & August. Oct 1 Dirty & untidy at times: In restraint. Oct 30 Considerably improved of late. Thinks himself a great inventor but is more rational. Trans. to B3. Dec 1 Mut. Improving considerably during last month. Quite rational in talk & behavior.

Discharged.

Personal and Medical History of Henry Elias

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 44440.

Residence, Stillwater, Washington Co.

Date Admission, 6th July 1895.

Admitted by Dr. Phelps Hour, 6:45 PM

How Sent, E. G. Butts, Jail. Washington County

Sex, Male

Age, 72

Civil Condition, married

Children, four

Age Youngest Child,

Occupation, Laborer

Degree Education, limited: can read & write.

Profession Religion, Yes: German Catholic.

Habits, not intemperate —

Nativity, Germany: (parents also born there).

Physicians Committing, W. H. Pratt and T. C. Clark

Correspondents, no relatives.

friend — Jno. S. Propls Stillwater Minn

No. for Year, 268

Insane Relatives,

Cause Exciting, Au

Cause Predisposing,

Form, Melan

Accompanying Bodily Di

Suicidal or Not, Jal

Date of this Attack,

Duration,

No. of Attack,

No. of Admissions,

Age First Attack,

Time of Leaving,

Time in Hospital,

Result, Died

Dewitt

Two More For Rochester.

A court of lunatico inquirendo was organized today in the office of the judge of probate, consisting of Doctors Pratt and Clark for the express purpose of investigating the mental conditions of two suspected persons—Henry Elias and Joseph Maisch.

Mr. Elias is 72 years of age and has been infirm and feeble in mind, body and estate for several years. He has made his home at John Proctor's on Sixth street, and always had an idea he was rendering a valuable consideration to the Proctor family for his keeping. He has been on the border of insanity for several years. He was born in Germany, but has lived in this city for 30 years or more. He was for many years in the employ of the Schulenberg-Boeckler Lumber Co., and about thirteen years ago, received injuries from a flying monkey wrench which got away from the foreman or somebody else, at an unfortunate moment. Mr. Elias was laid up for several weeks or months, but finally received a money compensation which had a remarkable effect on him. It cured him. But whether the people who run the hospital at Rochester can do as well by him, is a matter of doubt.

Stillwater Gazette July 8th 95

EXAMINATION ON ADMISSION.

Exam 9/18/95 by R. W. Phelps

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused somewhat

Quick or Sluggish,

MEMORY:

Past Events, } Probably not very accurate.

Recent Events, }

Special Subjects, }

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, } Feeble

Own Mental State, }

Special Subjects, }

GENERAL DESCRIPTIVE REMARKS: Tremulous, feeble minded - Complains of bad feeling in head for past 2 years - Complains of colic & general bad feelings - Says is dizzy has cold feet. The circulatory troubles are probably enough to account for all that.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, slightly & emotional.

DELUSIONS:

Systematized or Not, Ideas of own failure

Special Subjects, Paltry true.

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Henry Elias

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in WEIGHT, 140 pds NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, No. Condition of skin not very poor.

TONGUE, Tremors, Tremulous Coatings, slight coat. Promptness Movement,

PUPILS, Equality, Equal. Size, Somewhat small.

Response Light, Slight. Accommodation,

SIGHT, Says poor.

HEARING, Partly poor.

COORDINATION, Arms,

Legs,

TREMORS, Hands, Tremulous. Tongue, Tremulous.

Facial Muscles, General,

REFLEXES, Patellar, ? EXAM. URINE,

Other

ARTICULATION,

Slurred, not much.

Hesitating, slightly & tremulous as if from age.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Gross atheroma

HEART, Murmurs after 1st Sound. Sounds fair

LUNGS, Fair.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, C.C. 39 (Occ) 38 Fr.o.a. 37 Bim.a. 34½ Aur.p.d. 20½ Fr.aur.d 16.3 Bim.d. 14.6 Fl.C.2.3

HISTORICAL, Drinks drinking much - Headaches sometimes - Head always feels badly - Dont remember

LENGTH OF INVASION, 2 yrs. ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Henry Elias

EGBERT, FIDLAR & BRAKHORN, DAVENPORT, IOWA

Whole No. 11440.
Residence, Stillwater, Washington Co.
Date Admission, 6th July 1896.
Admitted by Dr. Phelps Hour, 6:15 PM
How Sent, E.G. Butts, Jos. P. Washington County
Sex, Male.
Age, 72.
Civil Condition, married
Children, four
Age Youngest Child,
Occupation, Laborer
Degree Education, limited: can read & write.
Profession Religion, Yes: German Catholic.
Habits, not intemperate.
Nativity, Germany: (parents also born there).
Physicians Committing, W.H. Pratt and J.C. Clark
Correspondents, no relatives.
friend - Jno. A. Proble, Stillwater, Minn

No. for Year, 268
Insane Relatives, Not known
Cause Exciting, An ungovernable temper
Cause Predisposing, previous attacks
Form, Melancholia senile
Accompanying Bodily Disorder, much feebleness.
Suicidal or Not, Talks of Drowning himself.
Date of this Attack, 3 Days ago
Duration, 3 days
No. of Attack, Several; at intervals in past 10 yrs.
No. of Admissions, 1st
Age First Attack, about 62
Time of Leaving, Dec 26. 1899
Time in Hospital, 3 yrs. 5 m. 20d
Result, Died Exhaustion si
Senile Dementia.

EXAMINATION ON ADMISSION.

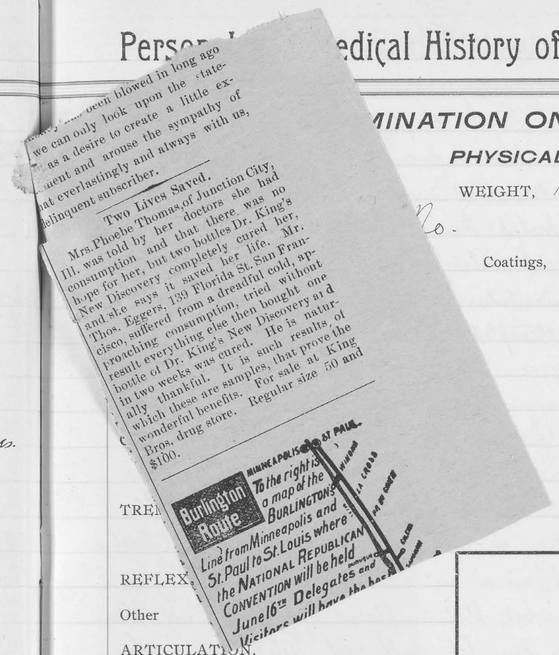
Exam 9/18/96 by R.M. Phelps **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused somewhat.
Quick or Sluggish,
MEMORY:
Past Events, Probably not very accurate.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Feeble
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly & emotional.
DELUSIONS:
Systematized or Not, Ideas of own failure
Special Subjects, Partly true.
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Tremulous, feeble minded - Complains of bad feeling in head for past 2 years - Complains of colic & general bad feelings - Says is dizzy has cold feet. The circulatory troubles are probably enough to account for all that.

Personal and Medical History of Henry Elias



EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 140 lbs NUTRITION, Fair.
No. Condition of skin not very poor.
Coatings, slight coat. Promptness Movement,
Size, Somewhat small.
Accommodation,

TREM... Tongue, Tremulous.
General,
REFLEX... EXAM. URINE,
Other
ARTICULATION,
Slurred, not much.
Hesitating, slightly & tremulous as if from age.
FACIAL EXPRESSION,
SENSIBILITY,
Arteries Gross atheroma
HEART, Murmurs apex 1st sound. Sounds fair
LUNGS, Fair.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, C.C. 39 (cm) 38 Ho.c.a. 37 Bi.a. 34½ Ant.p.d. 20½ Fr.a.r.d 16.3 Bi.d. 14.6 F.L. 12.3
HISTORICAL, Denies drinking much - Headaches sometimes - Head always feels badly - Dont remember
LENGTH OF INVASION, 2 yrs. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Henry Elias

1896

This patient was brought here by Deputy Sheriff G.W. Smith, attended by Alf Johnson, with the following history. Patient is in rather feeble condition. As to consanguinity or heredity, unknown: This is not 1st attack: these have occurred at intervals during last 10 years; duration, a short time. First symptoms of this attack manifested three days ago: wanted to kill himself: Disease seems increasing; variable with rational intervals, but these irregular. Derangement now shown in that he thinks that he is being persecuted. Patient is disposed to injure others: he talk about drowning himself, but has never attempted it: no filthy or destructive habits. Patient has always been a man of violent and ungovernable temper. No history of intemperance in parents or self, no of any severe disease &c or head-injury. He has not been restrained or confined. Supposed cause of the disease is an ungovernable temper: has had only general treatment. Nothing further found out, in examination, only as indicated by previous statements.

July 6 On admission, was put on T.W. (G.S.A.N.R.)t. Complexion fair: hair gray & bald: eyes blue; condition of skin good: no marks scars or bruises noted: is clean: behavior good. Was given bath & put to bed: appears quite weak: talks some: Complains of pain in side: habits clean: behavior good.

" 7 July 7/96 Slept 2 hours, last night: lies very quiet, in bed: still complains of pain, in side & abdomen.

" 8/9 July 8/96 Slept 6 hours, last night. Very quiet during day. Eat quite well. July 9/96. Noisy 3 hours, last night: slept 5 hours: talks very little: still complains of pains. July 10/96. Seemed in pain & was moaning, last night: slept 7 hours. Very quiet all day: can see no change in condition.

" 11 July 11/96 Slightly noisy part of night & slept only 4 hours. No change noticed: appears very weak & still complains. July 12/96. Slept only 6 hours, last night. July 13/96. Lies very quiet, in bed: talks but little: slightly noisy, at night & sleeps poorly: physical condition does not seem to change.

" 18 Still complains of pains in abdomen. July 15/96. Appears some easier, today. Groans some, during night & is very uneasy, but seems better, toward morning. Still sleeps poorly: occasionally, sleeps some, during day. July 17/96. Appears about the same. Still complains. Behavior good: habits clean: is very quiet in bed: he has delusions. Sleeps poorly, at night.

Summary: Patient has appeared very weak: has continually complains of pains in abdomen & in side: has groaned much, at night - but has been quiet, by day. He has slept poorly. Reads his Bible some, during day: Patient has delusions. Behavior good: appetite good: habits clean: bowels very irregular.

May/97 Summary Nurses Notes by Dr. Phelps. Notes show him to have lain in bed quite steadily during all of period from July '96. Imp. has been usually about normal health during last few weeks showed some disturbance: He complains chiefly of vertigo and weakness on attempt to go about. He complains of various pains & sensations which seemed somewhat hypochondriacal but are probably real & due to brain atheroma. May 3'97. Wt. 138th. Lies quietly in bed: complains at times of coming here of symptoms indicating atheroma of brain. Complained of dizziness: Kept in bed. Is however rather irritable & complaining at times. Aug 97 Wt. 141th Nov 97 Wt. 136th Aug 31'98 Still lying quietly in bed: no essential change in any respect. Jan 31'99 Almost exactly the same in condition & behavior as at time of last note. Still in bed.

Personal and Medical History of Henry Elias

1899

Feb 1'99 - July 31'99. (Dr Manous) Patient lies in bed: unable to walk: Clean in habits: Has delusions of

" persecution & continually talks to himself. Appetite fair: scolds a great deal

July 18 when nurses are about. July 28: Has been complaining of not feeling

well, but has no pain. Appetite has been very poor; no other symptoms

Aug 1/31 but 139lbs Aug 31. Pat remains quietly in bed; quite helpless: habits clean; appetite poor; grows weaker from day to

Nov 3 day; Complains frequently regarding delusions about other cases. Nov 3. Feely expresses delusions of persecution: talks

Dec 15 to himself. Dec 15 Refuses all nourishment: is fed: Dec 24. Patient shows rapid failing Dec 26 Continues

" 31/98 failing - Died at 12 am.

— Died —

Personal and Medical History of Joseph Maisch

ROBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 42441.
Residence, Nash. Co. Minnesota
Date Admission, 6th July 1896
Admitted by Dr. Phelps Hour, 6.45 PM.
How Sent, C. C. Butts. Jeff. Washington Co.
Sex, Male
Age, 26
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Laborer
Degree Education, Common School
Profession Religion, Yes. German Methodist
Habits, Not intemperate.
Nativity, Nash. Co. (Parents born in Germany).
Physicians Committing, W. H. Pratt and D. Clark
Correspondents, Jacob Maisch
Woodbury: Minn

No. for Year, 269
Insane Relatives,
Cause Exciting,
Cause Predisposing,
Form, Melan
Accompanying Bodily Di
Suicidal or Not,
Date of this Attack,
Duration,
No. of Attack,
No. of Admissions, 1st
Age First Attack, about 24.
Time of Leaving, Apr. 26th. 1897.
Time in Hospital, Ques. 30 da.
Result, Discharged Aug. 11. 1897. Unimproved.

Stillwater Gazette July 8 1896

The other subject is young, only 2[illegible] and a native of Stillwater, although his ancestors came from Germany. He is a single man and belongs to the German Methodist church. About two years ago he began to act queer; had spells of being morose and insisted that he wasn't hungry at meal time. He was also suspicious of his friends and had a wild notion that somebody wanted to feed him a dog button or something of that sort. He goes to Rochester.

Thos Kelly, who was examined for insanity last Friday, was pronounced sane.

EXAMINATION ON ADMISSION.

Exd by Dr Hargey 7/7/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Slightly Confused
Quick or Sluggish, 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 Joseph Maisch

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 Ft 11 1/2 WEIGHT, 161 1/2 lbs NUTRITION, Considerably impaired
WOUNDS OR ABNORMALITIES, neck long Skin - yellow - greasy
TONGUE, Tremors, Coatings, Tooth marked - Slight gray coating on Promptness Movement, Slow, Anaemic
PUPILS, Equality, Normal Size, normal
Response Light, Excessive Accommodation, Excessive
SIGHT, Good - Sclerotics jaundiced
HEARING, Good.
COORDINATION, Arms, Fair
Legs, Fair
TREMORS, Hands, none Tongue, Slight
Facial Muscles, none General, none
REFLEXES, Patellar, & equal EXAM. URINE,
Other
ARTICULATION, —
Slurred,
Hesitating, Slow.
FACIAL EXPRESSION, —
SENSIBILITY, —
HEART, All sounds soft anaemic murmur
Sounds weak - Apex beat feeble. 5th inter space 1/2 in to right of nipple line. Rapid & marked, irregular.
LUNGS, Seem good
TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, No prominent diseases (boy)
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Mother living - Age 70. Says healthy
Father or Pat. Relations, Father died - Age 73. Says was healthy
Brothers or Sisters, Four brothers, One sister. Says healthy

Personal and Medical History of Joseph Maisch

EBERT, FIDLAR & BRAMBERG, DAVENPORT, IOWA

Whole No. 4241.
Residence, Ozark Co. Missouri
Date Admission, 6th July 1896.
Admitted by Dr. Phelps Hour, 6.45 PM.
How Sent, E. L. Butts. Jeff. Washington Co.
Sex, Male.
Age, 26.
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Laborer
Degree Education, Common School.
Profession Religion, Yes: German Methodist
Habits, Not intemperate.
Nativity, Mich. Co: (Parents born in Germany).
Physicians Committing, W. H. Pratt and D. C. Clark.
Correspondents, Jacob Maisch
Woodbury: Minn

No. for Year, 269
Insane Relatives, None
Cause Exciting, Self abuse
Cause Predisposing, "Chronic"
Form, Melancholia chronic
Accompanying Bodily Disorder, Are 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 24.
Time of Leaving, Apr. 26th. 1897.
Time in Hospital, Pres. 30 da.
Result, Discharged Aug. 11. 1897. Unimproved.

EXAMINATION ON ADMISSION.

Ex by Dr. Herzog 7/7/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Slightly Confused.
Quick or Sluggish, 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 Joseph Maisch

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ST. PAUL, MINN.
St. Louis

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 161½ lbs NUTRITION, Considerably impaired
neck long Skin- Yellow - greasy
Coatings, gray coating on tongue marked. Slight Promptness Movement, Slow, Anaemic
Normal Size, normal
Response Light, Excessive Accommodation, Excessive
HT, Good. Sclerotics jaundiced
HEARING, Good.
COORDINATION, Arms, Fair
Legs, Fair
TREMORS, Hands, None Tongue, Slight
Facial Muscles, None General, None
REFLEXES, Patellar, 8 equal EXAM. URINE,
Other
ARTICULATION, —
Slurred,
Hesitating, Slow.
FACIAL EXPRESSION, —



SENSIBILITY, —
HEART, All sounds soft anaemic murmurs
Sounds weak. Apex beat feeble. 5th inter space 2½ in to right of nipple line. Rapid & markedly irregular.
LUNGS, Seem good
TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, No prominent diseases (Says)
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Mother living - Age 70. Says healthy
Father or Pat. Relations, Father died - Age 78. Says was healthy
Brothers or Sisters, Four brothers, One sister. Says healthy

Personal and Medical History of Joseph Maisch

1896

This patient was brought here by Deputy-Sheriff G.W. Smith, attended by Alf. Johnson, with following history: Patient is in fair physical condition. No history of consanguinity or heredity. This is 1st attack. Symptoms manifested about 2 years ago: became moody, suspicious and listless. The disease seems increasing: variable + with rational intervals, but these are not regular: an occasional day, when he is partially rational. Derangement now shown in that he refuses to take food from others: thinks someone is trying to poison him. He threw rocks at his brother, once, without cause. Is not suicidal, nor filthy nor destructive in habits. No special peculiarities manifested, with the exception that he is of a rather strong religious turn of mind. No history of intemperance in self or parents. He has not been subject to any severe disease or had any head-injury: has not been restrained or confined. Supposed cause of disease is self-abuse. Has had no treatment. On personal examination, he is dull in appearance: disinclined to talk: suspicious of those around him.

July 6 On admission, was put on B³ (G.S.A.N.R.P.P.). Complexion light: hair brown: eyes blue: condition of skin good: no marks, scars or bruises noted: is clean: behavior good: he is very stupid.
" 7 July 7/96. Slept 6 hours, last night (was given bath, on admission): behavior stupid: is very quiet: bowels
" 8 costive: ate very light breakfast. Is on regular diet: (was given medicine). July 8/96. Slept 5 hours, last night. Is quiet: talks very little + in an hesitating manner. Is timid: bowels moved slightly
" 9 July 9/96. Slept 5 hours. Gave salts. Today bowels thus moved copiously: behavior quiet: is despondent.
" 10 Talks little: very timid: Is on medicine, 3 times, daily. July 10/96. Slept 4 hours. Appetite fair:
" 11 bowels moved today. He goes out on grounds, daily. Receives extra diet. July 11/96 Slept 4 hours: No
" 12 Change noticed. July 12/96. Slept 6 hours. Is quiet + despondent: talks fairly well: Physical
" 13 condition not good, apparently. July 13/96. Slept 7 hours. Is quiet: appears dull + confused: Mental
" 14/15 activity sluggish. July 14/96. Sleeps 7 hours, nightly: remains in room, day after day: July 16/96. Bowels
" 16 fairly regular: Goes out on grounds, daily: while outward, stands around in a stupid manner:
" 20 scarcely moving, even when spoken to. July 20/96. Sleeps 5 to 6 hours, nightly: No improvement noticed: behavior good: very quiet, at all times: appears confused + dull: talks very little, and in a slow, hesitating manner: answers questions rationally: no delusions noticed. - Is on medicine, 3 times a day. Summary: Patient has been quiet + rather despondent, Continually during past 2 weeks: talking very little + in a slow, hesitating manner. Answers questions rationally, but cannot carry on an extended conversation. Does not appear to have improved any. Mental condition seems stupid + dull, continually: No delusions or hallucinations noted. Physical condition fair: Is not in extra good flesh: Muscular activity sluggish.

Aug 30 Summary Nurses Notes by Dr. Phelps. Patient despondent - yet quite clean + neat. Sept 17
noted by friends: Has been recently found on A'. Has delusions of various kinds.
Oct. 1 Wt. 160 lbs. No change in any respect. Dec 2 Transferred to Infirmary Temp.
having been found to be 101 + he feeling somewhat sick - Seems to have bronchitis
Dec 5 Trans. yesterday back to A'. Dec 6 Taken back to Infirmary where he remained in
bed until the 14th. Jan 25 Patients appetite noted as poor: Seems to be failing
Feb 1 Again noted as failing in health + as coughing + expectorating a good deal.

Personal and Medical History of

Mch 1/97 Wt. 149 lbs. Still coughs considerably. Mch 25 Had a slight hemorrhage from lungs. Temp. 103. Trans. to Infirmary. Apr 1 Patients temperature shows an irregular rise from 100° to 101°. Has quite severe coughing spells: Is quite weak + stays in bed. Apr 26 Visited by his brother + taken home. Altho he has gained little: Temp. averages somewhat lower. Is still very weak.

Discharged.

Personal and Medical History of Carl Lambrecht

BERRY, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4444.
Residence, St Paul: Minn.
Date Admission, 5th July 1896.
Admitted by Dr. Phelps Hour, 6 PM
How Sent, G. Wilbrick, Jo. P. Ramsey County
Sex, — Male —
Age, — 23 years —
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Clerk in Ry office
Degree Education, Fair: Common School
Profession Religion, Yes: German Lutheran
Habits, — not good — (Probably)
Nativity, St Paul. Minn (father, Germany; Mother, Russia)
Physicians Committing, Vincent J. Hawkins and Geo B. Kinnikell.
Correspondents, None given in papers.

No. for Year, 270.
Insane Relatives, None: (Mother, in previous Commitment).
Cause Exciting, Father suicide and Self hard drinker - Sunstroke - (Tertiary Syphilis previous Cause).
Cause Predisposing, Heredity & previous attack.
Form, mania sub-acute
Accompanying Bodily Disorder, None mentioned, this time.
Suicidal or Not, — not —
Date of this Attack, at age of 16, had Sunstroke
Duration, — Some 7 years —
No. of Attack, 2nd (?)
No. of Admissions, 2nd
Age First Attack, about 17. (or 16)
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Ex by Dr. Frezog 7/7/96

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,
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 Carl Lambrecht

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8 in WEIGHT, 132 lbs. NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES, Skin hot and dry
TONGUE, Tremors, - Coatings, Heavy yellow coat- Promptness Movement, Prompt
PUPILS, Equality, normal Size, Contracted
Response Light, Slow Accommodation, Slow
SIGHT, Good
HEARING, Good.
COORDINATION, Arms, Some impairment.
Legs, Fairly good.
TREMORS, Hands, Slight Tongue, Coarse
Facial Muscles, None General, none
REFLEXES, Patellar, 8 equal EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs - Sounds weak
Apex beat feeble - Regular, rapid.
LUNGS, Fairly Good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Some Headaches- Some vertigo. (See previous history)
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Neurotic
Father or Pat. Relations, Quite well.
Brothers or Sisters,

Personal and Medical History of Carl Lambrecht

This patient was brought here by Deputy Sheriff Chas. Reichow, with following history. Patient is in fair physical condition. No history of Consanguinity: mother, stated there is one in previous Commitment. This is not 1st attack. Left home 3 years ago: then sent to Rochester X & left there 2 years: appeared much improved, when discharged. First symptoms of attack manifested at age of 16 yrs. had sunstroke: Three years ago, first noticed: did not attend to business: Spent money aspert as sent to him: Present condition of the disease, not stated: Not variable: No rational intervals: never quite right, though better some days. Derangement now shown by being Confusional: has hobbies: now trying to get on police force. Is not disposed to injure others, nor suicidal. Not filthy nor destructive in habits. Is talks loudly: seems good natured. Father and uncle used Alcohol - Drinkers. Patient had sunstroke at age of 16 years. Supposed cause of the disease is sunstroke: (tertiary Syphilis given as previous cause). Patient now has staring eyes, a bold expression: continuous movements of head and eyes. ——— 1 ———

X Note. Patient as stated, was here before, from May 3/93 to April 20/95. For some time after coming was very restless by night: restless, uneasy, walking about aimlessly & disintested, by day: often trying to escape: Had delusions: "that people were bothering him etc": habit very dirty: talking incoherently. From time to time, during that stay, patient had "spells", when he was restless & noisy: sleeping very poorly & inclined to be violent: and, again, "spells", when he was quiet, stupid, dull & depressed. Was not on trial (May 10/94 to July 14/94): During November '94, he commenced to improve. Talked freely & sensibly: became cheerful & contented: improved very much during the 3 months before leaving: Was usually quite clear. There were many traces of the old trouble left, but he was fairly well. (See Vol 23 Page 177 No 3336).

July 6 On admission, was put on B³ (G.H.R. Left. Complexion dark: hair brown: eyes blue: condition of skin good: no marks, scars or tumors noticed: Is clean: behavior good). July 7/96. Slept 11 hours, last night: (given bath, on admission): behavior restless, nervous: talks incoherently: cannot converse rationally: inclined to be noisy. July 8/96. Slept 11 hours, last night: behavior very restless and nervous: was given salts: bowels moved copiously: talks incoherently. July 9/96. Slept 5 hours: — no change in behavior: habits not neat & clean: talks loudly in a "tragical" manner: Eats poorly: (is on regular & extra Diet): very restless. July 10/96. Slept 5 hours: does not improve any: out on grounds, daily: cannot talk rationally. July 11/96. Slept 5 hours: no change in behavior: bowels constipated: patient is quite troublesome, requiring continual watching. July 12/96. Slept only 3 hours, last night: behavior restless & nervous: no change, otherwise. July 13/96. Slept 7 hours: Is still very restless & slightly noisy: Speech incoherent: habits not neat. Is quite troublesome. " 14 Is on medicine, 3 times a day: July 14/96. Slept 6 hours. Is nervous & restless: otherwise, no change. " 15 July 15/96. Slept 6 hours. Is noisy & troublesome: always greets anyone he sees with some slang & vulgar " 16 phrase & wants to be constantly talking. July 16/96. Slept 5 hours. no change in his behavior. Eats well: bowels not regular. Is frequently asking for tobacco. Is still on medicine. " 17 July 17/96. Slept 5 hours: Delights in ordering other patients around & is quite troublesome, in many ways. July 18/96. Slept 4 hours. Is restless & noisy. Continually. Quite full of original " 19 remarks often vulgar style. July 19/96. Slept 5 hours. No change: restless & noisy, most of " 20 the time. Goes out on grounds, daily. July 20/96. Slept 4 hours: Appetite good: bowels in

Personal and Medical History of Carl Laubrecht

1896

Summary good condition: physical Condition improving: Summary: Patient has been very restless & nervous; at times, becoming quite noisy & hilarious & it is almost impossible to keep him quiet. Mental Condition Good: Cannot Concentrate his thoughts enough to answer questions rationally: Power of attention poor: memory good: has not improved, since he came. Physical Condition apparently good: Is in fairly good flesh: muscular activity Quick & good. Is improving physically every day.

Aug 1'96 Summary of Nurses Notes by Dr Pilley Phelps Patient during summer of 1896 rather variable in behavior: During July he seemed to gain quite rapidly in physical condition & in quietness but afterwards became restless & noisy. Aug 7th was visited by mother. Sept 1st weight 137 lbs. Nov. 15 Restless, incoherent, full of delusions, has spells of crying March 31'97 Very changeable in behavior most of time: quite restless; is kept on violent ward. May 1st 97 Condition unchanged in any essential respect. May 31'97 Wt. 137# Visited by brother June 7th Visited by brother. July 27 Rather Troublesome - abusive. Health fairly good. Is at times destructive of clothing Feb. 18'98 Trans. to B. Feb 24 Attempted to elope. March 7'98 Trans to B.³ July 31'99 Patient seems to grow gradually more stubborn & troublesome as time goes on: Is noisy, incoherent & troublesome & cannot be reasoned with Feb 1 - April 20. Answers questions rationally but when not in conversation sings, whistles & is noisy. Has exalted ideas. May 15 Attacked nurse: Had to be held on floor. July 31 1899 (Dr Wanous) Wt. 184. Stubborn, troublesome & at times maniacal, noisy & profane Aug 1 - Jan 31 1900 (Dr Chapple) Aug 1. Wt. 140# July 0 Wt. 136# Sept 15 Visited by mother Nov 15. Nose bruised by another patient. No change nor improvement during period - Has been restless & somewhat exalted & occasionally has trouble with other patients. but is not vindictive. Is tidy in habits & does some work. — Feb 1 Wt 135# Pos. April 5. Visited by mother. July 31. No change of importance - Physical Condition quite good. Works April 5 some on ward, and, at times, active: behavior variable - Somewhat exalted, & at times, quite noisy - Is very July 31 quick-tempered, and fights with little provocation - Quite incoherent: irrational in speech and silly in Aug 1/30 manner. Addicted to Masturbation - Aug 1. Wt 139# — Aug 30. Visited by his mother. — Sept 10 Transferred to T.W: Has severe diarrhoea: put on medicine, every 3 hours & liquid diet. 1st 1901 Recovered & Transferred to C. — Jany 31'901. Little Change during period. Walks some Jan 31 on ward: Quite well-behaved. Talks very irrationally & incoherently: is Quite Childish & irritable & will fight on slightest provocation. Habits quite tidy: Masturbates frequently Feb 3/97 Wt 137# — Feb 6 - 11. In bed (La Grippe) — April 30. No change noticeable: very irrational April 30 irritable: Pugnacious: Slightly exalted. Incurs Jan B²: behavior somewhat improved July 31 of late. July 31. has been working on the Dray. Nov. Wt 147# — Mentally, not so well Nov 1 1901 Jany 31'02 some confused: destructive. Dec 15 Jan C. Jany 31'02. No change noticeable. July 31 Still very irritable & at times pugnacious. May 15.02 Visited by Mother

Aug 1 - 143#. Jan. 31.03 Has been drifting along in about the same way. At times is quiet & good natured at others at other times is ugly & wants to fight. Very easily excited - Works a little about ward and around building with nurse.

Personal and Medical History of Thomas G. Gray.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 44443.

Residence, Lake City, Minnesota

Date Admission, 7th July 1896. —

Admitted by Dr Kilbourne Hour, 3.30 P.M.

How Sent, Malcolm Kennedy, Sh. Wabasha County

Sex, Male

Age, 31

Civil Condition, Single

Children, None

Age Youngest Child, —

Occupation, Laborer, in Nursery.

Degree Education, Common school Education —

Profession Religion, not a church member

Habits, not stated —

Nativity, Crawfordsville, Indiana: Father, Cincinnati, Ohio. Mother's Indiana

Physicians Committing, Wm J. Wilson and Emery A. Farley

Correspondents, J.M. Gaylord. (bro-in law). Lake City, Minn
Chas L. Gray (bro) Rochester, Minn

No. for Year, 271.

Insane Relatives, None so far as known.
Father moderate drinker

Cause Exciting, Nothing definite: was hit already stone, when 9 years old

Cause Predisposing, "Chronic"

Form, Imbecility

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not

Date of this Attack, Since 9 Years of age

Duration, — about 22 years —

No. of Attack, 1st (Continuous) —

No. of Admissions, 1st

Age First Attack, 9 years.

Time of Leaving, May 9. 1897.

Time in Hospital, 10 mos.

Result, Discharged Nov. 3. 1897
Improved.

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 Thomas G. Gray.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7½ WEIGHT, 153 lbs 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, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

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 *Thomas G. Gray.*

Personal and Medical History of

1896

This patient was brought here by Deputy-Sheriff D.P. Foley & attended by J.M. Taylor, with following history. There is no history of Consanguinity: Patient has never been right mentally, since 9 years of age: has never been to hospital: he has been gradually becoming demented, and quarrelsome for some years back. The disease appears increasing: variable: no regularity as to intervals, but exacerbations of symptoms, at times. Derangement now shown by mental Enfeeblement and irritability. Patient is disposed to injure others, but not suicidal, nor filthy nor destructive in habits. No insane relatives, so far as known. The peculiarities shown are co-incident with the development of the disease. Patient & his father used tobacco considerably: father, moderate drinker. Nothing definite, as to cause of disease, though patient was hurt in the head, by a stone, when 9 years old: he has not been restrained or confined: has had no treatment: mind is now feeble: sensitive as to feelings. ———

July 7 On admission was put on B³ (G.F.N. Kph. Complexion dark: hair black: eyes blue: condition of skin good: remarks, scars & bruises noted. Is clean: behavior good). ———

" 8 July 8/96 Given bath, on admission: slept 6 hours: behavior quiet: is timid & afraid: says "he

" 9 struck his mother & was sent here, as punishment". July 9/96. Slept 6 hours: appetite good: bowels moved today: Is more cheerful: behavior good: talks little: voice is unsteady, faltering:

" 10 July 10/96. Slept 6 hours - Is more contented & cheerful - Talks some but still in a timid,

" 11 faltering manner. Physical condition apparently good. July 11/96. Slept 6 hours: behavior

" 12 good: habits neat & clean: patient improves daily: works in dining-room. July 12/96. Slept

" 13 6 hours: no change noticed. July 13/96. Slept 7 hours: behavior good: is very quiet:

" 14 Works on ward & yard. More cheerful of late. Visited by brother. July 14/96. Slept 7 hours. Appears to improve since, every day. Says he is going to escape the first chance he gets:

" 15 July 15/96. Slept 6 hours. Appetite good: bowels in good condition. Physical condition apparently

" 16 quite good. behavior very good. July 16/96. Slept 7 hours. Still seems to improve: works on

" 17 ward & in dining-room: out on grounds, daily. July 17/96. Slept 7 hours: seems to grow more bright every day: is rather quiet: talks rationally: no delusions & hallucinations noticed.

" 21 July 21/96. Slept 6 to 7 hours, nightly - Has seemed to improve, since he came, both mentally & physically. Behavior good: Quiet & inoffensive: works on ward & in the dining room.

Summary: Behavior has been very good: Quiet & obedient: working in dining-room and hall: Mental condition has perceptibly improved, during past 2 weeks: is more bright & cheerful, every day: talks rationally & well: no delusions or hallucinations noticed. Physical condition good: Has good flesh: muscular activity good.

Aug 1/96 to Apr 30/97 Summary Nurses Notes by Dr Phelps Patient very quiet: is feeble-minded, Talks is usually rational but conversation poor: has a hesitating manner. Sept 1st 96 Trans. to A'. Apr 1st 97 Has been uniformly quite well-behaved, no special delusions but is childish & feebleminded. Health good. May 8/97 Quite well behaved: rather easily irritated. Went home with brother on trial.

Discharged.

Personal and Medical History of Frank Riebel ("Holy Joe")

"Names given in previous commitments have been Frank Reidel - Frank Joseph - Joseph Riebob

BIBBERT, FIGLAN & CHAMBERS, DAVENPORT, NWA

Whole No. 4444.	No. for Year, 277.
Residence, St Paul. Minn.	Insane Relatives, Not known: (Brother said to be)
Date Admission, 7th July 1896.	Cause Exciting, Religion
Admitted by Dr Fitzpog Hour, 6.45 P.M.	Cause Predisposing, Chronic
How Sent, C. Wilbrich Jail. Ramsey County	Form, Paranoia
Sex, Male	Accompanying Bodily Disorder, None mentioned
Age, 50	Suicidal or Not, Not
Civil Condition, Single	Date of this Attack, not stated
Children, None	Duration, Long
Age Youngest Child,	No. of Attack, Several
Occupation, Tree-trimming	No. of Admissions, 3rd
Degree Education, Don't know: (10 years Military School)	Age First Attack, not given
Profession Religion, Yes: Catholic	Time of Leaving, Mar. 24. 1898
Habits, Good - probably good	Time in Hospital, 1 yr. 8 m. 17 d.
Nativity, Germany: (Parents also born there)	Result, Discharged Aug. 10. '98 Minnesota.
Physicians Committing, A Macdonald and Park Ritchie	
Correspondents, None Given in papers	

EXAMINATION ON ADMISSION.

Ex by Dr R. M. Hicks 9/10/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: —	EMOTIONAL STATE: —
Clear or Confused,	Normal, Calm,
Quick or Sluggish,	Indifferent,
MEMORY: —	Exalted,
Past Events,	Depressed,
Recent Events,	DELUSIONS: —
Special Subjects,	Systematized or Not, —
PERCEPTIVITY: —	Special Subjects,
Alert or Dull,	Transitory or Not,
Correct or Illusive,	HALLUCINATIONS: —
REASONING POWER: —	ILLUSIONS: —
Ordinary Subjects,	CONVERSATION: —
Own Mental State,	Coherent or Incoherent,
Special Subjects,	Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Has lived for five years bareheaded and praying on the street - Lies on ground & stone for pillow - In a shanty. This is to him the reason for his claim to be able to cure by praying - To have power to do cures by other people. Claims that he does this as a lesson of God to people. The preachers do nothing - Their preaching does nothing - Living in this way is the lesson

Personal and Medical History of Frank Riebel

"HOLY JOE" AT LARGE. 6/24/96

He Escapes From an Asylum and Is Arrested in St. Paul.

Joseph Reidell, who for many years traveled the streets of St. Paul bareheaded and barefooted, known to the street xamins as "Holy Joe," escaped from the Rochester insane asylum on Tuesday, and was arrested last evening in St. Paul at the home of his brother in the rear of 740 Mississippi street. He was committed to the asylum by Judge Willrich more than a year ago. The asylum authorities notified the police department of his escape, and the patrolmen were instructed to watch his old haunts near the Mississippi street bridge and to place him under arrest if found. Frank Reidell, Joe's brother, notified the police, claiming that he was afraid to remain in the cottage with Joe.

A HAPPY, HAPPY MAN

St Paul Pioneer Press 6/25/96

JOHN THE BAPTIST NEEDS NO MON.

Minnesota Freak in Chicago Asks for Seclusion and Gets Six Months of It.

Pioneer Press Special Service.

Chicago, June 26.—"John the Baptist," a Minnesota product, was arrested yesterday on a charge of disorderly conduct. He was arraigned in the Harrison street police court to-day.

The prisoner is sixty years old. He calls himself "John the Baptist II." His unique dress and peculiar actions attracted a large crowd at State and Adams streets, where he was delivering a sermon, with a large packing box for a pulpit.

The police did not interfere at first, but finally the crowd became so large that traffic was delayed. Then two officers ordered the throng to disperse. "John the Baptist" became indignant when he saw his congregation disbanding. He protested in a loud voice, and, the police say, became so troublesome that they arrested him for disorderly conduct.

For some time the man has caused trouble to Detective Evans of the Fair store. Finally the detective secured a warrant for the man's arrest. When "John" was arraigned before Justice Hall at the Harrison street police court he was greeted cordially.

"Good morning, Jack," said Justice Hall.

"Use not the name of such exalted person as myself in such a familiar way, if you please," replied the man.

"When did you last hear from headquarters?" asked the justice.

"Please do not bother me," replied the man. "I wish to be left in seclusion, if you please."

"All right, my friend," replied the justice. "Six months to seclusion. I'll give you $85."

"Oh, no; thank you," said John. "I need no money."

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 199½ lbs. NUTRITION, Normal

MALITIES, Condition of Skin - Good.

normal Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, normal

Response Light, Accommodation,

SIGHT, Eyes normal

HEARING,

COORDINATION, Arms, } normal

les, } normal Tongue, } normal

General,

ormal

EXAM. URINE,

TAKEN,

XAM.,

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

CRANIAL MEASUREMENTS, Cir.(h.) 59½ Cir.(um.) 70 Naso Oc. a. 38 Bin. a. 36 Art. f. diam. 30.1 Frontal d. 17.4 Bin. d. 15.5 Fac. l. 13.0

HISTORICAL,

LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Died - Cholera.

Father or Pat. Relations, Died - age.

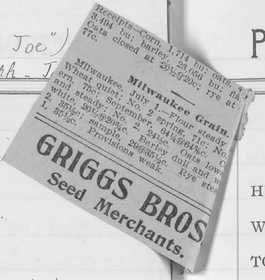
Brothers or Sisters,

Personal and Medical History of Frank Riebel ("Holy Joe")

"Names given in previous Commitments have been Frank Reidel; Frank Joseph - I..."

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4444.	No. for Year, 277.
Residence, St Paul, Minn.	Insane Relatives, Not known: (Brother sa...
Date Admission, 7th July 1896.	Cause Exciting, Religion
Admitted by Dr Herzog Hour, 6.45 P.M.	Cause Predisposing, Chronic
How Sent, G. Wilbrich Jail Ramsey County	Form, Paranoia
Sex, Male	Accompanying Bodily Disorder, None mentioned
Age, 50	Suicidal or Not, Not
Civil Condition, Single	Date of this Attack, not stated
Children, None	Duration, Long
Age Youngest Child,	No. of Attack, Several
Occupation, Tree-trimming.	No. of Admissions, 3rd
Degree Education, Don't know: (8 years Military School)	Age First Attack, not given
Profession Religion, Yes: Catholic	Time of Leaving, Mar. 24. 1898
Habits, G — probably good —	Time in Hospital, 1 yr. 8 m. 17 d.
Nativity, Germany: (Parents also born there)	Result, Discharged Aug. 10. '98 Unimproved.
Physicians Committing, A Macdonald and Park Ritchie	
Correspondents, None seen in papers	



EXAMINATION ON ADMISSION.

Ex by Dr R. B. Kleeb 9/10/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: —	EMOTIONAL STATE: —
Clear or Confused,	Normal, Calm,
Quick or Sluggish,	Indifferent,
MEMORY: —	Exalted,
Past Events,	Depressed,
Recent Events,	DELUSIONS: —
Special Subjects,	Systematized or Not, —
PERCEPTIVITY: —	Special Subjects,
Alert or Dull,	Transitory or Not,
Correct or Illusive,	HALLUCINATIONS: —
REASONING POWER: —	ILLUSIONS: —
Ordinary Subjects,	CONVERSATION: —
Own Mental State,	Coherent or Incoherent,
Special Subjects,	Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Has lived for five years bareheaded and praying on the street - Lain on ground & stone for pillow - In a shanty. This is to him the reason for his claim to be able to cure by praying - To have power to do cures by other people. Claims that he does this as a lesson of God to people. The preachers do nothing - Their preaching does nothing - Living in this way is the lesson.

Personal and Medical History of Frank Riebel

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 10in WEIGHT, 199½ lbs NUTRITION, Normal

WOUNDS OR ABNORMALITIES, Condition of Skin - Good.

TONGUE, Tremors, Normal Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Normal

Response Light, Accommodation,

SIGHT, Eyes normal

HEARING,

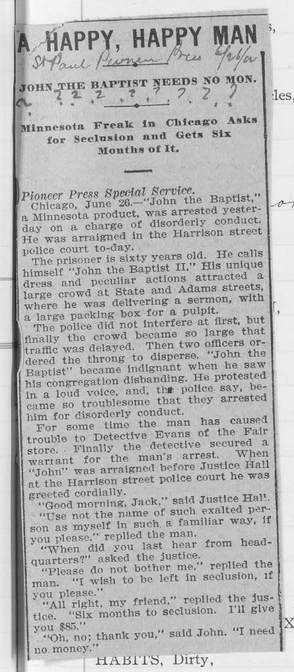
COORDINATION, Arms, } normal

..., } normal Tongue, } normal

..., General, }

...normal EXAM. URINE,

TAKEN,



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

CRANIAL MEASUREMENTS, Cir(h) 59½ Cir(um) 70 Naso Oc. a. 38 Bin. a. 36 Ant. p. diam 30.1 Transv. d. 17.4 Bin. d. 15.5 Auc. l. 13.0

HISTORICAL,

LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Died - Cholera.

Father or Pat. Relations, Died - age.

Brothers or Sisters,

Personal and Medical History of Frank Riebel ("Holy Joe")

Names given in previous commitments have been Frank Reidel: Frank Joseph - Joseph Riebel

EUBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4444.

Residence, St Paul, Minn.

Date Admission, 7th July 1896.

Admitted by Dr Sterzing Hour, 6 45 PM

How Sent, G. Wilbrich Jail. Ramsey County

Sex, Male

Age, 30

Civil Condition, Single

Children, None

Age Youngest Child,

Occupation, Tree-trimming.

Degree Education, Don't know: (8 years military school)

Profession Religion, Yes: Catholic

Habits, G — probably good —

Nativity, Germany: (Parents also born there)

Physicians Committing, A Macdonald and Park Ritchie

Correspondents, None Given in papers

No. for Year, 277.

Insane Relatives, Not known: (Brother said to be)

Cause Exciting, Religion

Cause Predisposing, Chronic

Form, Paranoia

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not

Date of this Attack, not stated

Duration, — long —

No. of Attack, Several

No. of Admissions, 3rd

Age First Attack, not given

Time of Leaving, Mar. 24. 1898

Time in Hospital, 1 yr. 8 m. 17 d.

Result, Discharged Aug. 10. '98 Unimproved.

EXAMINATION ON ADMISSION.

Ex by Dr. P. M. Sharples 9/10/96

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: —

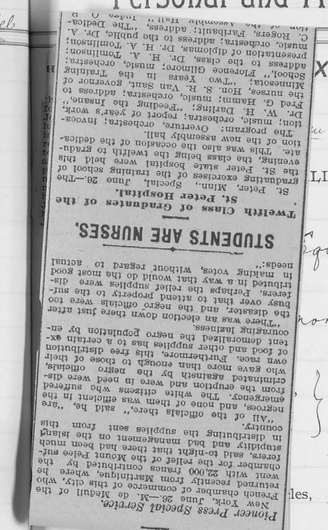
CONVERSATION: —

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Has lived for five years bareheaded and praying on the street - Lain on ground & stone for pillow - In a shanty. This is to him the reason for his claim to be able to cure by praying - To have power to do cure by other people. Claims that he does this as a lesson of God to people. The Preachers do nothing - Their preaching does nothing - Living in this way is the lesson

Personal and Medical History of Frank Riebel



Pioneer Press Special Service.

New York, June 25.—At the behest of the French chamber of commerce of this city, who went with 22,000 francs contributed by her chamber for the relief of the Mount Pelee eruptors, and had management of the island in distributing the supplies sent from this country.

"All of the officials there," said he, "are heroes, and none of them was efficient in the emergency. The white citizens who suffered from the eruption and were in need were discriminated against by the negro officials, who gave more than enough to those of their own race. Furthermore, the free distribution of food and other supplies has to a certain extent demoralized the negro population by encouraging laziness.

"There was an election down there just after the disaster, and the negro officials were too busy over that to attend properly to the surferers. Perhaps the relief supplies were distributed in a way that would do the most good in making votes, without regard to actual needs."

STUDENTS ARE NURSES.

Twelfth Class of Graduates of the St. Peter Hospital.

St. Peter, Minn., Special, June 25.—The graduating exercises of the twelfth class of the St. Peter state hospital were held this evening, the class being the largest to graduate. This was also the occasion of the dedication of the new assembly hall.

The program: Overture; orchestra; invocation of the nurses, Rev. S. R. Van Sant, governor of Minnesota; "Two Years in the Training School," Florence Gilmore; music, orchestra; address to graduates, Hon. W. H. Darling; "Reading the Theme," Dr. W. H. Darling; music, orchestra; report of year's work, Fred G. Hamm; music, orchestra; address to the public, Dr. H. A. Tomlinson; presentation of diplomas, Dr. H. A. Tomlinson; music, orchestra; address to the class, Dr. H. A. Tomlinson; music, double quartet; address, "The Dedication of the New Assembly Hall," Judge D. R. C. Rogers, Faribault; address, "The Dedication of the Assembly Hall," Judge D. R.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 199½ pds NUTRITION, Normal

Condition of Skin - Good.

LITIES, normal Coatings, Promptness Movement,

qual Size, normal

Accommodation,

normal

normal

normal Tongue, normal

les, General,

Other

ARTICULATION, Normal

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

EXAM. URINE,

TAKEN,

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) 59½ Cir(um) 70 Naso Oc. a. 38 Bin. a. 36 Ant. f. diam 30.1 Diamet. d 17.4 Bin. d 15.5 Jac. l. 13.0

HISTORICAL,

LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Died - Cholera.

Father or Pat. Relations, Died - age.

Brothers or Sisters,

1896

This patient was brought here by Deputy Sheriff E. J. Horst, with following history. Patient is in good physical condition. As to consanguinity, don't know: brother said the nuisance This is not 1st attack: probably several: duration not known: has been in this (Rochester) Asylum: temporary improvement: Patient has always seemed demented: disease appears to be harassing: variable & with rational intervals; these occur regularly: Patient is a religious fanatic. Is disposed to injure others, but not suicidal, no filthy nor destructive in habits: he has known religious impressions. As to any history, intemperance, severe disease or head injury, don't know. Supposed cause of the disease is religion. Only treatment when confined in asylum. Note. As above stated, Patient has been here before: 1st time from June 7/90 to Jany 26/91: (for details of history see Vol 14 Page 69 No 2409): and the 2nd " " Nov 1/93 to May 14/94 (" " " " 25 " 217 " 3536). On both of these occasions he came here barefoot and without hat: showed, all the time, strong religious impressions: was always quiet & well-behaved & in good physical health, and, each time, seemed & home improved. —

July 7 On admission, was put on B3 (G.S.A.N.R.Pt. Complexion light: hair gray: eyes blue: nutrition of skin good: no marks, scars or bruises noticed: is dirty: behavior good).

" Mental condition not improved. Prays & talks about religion: sleeps well: appetite good. Has delusions: Habits neat. Does no work. July 30 '96 Visited by brother: Assisted by his brother made an attempt to escape; was overtaken at Dodge Center & brought back. Aug 1 96 Wt. 199½ lbs. Aug 7 While out with crowd tried to escape by hiding behind tree: Aug 10 Works some on ward but spends most of time in room praying: Mental state unchanged.

Aug 14/96 Patient escaped about 4:30 Am. by unlocking screen on windows & letting himself down on a rope of blankets. Aug 21 96 Returned: Had a large bruise on left thigh received from fall in escaping through window. Is very quiet and orderly Oct 3 96 No change in patient either mentally or physically: Wt. Oct 1 96 202½ lbs, Dec 1 96 Wt. 208 lbs Jan 1 97 Has a habit of hiding when preparing to go out with crowd: Wt. 210½ lbs, Mch 1 Has become rather discouraged of late at not receiving answer to his prayers. Mch 19 Eloped: Made key from back of comb & unlocked door. Mch 20 Brought back. Kept in bay. Sleeps on floor. Is watched continually. Mch 25 After returning from walk deliberately picked up chair & smashed it on floor: Threatened to break all the furniture. Trans. to C. Gave no trouble & was taken back to B3 on the 26th. May 1 97 Wt. 206 lbs June 10 Tried to escape: Brought back from grounds.

June 17 Tried to escape: Caught at foot of stairs. June 26 Escaped from crowd this morning through rye-field. July 1st Returned. Looks somewhat emaciated: Is very sensible. Sept 1st Is said to be in plot to attack night nurse get keys & escape: Trans. to C. Mch 24th 98. Escaped while out for a walk.

Discharged.

Personal and Medical History of Frank Wakla

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 44148.
Residence, St Paul: Minn.
Date Admission, 13th July 1896.
Admitted by Dr. Neyon Hour, 6th PM.
How Sent, Benn Davis, Court Commr. Ramsey Co.
Sex, Male
Age, — 34 —
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Labarer
Degree Education, not educated.
Profession Religion, Yes: Catholic
Habits, not intemperate
Nativity, Minn: U.S.a (parents born in Bohemia)
Physicians Committing, J Chase and A.S. Bole
Correspondents, Mrs Rosa Wakla (mother) 770 Logan St St Paul Minn

No. for Year, 276.
Insane Relatives, None
Cause Exciting, Fear of prosecution
Cause Predisposing, not stated.
Form, acute melancholia.
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, Suicidal, by hanging.
Date of this Attack, July 12th
Duration, a Days or so
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 34 —
Time of Leaving, May 15: 1900
Time in Hospital, 3yr 2mo. 3 d.
Result, Disc. Nov. 7. 1900 Improved

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps 9/27/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Fairly quick now.

MEMORY:
Past Events,
Recent Events, } Seems good
Special Subjects,

PERCEPTIVITY:
Alert or Dull, } Fair
Correct or Illusive,

REASONING POWER:
Ordinary Subjects,
Own Mental State, } Rather poor
Special Subjects,

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

DELUSIONS:
Systematized or Not,
Special Subjects, } None noted
Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient young man, somewhat silly and childish in manner. Says got drunk, went in barn tried to hang himself. Brother took him and sent for patrol wagon. Don't know why did it - only "whirls." Stammers so extremely that it is hard to get information. Appears healthy and well.

Personal and Medical History of Frank Wakla

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, 140lbs NUTRITION, Good
WOUNDS OR ABNORMALITIES, Condition of Skin - Good.
TONGUE, Tremors, Good. Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, normal.
Response Light, normal Accommodation,
SIGHT, Good - Eyes normal
HEARING, Good.
COORDINATION, Arms, } good.
Legs, }
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 8-9 Equal. EXAM. URINE,
Other
ARTICULATION,
Slurred, Extreme stam-
Hesitating, mering
FACIAL EXPRESSION,



SENSIBILITY,
HEART, Normal
LUNGS, Normal

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Cir.(R.) 57 (v.m) 67 Naso Oc. a 34½ Bin.a. 34 Ant.p.d 19.4 Transvd 16.4 Biz.d 13.5 Fac. L 12.0 Head rather wide.
HISTORICAL, No prominent diseases. Troubled a little with headaches.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies
Mother or Mat. Relations, Living
Father or Pat. Relations, Died 7 yrs ago
Brothers or Sisters, 1 sister married - 1 sister working out.

Personal and Medical History of *Frank Wakla*

1896

This patient was brought here by Deputy Sheriff Emanuel Johnson, with following history: patient is in fair physical condition. There is no history of consanguinity, or heredity. This is 1st attack; symptoms manifested, July 12th by suicidal intentions. Derangement is now shown by suicidal intentions; has attempted same, by hanging: not disposed to injure others, nor of filthy & destructive habits. No peculiarities had been previously shown; no history of intemperance in his parents or self, nor of any severe disease &c of head injury. He has not been restrained or confined. Supposed cause of the disease is fear of prosecution: no treatment: repeated attempts to suicide. —

July 13 On admission, was shaven B.3. (G.H.R.R.H. Complexion dark: hair dark brown: eyes dark: condition of
" 14 skin good: no marks, scars or bruises noticed: is clean: behavior good). July 14/96. Slept only 4 hours, last night. Behavior good: is quiet. Patient is "tongue-tied" but can make himself understood.
" 15 Complains of being sick at stomach. July 15/96. Slept 5 hours. Is apparently contented. Appears
" 16 quite bright & rational. Works on ward & is quite anxious to get along well. July 16/96. Slept 5 hours. Is quiet. Bowels in good condition. Physical condition apparently good. Still complains of
" 17 feeling sick, at stomach. July 17/96 Slept 6 hours. Appears rational: no marked indications
" 18 of insanity noticed: habits neat & clean. July 18/96. Slept 5 hours: behavior very good. Is a little discontented. Anxious to work, at all times. Says "this is a good place & he wants to stay here". July 19/96. Slept 6 hours. Patient is more restless while out of doors, than inside:
" 20 his actions indicate that he would like to escape. July 20/96. Slept 6 hours: behavior good.
" 27 Is quiet. Takes considerable interest in his surroundings. July 27/96. During this the 2nd week, patient has been resting & sleeping better, (6 to 7 hours) nightly: has been somewhat discontented; restless while out of door; wants to walk considerable: appetite good: bowels in good condition, and physical condition, apparently, very good: makes no complaints. Tried to hide himself in the grass & escape on 26th; said "he just wanted to sleep" Says: he wants to leave here". Is of late, restless, most of the day. Summary: Patient has been quiet & well-behaved during past two weeks. Appears fairly bright & sensible; acts & dresses himself rationally: Cannot speak a word plainly, but can make himself understood easily. Physical Condition good; is in fairly good flesh. Skin good: muscles well-developed. —

July 96 Summary Nurses Notes by Dr Phelps. Patient quiet & fair-minded: Works some
to Is somewhat restless on ward. Sept 1st wt. 149 lbs. Dec 4 Wt. 151 lbs. Apr 30 157 lbs
May 97 Patient uniformly somewhat feebleminded & slightly stutters which makes him talk with difficulty. Has a fair degree of intelligence on ordinary subjects
May 31 Wt. 157th. Patient has worked quite steadily in dining room: Stammers so much that he can hardly talk at all at times. Is quite thoroughly imbecile:
Jan 31 99 Has tried to elope several times: No special change.
Feb 1 99 July 31 99. (Dr Wanous) Wt. 149th. Well behaved. Works in dining room: Rather foolish & simple in speech. Mch 31 Trans. to A. Is very anxious to go home.

Aug 1 Wt 148 lbs p 78. Patient works in Centre Dining room. Is rather silly in manner; generally well-behaved. Oct 31. Continues
Oct 31 about the same in every way. Has to be watched as he tries to get away. Feb 1/1900. Wt 153 lbs - p 76: has transitory
Feb 1/1900 delusions. April 13/1900. Seems very nervous: tried hard to get away, while out walking. Patient has severe defect with
April 13 speech. May 15/1900 Visited by Sista & taken on trial.
May 15

Discharged

Personal and Medical History of

Personal and Medical History of Charles Sylvester

C. F. Finn

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 44449 No. for Year, 277.

Residence, St Paul Minn.

Date Admission, 13th July 1896.

Admitted by Dr. C.B. Ebert Hour, 7 P.M.

How Sent, Benn Davis, Court Commr. Ramsey County

Sex, Male

Age, 28

Civil Condition, Married

Children, —

Age Youngest Child, —

Occupation, Telegraph Operator

Degree Education, Common

Profession Religion, Yes. Catholic

Habits, History of Intemperance

Nativity, Bangor, Maine. Father, Ireland. Mother, New Brunswick.

Physicians Committing, J.B. Brimhall and A.O. Deming

Correspondents, none given in papers

Sister's name - Margaret Smith or Wright

Rochester Minn July 7th

Friend D M

I want to tell you what my wife and people in St Paul have done to me and perhaps you can have me released out of this place. They are to keep me in here a year or more as there are others with nothing the matter with them. I dont see that there is anything the matter with me and I was pronounced by 12 drs of St Paul as in the best of condition. I am losing $ 150.00 dollars

Rochester Minn -

Feby 8th 97

Drs Kilbourne and Herzog

I am in my opinion in a very bad fix in this hospital and would prefer to be taken to operating room and disposed of as quickly as possible. I abhor the dull routine of existence longer and would be satisfied if you could do it without the knowledge of anyone but yourselves. I am tired of holding on any longer, and no one will ever miss me. Dispose of me any way

EXAMINATION ON ADMISSION.

Early D. Herzog: July 1896

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Somewhat Confused

Quick or Sluggish, Quick

MEMORY:

Past Events, Slight impairment

Recent Events, — do —

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Disconnected

Own Mental State, Does not realize

Special Subjects,

Systematized or Not, Systematized, somewhat

Special Subjects, of Grandeur

Transitory or Not, Quite fixed

HALLUCINATIONS: —

ILLUSIONS: /

CONVERSATION:

Coherent or Incoherent, Slightly incoherent

Voluble or Reticent, Voluble —

GENERAL DESCRIPTIVE REMARKS:

Claims had Syphilis 11 years ago: gives good description: remarks: probably both habits, drinking & smoking. Says "has had headaches & vertigo; not now: is Telegraph Operator: was arrested in Chicago, a week ago. Says nervous, sleepless, poor appetite, confused, memory poor: "all right now". Patient is in a mildly maniacal state, with delusions of grandeur - as that he is worth a hundred million, inherited from his uncle: that he is the best telegraph operator in the world & he has probably from his account passed through a period of mental confusion & depression. Bowels unloaded & breath foul. Previous mental grade was probably fair, but a trifle unstable.

Personal and Medical History of Charles Sylvester

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

lbs NUTRITION, Considerable impairs. Condition of skin, quite good.

brown coat Promptness Movement, prompt

Size, contracted

Accommodation, normal

tests.

Tongue, large coarse

General, general restlessness

EXAM. URINE,

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, mother living: healthy. Says "an aunt insane"

Father or Pat. Relations, father died - 66 - pneumonia

Brothers or Sisters, 1 Brother & 2 sisters: Says all healthy: says 2 brothers epileptic.

Personal and Medical History of Charles Sylvester

C. J. Finn

EGERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 14449 1/2 No. for Year, 277.

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per month so I get $8.00 from the Postal Telegraph Co and $7.00 from the Western Union for Chicago I work 7 hours for each a day in Chicago my folks has me put in the farm I get to 10 am and then I was [illegible] put in the hospital for over a week I can't [illegible] all my time in those places I do not care to live any longer as I could just leave be dead I have a note to my folks and mother and think they are more crazy than I am

John if you dont want to see me dead. for heavens sake come down and take me out they dont treat me of anything and can only say I got a boarder at the place how-how my wife and Mamie schemed to get me down it cost to care for me they took me down to Cook House and they sent into a room and talked to someone and came out but told me to take the name of Charles Sylvester I did as they done that in Chicago I suppose

Rochester Minn-

Feby 8th 97

Drs Kilbourne and Herzog

I am in my opinion in a very bad fix in this hospital and would prefer to be taken to operating room and disposed of as quickly as possible. I abhor the dull routine of exsistence longer and would be satisfied if you would do it without the knowledge of anyone but yourselves I am tired of holding on any longer, and no one will ever miss me. Dispose of me any way

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Disconnected

Own Mental State, Does not realize

Special Subjects,

Systematized or Not, Systematized, somewhat

Special Subjects, "of Grandeur"

Transitory or Not, Quite fixed

HALLUCINATIONS: —

ILLUSIONS: /

CONVERSATION:

Coherent or Incoherent, Slightly incoherent

Voluble or Reticent, voluble —

GENERAL DESCRIPTIVE REMARKS:

Claims had syphilis 11 Years ago: gives good description: remarks: probably bad habit, drinking & smoking. Says "has had headaches & vertigo; not now: is Telegraph Operator: was arrested in Chicago, a week ago. Says nervous & restless, poor appetite, confused, memory poor: "all right now". Patient is in a mildly maniacal state, with delusions of Grandeur - as that he is worth a hundred million, inherited from his uncle: that he is the best telegraph operator in the world & he has probably from this account passed through a period of mental confusion & depression. Bowels retarded & breath foul. Previous mental grade was probably fair, but a trifle unstable.

Personal and Medical History of Charles Sylvester

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

lbs NUTRITION, Considerably impaired.

Condition of skin, quite good.

brown coat Promptness Movement, prompt

Size, Contracted

Accommodation, Normal

tests.

Tongue, large Coarse

General, General restlessness

EXAM. URINE,

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, Mother living: healthy. Says "An aunt insane"

Father or Pat. Relations, Father died - 66 - Pneumonia

Brothers or Sisters, 1 Brother & 2 sisters: Says all healthy: Says 2 brothers epileptic.

Personal and Medical History of Charles Sylvester

C. J. Finn

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 14449 ½ 8 l 3

No. for Year, 277.

They did not want to know the name of Finn (my name will never be Finn again I will go to a Judge and have it changed so I never can be seen them again "I'll get this" after I left the Court House I was taken to the Depot in a hack by a Deputy Sheriff and he started me to get on a Milwaukee train. I told him my pass was not for

that road and he said we could just take a ride down the road a ways I thought that and all right as it was 3 2 5 and my train did not leave until 6 30. We got in [illegible] do Rockford & wanted to go no further but the Rock Co. Catch a train at Rochester We got there and it was about supper time & he asked me if I would go up to the hotel with him I might as well as I had lost my

Rochester Minn-

Feby 8th 97

Drs Kilbourne and Herzog

I am in my opinion in a very bad fix in this hospital and would prefer to be taken to operating room and disposed of as quickly as possible. I abhor the dull routine of exsistence longer and would be satisfied if you would do it without the knowledge of anyone but yourselves Past tired of holding on any longer, and no one will ever miss me Dispose of me any way

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Disconnected

Own Mental State, Does not realize

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

Systematized or Not, Hypersensitized, somewhat

Special Subjects, of Grandeur

Transitory or Not, Quite fixed

HALLUCINATIONS: —

ILLUSIONS: /

CONVERSATION:

Coherent or Incoherent, Slightly incoherent

Voluble or Reticent, Voluble —

Claims had syphilis 11 Years ago: gives good description: remarks: probably both habits, drinking & smoking. Says "has had headaches & vertigo; not now: is Telegraph Operator: was arrested in Chicago, a week ago. Says nervous & restless, poor appetite, confused, memory poor: "all right now". Patient is in a mildly maniacal state, with delusions of grandeur - as that he is worth a hundred million, inherited from his uncle: that he is the best telegraph operator in the world & that he has probably from this account passed through a period of mental confusion & depression. Bowels unloaded & breath foul. Previous mental grade was probably fair, but a trifle unstable.

Personal and Medical History of Charles Sylvester

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

lbs NUTRITION, Considerably impaired. Condition of skin, quite good.

brown coat Promptness Movement, prompt

Size, Contracted

Accommodation, Normal

e test.

Tongue, large Coarse

General, General restlessness

EXAM. URINE,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Read & left	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, mother living: healthy. Says "an aunt insane"

Father or Pat. Relations, father died - 66 - Pneumonia

Brothers or Sisters, 1 Brother & 2 sisters: Says all healthy: Says 2 brothers epileptic.

Personal and Medical History of Charles Sylvester

C. J. Finn

EUGLEY, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4449 — No. for Year, 277.

Resi... — Insane Relatives — None

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Co...

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Disconnected

Own Mental State, Does not realize

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

Claims has syphilis 11 Years ago: gives good description: remarks: probably both habits, drinking & smoking: says "has had headaches & vertigo; not now: is Telegraph Operator: was arrested in Chicago, a week ago: says was sleepless, poor appetite, confused, memory poor: "all right now". Patient is in a mildly maniacal state, with delusions of grandeur — as that he is worth a hundred million, inherited from his uncle: that he is the best telegraph operator in the world & he has probably, from his account passed through a period of mental confusion & depression. Bowels reloaded & breath foul. Previous mental grade was probably fair, but a trifle unstable.

train and I have not seen the Deputy since they took off my clothes and changed them for a Hospital garment, I have been here since the 8th of July. Now what I want you do if you are my friend is for you to go to Dr. Enoch or any other Chicago Dr. Queeney that you know there are Dr. Queeney to ask Dr. Queeney where his office is think it is on W. Lake St near 4th

John Doick you would do all you can to prove I am not a Monster. I wrote 3 letters home you know and never answered & do think more of my wife than any woman in the world does she has played her last Card with me and I cannot have anything more to do with her unless she can give me an explanation to the satisfaction of myself. Yours in Very Bad trouble I don't

Rochester Minn.

Feby 8th 97

Drs Kilbourne and Herzog

I am in my opinion in a very bad fix in this hospital and would prefer to be taken to operating room and disposed of as quickly as possible. I abhor the dull routine of exsistence longer and would be satisfied if you would do it without the knowledge of anyone but yourselves I am tired of holding on any longer, and no one will ever miss me. Dispose of me any way

Personal and Medical History of Charles Sylvester

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

...lbs — NUTRITION, Considerably impaired. Condition of skin, quite good.

...brown coat — Promptness Movement, prompt

Size, Contracted

Accommodation, Normal

...tests.

Tongue, large Coarse

General, General restlessness

EXAM. URINE,

Systematized or Not, Hypochondriacal, Delusional

Special Subjects, "of Grandeur"

Transitory or Not, Quite fixed

HALLUCINATIONS: —

ILLUSIONS: /

CONVERSATION:

Coherent or Incoherent, Slightly incoherent

Voluble or Reticent, Voluble —

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Left	Clean,	Careless,
BOWELS, Normal,	Record	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, Mother living: healthy. Says "An uncle insane"

Father or Pat. Relations, Father died — 66 — Pneumonia

Brothers or Sisters, / Brother & Sisters: Says all healthy: Says 2 brothers epileptic.

Personal and Medical History of Charles Sylvester

C. J. Finn

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4449 — No. for Year, 277.

Residence, St. Pa[ul] — [illegible]

Date Admission, 13th July — [illegible]

Admitted by Dr. C B Ebo[rall] — [illegible]

How Sent, Benn Davis, Cou[nty] — [illegible]

Sex, Male — [illegible]

Age, 28 — [illegible]

Civil Condition, Marri[ed] — [illegible]

Children, — [illegible]

Age Youngest Child, — [illegible]

Occupation, Telegra[pher] — [illegible]

Degree Education, [illegible] — [illegible]

Profession Religion, Yes. — [illegible]

Habits, history of [illegible] — [illegible]

Nativity, Bangor, Maine. [illegible] — [illegible]

Physicians Committing, [illegible] — [illegible]

Correspondents, none given — [illegible]

Sister's name — Marga[ret] — [illegible]

Early D Herzog: July 5/96 — [illegible]

MENTAL ACTIVITY:

Clear or Confused, Fo[gged] — [illegible]

Quick or Sluggish, — [illegible]

MEMORY:

Past Events, Di[sordered] — [illegible]

Recent Events, — [illegible]

Special Subjects, — [illegible]

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Disconnected

Own Mental State, Does not realize

Special Subjects, — [illegible]

GENERAL DESCRIPTIVE REMARKS:

Claims had syphilis 11 years ago: given good description: no marks: probably both habit, drinking & smoking. Says "has had headaches & vertigo; not now: is Telegraph operator: was arrested in Chicago, a week ago: says was Reckless, poor appetite, confused, memory poor: "all right now". Patient is in a mildly maniacal state, with delusions of Grandeur — as that he is worth a hundred million, inherited from his uncle: that he is the best telegraph operator in the world & he has probably, from his account passed through a period of mental confusion & depression. Bowels unloaded & breath foul. Previous mental grade was probably fair, but a trifle unstable.

Blue sky 3 hours at night just worrying about this to [illegible] two for [illegible] and [illegible] that there is [illegible] St Paul even my mother is against me

C. J. Finn.

[illegible] Hospital

Have sent after 2 revolvers & Cartridges and any man getting that [illegible] no [illegible]

[illegible] to be taken

Personal and Medical History of Charles Sylvester

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

[illegible] lbs — NUTRITION, Considerably impaired. Condition of skin, quite good.

[illegible] brown coat — Promptness Movement, prompt

Size, Contracted

Accommodation, Normal

[illegible] test.

Tongue, large Coarse

General, General restlessness

EXAM. URINE,

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, mother living: healthy. Says "an aunt insane"

Father or Pat. Relations, father died — 66 — Pneumonia

Brothers or Sisters, / Brother & Sisters: Says all healthy: Says 2 brothers epileptic.

Special Subjects, "of Grandeur"

Transitory or Not, Quite fixed

HALLUCINATIONS: —

ILLUSIONS: /

CONVERSATION:

Coherent or Incoherent, Slightly incoherent

Voluble or Reticent, voluble —

Rochester Minn.

Feby 8th 97

Drs Kilbourne and Herzog

I am in my opinion in a very bad fix in this hospital and would prefer to be taken to operating room and disposed of as quickly as possible. I abhor the dull routine of existence longer and would be satisfied if you would do it without the knowledge of anyone but yourselves. Am tired of holding on any longer, and no one will ever miss me. Dispose of me any way

Read [illegible]

Personal and Medical History of Ch... C. J.

GIBBART, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 14449

Residence,

Date Admission, 13...

Admitted by Dr. C.B. ...

How Sent, Benn Davis

Sex, M...

Age, 2...

Civil Condition, ma...

Children,

Age Youngest Child,

Occupation, Tel...

Degree Education,

Profession Religion, Yes

Habits, Histor...

Nativity, Bangor, Main...

Physicians Committing

Correspondents,

Sister's name - Ma...

Eddy D. Herzog: Subs...

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Disconnected

Own Mental State, Does not realize

Special Subjects,

Systematized or Not, Systematized somewhat

Special Subjects, "of Grandeur"

Transitory or Not, Quite fixed

HALLUCINATIONS: —

ILLUSIONS: /

CONVERSATION:

Coherent or Incoherent, Slightly incoherent

Voluble or Reticent, voluble —

GENERAL DESCRIPTIVE REMARKS:

Claims had syphilis 11 Years ago: gives good description: no marks: probably both habit, smoking & chewing. Says "has had headaches & vertigo; not now: is Telegraph Operator: was arrested in Chicago, a week ago. Says was sleepless, poor appetite, confused, memory poor: "all right now". Patient is in a mildly maniacal state, with delusions of Grandeur — as that he is worth a hundred million, inherited from his uncle: that he is the best telegraph Operator in the world &c. He has probably, from his account, passed through a period of mental confusion & depression. Bowels reloaded & breath foul. Previous mental grade was probably fair, but a trifle unstable.

Personal and Medical History of Charles Sylvester

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7 in WEIGHT, 134 lbs NUTRITION, Considerably impaired.

WOUNDS OR ABNORMALITIES, See "S. R." — Condition of skin, quite good.

TONGUE, Tremors, — Coatings, heavy brown coat Promptness Movement, prompt

PUPILS, Equality, Yes Size, Contracted

Response Light, somewhat excessive Accommodation, Normal

SIGHT, Good

HEARING, — Do —

COORDINATION, Arms, fairly good: } usual tests.
Legs, — Do — }

TREMORS, Hands, None Tongue, Large Coarse

Facial Muscles, No General, Great restlessness

REFLEXES, Patellar, 9 = equal EXAM. URINE,

Other abdominal reflex exagg.

ARTICULATION,

Slurred, No

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY, claims an area of anaesthesia inclfrido, tests unsatisfactory

HEART, no murmurs: strength Sounds somewhat weak: size normal: apex beat slightly feeble — regular: somewhat rapid arterial good —

LUNGS, Good

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

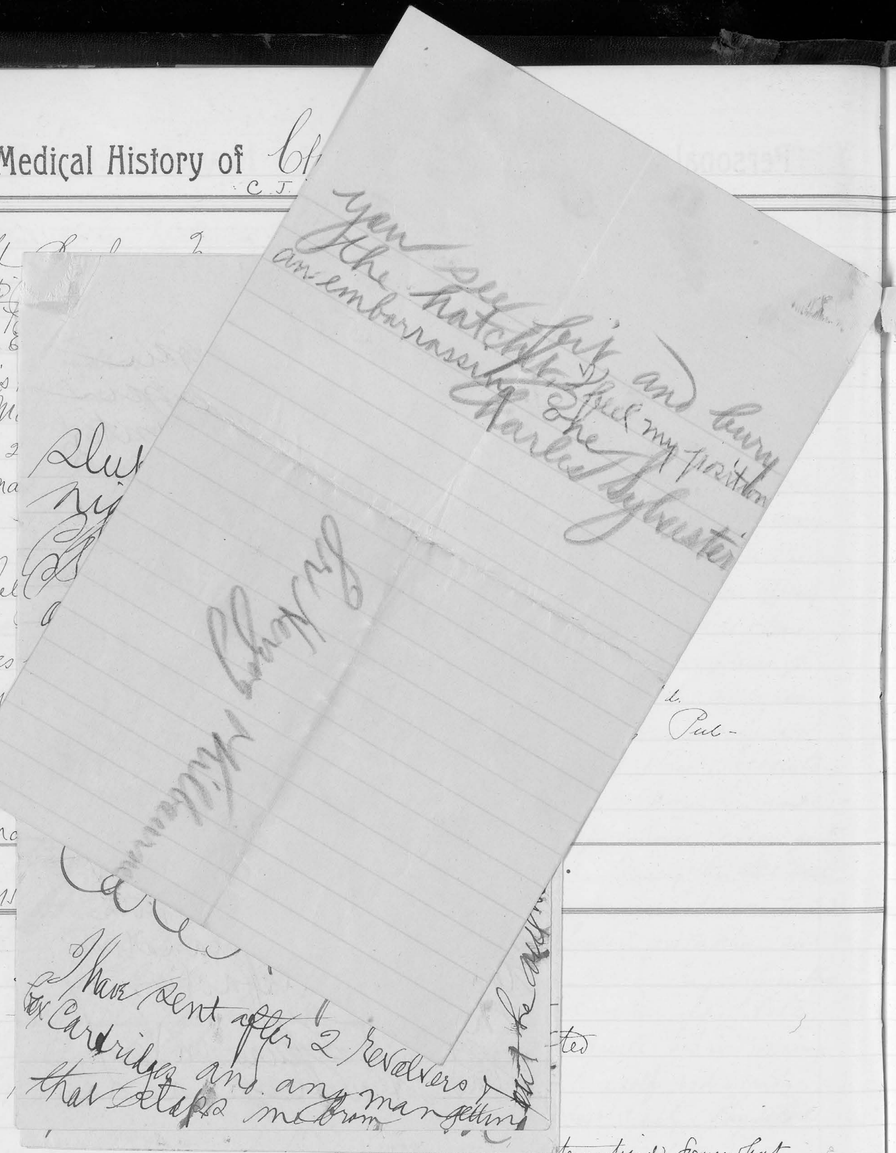
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Mother living: healthy. Says "an aunt insane"

Father or Pat. Relations, Father died - 66 - Pneumonia

Brothers or Sisters, / Brother & 2 sisters: says all healthy: says 2 brothers epileptic.



Personal and Medical History of *Charles Sylvester*.

1896

This patient was brought here by Deputy Sheriff Charles Reichow, with following history - Patient is in fair condition. No history of consanguinity or heredity. This is 1st attack: not before in hospital: first symptoms manifested in May 1896. Disease seems increasing: not curable: no rational intervals. Derangement now shown in the subjects of grandeur & wealth. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. Was inclined to be quick tempered, two years ago. There is history of intemperance. He has not been subject to any severe disease or had any head injury: has not been restrained or confined. Supposed cause of the disease is alcoholism: he has had no treatment.

July 13 Dr. admission, was put on B.3 (G.H.N.R's). Complexion fair: hair dark gray: eyes blue: condition of skin good: 2nd fingers right hand off. Unclean: behavior good). July 14/96. Gave him a sleeping dose, during the night, but he slept only 4 hours. Behavior very restless: he talks much: is psychistic: had trouble with John Casey & scratched Casey's face. Also had trouble with Nurses, (Allen & Judge). 14 " 8 11th P.M. Transferred to C. July 15/96. Received hyp. & also cathartic. — 15 " Slept 6 hours, during night: behavior restless: appetite fair: has delusions: no complaints physically. July 16/96. Slept 8 hours, during night: behavior restless & talkative: appetite very fair; bowels regular: no complaints. July 17/96. Slept 8 hours during night: behavior still restless & inclined to be quarelsome: appetite very fair, but physical condition emaciated. July 18/96. Slept 8 hours: Still restless & has quarrelsome "spells". During day. 18 " 19 " July 19/96. Slept 8 hours: some improvement noticed in behavior: no complaints: desirous of going home. July 20/96. Slept 7 hours: behavior improving: seemed to be uneasy for a short time & desirous to go home: bowels regular. Ordered Sch. Diet. July 21/96. During this, 20 " 21 " the 2nd week patient has been resting & sleeping well, apparently (7 to 8 hours) nightly. Seems to be improving: talks but very little: quite uneasy & very noisy, at times at being shut up. would ask "why they kept him here?" Has various delusions, as "that he is going to cut the Earth in two and sink the place": also has delusion that his name is "Finn". Walks about ward & tries to kill flies; says "that they haunt him". Of late, somewhat more quiet: and does not talk as much: says "he is not going to stay here". Eat well: bowels regular. Ordered regular & Sch. Diet: has been refusing medicine quite often. Summary: Behavior very restless and troublesome & inclined to be pugnacious, from date of admission until the 20th, when he became somewhat quieter & would mind fairly well, when spoken to; yet he is still restless and uneasy. He has had a cathartic occasionally & while on B.3 received a sleeping dose. On medicine (bromide), but, most of the time, refused to take it. Is above statute, has delusions, very numerous. Says "his name is Flynn & not Sylvester". Keeps constantly writing notes & gives them to the nurses, saying "they are telegrams - he must send at once". (Average Sleep 7 hours, during the 24 Days).

July 96 to May 97 Summary. Nurses Notes by Dr. Phelps. Patients physical condition noted as good. Appetite & sleep good. Persists in delusion that name is not Sylvester. Is somewhat melancholy & restless. Aug 1st Wt. 163 lbs. Sept 1st Wt. 147½. Oct 1st Wt. 162. Patient commenced improved both mentally & physically but on Oct. 1st became depressed, dull & stupid. Oct. 15 Trans. to Infirmary, not feeling well, appetite not good. Oct 20 Has become

Personal and Medical History of

extremely melancholy, refused to eat, at 7:30 had chill & temp. went up to 103°. Oct 23 Temp. down to 99° but condition not very good. Oct 27 Temp. gradually gaining again 103½ today: Cold sponge baths given as ordered: has had to be catheterized for several days. Oct 31 Temp. still up - from 100 to 102. Nov. 7 During the past week patient has at times had a normal temperature but has not seemed at all well. Nov. 19 Is sitting up today. Temp. has not been above 100 during month but he has been very melancholy & quite run down & disturbed. Dec. 6 Temp. again up to 102⅘ altho it has been running pretty nearly normal for some time back. Patient is quite depressed yet somewhat dull & stupid. Has a slight bedsore. Dec. 31 Up on ward for ten days past. Blue ointment & iodine treatment given: Seems to be improving. Dec 31. Wt. 134 lbs. Jan'y Appetite improving. Feb 1. Nots nearly so well, at times irritable, depressed & deluded. Mch 1 Wt. 140 lbs. May 1/97 Wt. 146th. Has mild delusions: is very quiet. Not in very good health physically: Is discontented. Is receiving treatment blue ointment & iodide potash. Aug 1/97 Is very emaciated & has a slight cough. Aug 19/97. Trans. to Infirmary: Seems to have failed considerably of late. Temp. in A.M. 105. Taken with a chill at six P.M. Aug 12 Am. 102. Pm. 104. Expectorates considerable blood. Visited by mother. Aug 14 Visited by mother & father. Temp. still up. 23 Temp. still continues up to 102: Seems to be failing: Coughs, expectorates & symptoms are progressing rapidly. Sept 1 Still has temp. from 102-103. A quite rapid change going on. Sept 22 Died at 8 A.M. Temp. has hardly been below 101 since beginning of attack and change has been very rapid in this case.

Died.

Personal and Medical History of Adam Stenger

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. #451. | No. for Year, 279.

Residence, Rochester, Minn.

Date Admission, 14th July 1896.

Admitted by Dr. Kilbourne | Hour, 10 am.

How Sent, Thomas Fraser, Jo P. Olmsted County

Sex, Male

Age, 60 - (?)

Civil Condition, Divorced

Children, none

Age Youngest Child,

Occupation, Machine Brewer

Degree Education, Common School.

Profession Religion, Yes: Catholic.

Habits, Have been very Intemperate.

Nativity, Bavaria: (Parents also born there).

Physicians Committing, A. W. Stinchfield & Chas. T. Granger

Correspondents, none given on papers

Insane Relatives, not known

Cause Exciting, Drinking

Cause Predisposing, "chronic"

Form, Dementia alcoholic chronic

Accompanying Bodily Disorder, none mentioned

Suicidal or Not, not

Date of this Attack, 5 or 6 years ago

Duration, 5 or 6 years

No. of Attack, - 1st -

No. of Admissions, 3rd (here before as Inebriate)

Age First Attack, 54 - 12 (some years ago) -

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, } Rather poor.

Recent Events, }

Special Subjects, }

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, }

Own Mental State, } Poor

Special Subjects, }

GENERAL DESCRIPTIVE REMARKS: Patient here several years ago as Inebriate. Demented from the start. gradually growing worse. mind always on some property which he imagines he still owns & on going to Bavaria etc. Very dull in reality.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Vague erroneous & exaggerated beliefs.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Adam Stenger

CALVARY CEMETERY.
St. Paul, Minn. May 15 18 89
The body of Adam Stenger
Age 49 years, — months, — days,
was interred in Grave 27 Bl 7 Sec 27
SINGLE GRAVES. No Bl Sec
ACTUARY.
Whenever it is desired to find the above described Grave, the party will please present this card to the Actuary.

ON ADMISSION, CONTINUED.

AL CHARACTERISTICS.

about 195 lbs NUTRITION, Fair.

Condition Skin Rather old + dry.

Promptness Movement,

Size,

Accommodation,

HEARING, Normal

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Normal Tongue, Tony

Facial Muscles, " General, "

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries - Some atheroma

HEART,

Sounds rather distant

LUNGS,

Normal.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ (a) 57 (b) 55 685 N. oc. a. 35 Bi. a. 35 Ant. p. d. 19.4 Trans. d. 16.2 Bi. d. 13.5 Fl. 120

HISTORICAL, Says age is 70.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, Died when 5 yrs. old.

Father or Pat. Relations, Dead.

Brothers or Sisters,

Personal and Medical History of Adam Stenger

EBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. #451.
Residence, Rochester, Minn.
Date Admission, 11th July 1896.
Admitted by Dr. Kilbourne Hour, 10 am.
How Sent, Thomas Fraser, Jo P. Olmsted County
Sex, Male
Age, 60 (?)
Civil Condition, Divorced
Children, none
Age Youngest Child,
Occupation, Machine Brewer
Degree Education, Common School.
Profession Religion, Yes: Catholic.
Habits, Have been very Intemperate.
Nativity, Bavaria (Parents also born there).
Physicians Committing, A. W. Stinchfield & Chas. T. Granger
Correspondents, none given on papers

No. for Year,
Insane Relative
Cause Exciting
Cause Predispo
Form, Dem
Accompanying
Suicidal or Not
Date of this Att
Duration, 5 or 6 years
No. of Attack, 1st
No. of Admissions, 3rd (here before as Inebriate)
Age First Attack, 54 (?) (some years ago)
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish,
MEMORY:
Past Events, Rather poor.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Poor
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Patient here several years ago as Inebriate. Dismissed from the stat. gradually growing worse. mind always on some property which he imagines he still owns & on going to Bavaria etc. Very dull in reality.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Vague erroneous & exaggerated
Special Subjects, belief.
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Adam Stenger

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, about 195 lbs NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, Condition Skin-Rather old & dry.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT,
HEARING, Normal
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, Normal Tongue, Tony
Facial Muscles, " General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries - Some atheroma
HEART,
Bounds rather distinct
LUNGS,
Normal.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ (a) 57 (m) 685 N. o. a. 35 Bi. a. 35 Ant. p. d. 19.4 Trans. d. 16.2 Bi. d. 13.5 7½ 20
HISTORICAL, Says age is 70.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any
Mother or Mat. Relations, Died when 5 yrs. old.
Father or Pat. Relations, Dead.
Brothers or Sisters,

Personal and Medical History of Adam Stenger

1896

This patient was brought here by James Smart, with the following history: (said patient appearing for examination in person and by his Attorney G.W. Granger): There is no history of consanguinity. This is 1st attack: (he has been confined in this Hospital, as an Inebriate); first symptoms of this attack manifested 5 or 6 years ago. Disease appears to be stationary; variable. Derangement now shown by delusions of grandeur. Patient is not disposed to injure others, nor suicidal; propensity not active: no filthy, or destructive habits. As to any relatives being insane, any peculiarities &c previously shown, do not know. He has not been subject to any severe disease nor had any head-injury. Supposed cause of the disease is drinking: has had "treatment" in this hospital. Shows, now, undue excitement + delusions.

x Note. Patient was committed here, on 2 occasions, as an Inebriate. He was, today, July 1/96 - taken out + is now committed as Insane.

July 1 On admission was put on B2 (G.A.N. Ofc). Complexion dark: hair gray: condition of skin seems good: behavior good, though liable to become easily excited: discontented at being kept here). No 14 day record kept as patient was simply taken down + committed as Insane.

Aug 1/96 to Apr 30/97 Summary Nurses Notes by Dr Phelps. Aug 1. Wt. 204 lbs. Is very quiet, does no work. Complains at times of rheumatism in knee. Apr 30 97 Wt. 209 lbs. Patients condition so uniformly the same as to require little comment. Always talks in a somewhat childish way: has the same ideas as before about having money in the old country and considerable here. May 1 97 Wt. 210#. July 1 Wt. 220#. Quite thoroughly demented: talks very little but in conversation shows the same old delusions about property which he has expected for many years. Nov 31 97 Complains of rheumatism: Placed on Infirmary. Dec. 3 Improving. Trans. to B2.

Jan 31 99 No special change in condition: Wt. 122#. Still talks + behaves in the same way, altho he is perhaps more quiet + demented than before.

Feb 1 - July 31 99 (Dr Wanous) Wt. 220#. Is inclined to be cross + profane at times. Has rheumatism. Is well behaved + spends most of time sitting around on ward.

To 1900 Aug 1. - Jan 31 1900. (Dr Chapple) Wt. 225# No change of importance mentally or physically. Is very quiet + well-behaved. Occasionally becomes quite talkative. Appears rather childish. Habits tidy. —

Jany 31 Feby 1 July 17 - 31 Appetite good: sleeps soundly. Does no work. Feby 1 Wt 227# P80. July 17 Was vaccinated: result negative. July 31. (very little change), during the period: has complained a good deal of rheumatism in limbs: has some difficulty in getting about; otherwise, quite well. Works some on ward: habits quite tidy: always well-behaved: talks quite sensibly, on ordinary subjects, but is demented and senile.

Nov 1 13 17 Nov 1. Wt 236#. P76. Is somewhat demented + irritable: loves limbs stiff and painful: complains of rheumatism. Nov 13. Left knee badly swollen. Transferred to IW, and put to bed. Nov 22. Improved: up on ward. Nov 24. Transferred to A4. Dec 1 Wt 215#. P80.

1901 Jan 31 Still has trouble, at times, with his knee. Is childish + demented. Has limited parole —

Feby 1 May 31 Wt 214# P84 - May 31. Is easily irritated + becomes abusive + obscene. Is, most of the time, drowsy. Does no work: complains of rheumatism: smokes a great deal. Says he does

Personal and Medical History of Adam Stenger

1901

July 31 Aug 1 1902 Jany 31 Jan 31 03 not belong here + want to go out." July 31. No change to report in patient's condition — Wt 218#. - Jany 31/02. No change in this patient: makes great difficulty in walking and is quite demented and silly.

(Dr. Phelps) During past year patient has grown more dull and less able to walk. Complained of feeling sick for the first time this winter. Is very demented but in a rather imbecile way.

Personal and Medical History of Joseph Flouin

BRIGHT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4452
Residence, St. Paul Minn.
Date Admission, 15th July 1895
Admitted by D. C. B. Eby Hour, 6.15 P.M.
How Sent, Benn Davis, Court Commr. Ramsey County
Sex, Male
Age, 37
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Laborer
Degree Education, Common School
Profession Religion, Protestant
Habits, unknown
Nativity, Michigan (Parents born in Germany).
Physicians Committing, John B. Nelson & Arthur Sweeny
Correspondents, name given in papers

No. for Year, 280.
Insane Relatives, None
Cause Exciting, Unknown
Cause Predisposing, Not Stated
Form, Melancholia acuta
Accompanying Bodily Disorder, (wound of scrotum)
Suicidal or Not, Not
Date of this Attack, not stated
Duration, - not stated -
No. of Attack, 1st
No. of Admissions, 1st time (was in Co. Hosp. St Paul)
Age First Attack, (?)
Time of Leaving, 7 May 7, 1897.
Time in Hospital, 9 mo. 22 da.
Result, Discharged Sept. 28, '97 Recovered.

EXAMINATION ON ADMISSION.

Exam. 4/10 by R.M. Phelps, M.D.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, 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: Patient at times very melancholy was agitated active melancholy. Again becomes quiet. Ability to answer questions fairly good. Is afraid of something.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Melancholy.
DELUSIONS:
Systematized or Not, Yes partially
Special Subjects, Persecution.
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Joseph Flouin

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 Ft 10 in WEIGHT, 154½ lbs NUTRITION, Good.
WOUNDS OR ABNORMALITIES, Condition of skin good.
TONGUE, Tremors, 0 Coatings, Promptness Movement, Good.
PUPILS, Equality, Equal Size, Normal.
Response Light, Yes Accommodation,
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Not marked Tongue, Not marked
Facial Muscles, " General, "
REFLEXES, Patellar,
Other
ARTICULATION, Fair
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Good.
LUNGS, Good.



TAKEN,

EXAM. URINE,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ. (c) 55 L.m. 66.5 L.o.a. 37 Bi.a. 36.5 Aut.p.d. 19.1 Fr.a.d. 16.6 Bi.d. 13.7 F.Z. 10.7
HISTORICAL, Operation for enlarged veins of scrotum 6 weeks before coming. Has headaches some lately.
LENGTH OF INVASION, 7 years (?) ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any.
Mother or Mat. Relations, Living Healthy
Father or Pat. Relations, Living Healthy
Brothers or Sisters, 7 brothers + 4 sisters

Personal and Medical History of Joseph Florin

1896

This patient was brought here by Deputy Sheriff E. P. Horst, with following history. Patient is in fair condition. No history of consanguinity or heredity. This is 1st attack: has been in the City & County Hospital, St Paul, for 4 days: no result from treatment: he has wound of scrotum from an old operation. First symptoms of this attack manifested by general depression, suspicion of Doctors, crying and moaning. Disease seems increasing: not variable: no rational intervals: Derangement now shown in that he believes Dr. Miller is trying to kill him: is depressed because of his poor health: is afraid of strangers & much troubled: talks incoherently: cries easily. Patient is not disposed to injure others, nor suicidal, nor filthy, nor destructive in habits. As to any previous peculiarities, intemperance, any severe disease or head injury, unknown. Supposed cause of the disease is unknown. He has been treated by sedatives (K. B.): no effect. On usual examination, he is constantly crying & talking in a melancholy vein; & pressing fear of harm from Dr. Miller & others & fear that he will not get well. ———

July 15 On admission, was put on T.W. (G.H.R.Rpt. Complexion dark: hair black: eyebrows: condition of skin good: one scar on left thigh: is dirty: behavior good). Was given bath & put to bed. Wound on scrotum dressed & bandaged. Behavior good. Habits clean: has some delusions: talks but little. July 16/96. Slept 8 hours, last night. Eats well: bowels move. Very quiet today.
" 16 " 17 Up & out this Frn. Is afraid & wants to go home. Behavior good. July 17/96. Slept 8 hours, Expresses, today. Still afraid & wants to go home. Says "he don't believe he will ever get well."
" 18 Has spells of crying: a very poor memory: July 18/96. Slightly noisy, a part of the night, slept only 4 hours: very restless, today: crying, at times. Up & out, this Frn. Scrotum dressed &c.
" 19/20 daily. July 19/96. Slept 8 hours: appears about same, today: very restless: crying: July 20/96. Slept
" 21 7 hours, last night. Some quieter, today. Up & out for a walk, this Frn: behavior good. July 21/96. Slept 5 hours, last night. Quite restless & worries, greater part of time: has crying spells: wants to go home. Scrotum receives regular treatment. He talks same, at times, during night. Out & out this Frn.
" 22 July 22/96. Slept only 3 hours, last night. Is still restless & worries considerable: has crying spells:
" 23 up & out this Frn. July 23/96. Slept 7 hours: Still very restless: Thinks he is never going to get better. Has other delusions. Scrotum dressed &c regularly & appears to be improving.
" 24 July 24/96. Slept 6 hours. Patient still in bed: but very restless. Talks most all night & is
" 25 very restless today. Up & out this Frn. He eats well: bowels move. July 25/96. Slept only 1 hour, last night. Very quiet, all day. Appears to be improving. Up & out, this Frn. Given Shower bath 7½ min.
" 26/27 July 26/96. Slept 7 hours, last night: very quiet, all day. July 27/96. Slept 6 hours: very quiet: says "he feels much better, today". Is up & out, in afternoons. Scrotum dressed &c: is mostly well.
" 28 July 28/96. Slept 8 hours. Is quiet, & melancholy, at times. Has some delusions: habits clean,
" 29 July 29/96. Slept 8 hours. Scrotum is mostly well. Summary: Patient, when received on ward, had temp. 99.8. Was put to bed: wound on scrotum dressed &c. He is quite weak & at times, melancholy. Has various delusions: thinks his limbs are swollen up, & that he will never get well. Has been on medicine, 3 times a day. Has spells of crying & is very restless, at times. Memory very poor. Is given Shower bath, 3 times a week. Scrotum dressed daily & has improved. He is up & out, most every day. Sleeps some during day. Appears much better, physically & mentally, than on arrival. Behavior good:

Personal and Medical History of Joseph Florin

1896

habits fairly clean. Appetite good: bowels irregular: sleep good.

Aug 1/96 to Apr 1/97 Summary of Nurses Notes by Dr. Fields. Aug 1 Patient upon sick ward. Is rather melancholy & depressed, has a poor appetite, is somewhat run down but no special disease present. Aug 9 Patient cried nearly all day today, is quite melancholy. Aug 20 Out upon ward. Seems to have improved somewhat, but still thinks that someone is going to harm him. Cries considerably. Sept 5 Wt 108½ lbs. Is still rather melancholy & at times cries. Sept 25 Patient altho better is still at times very much worried over his delusive ideas. Oct 31 Has made several attempts to escape altho watched closely. Has improved somewhat but at times cries & is worried. Apr 30/97 Has improved very much but improvement very slow & gradual. Wt. 130 lbs. Wt 19th May 3rd 97. Is quiet. Talk quite rational at present altho a little childish. May 7th Sent home on trial.

Discharged.

Personal and Medical History of Henry Skelinski

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 44574.
Residence, Steele Co. Minn
Date Admission, 20th July 1896 -
Admitted by D.A.T. Silbaugh Hour, 7:30 PM
How Sent, W.B. Chadwick Jo.P. Steele County
Sex, Male
Age, 21
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farmer
Degree Education, Common School
Profession Religion, Yes. Lutheran.
Habits, not intemperate
Nativity, Steele Co. Minn. (Parents born in Germany)
Physicians Committing, J.H. Adair and A.B. Stewart
Correspondents, None given nip apers

No. for Year, 282.
Insane Relatives, None
Cause Exciting, Unknown
Cause Predisposing, not stated
Form, Acute mania
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Will injure others: has threatened Suicide.
Date of this Attack, July 1st 1896.
Duration, about 16 days
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 21
Time of Leaving, May 25. 1897
Time in Hospital, 10 months
Result, Discharged Nov. 20. 1897 Recovered.

EXAMINATION ON ADMISSION.

Edw. D. Herzog. 7/21/96.

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Exalted
Depressed,
DELUSIONS:
Systematized or Not, Unsystematized
Special Subjects,
Transitory or Not, Transitory, Yes.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Incoherent
Voluble or Reticent, very voluble

GENERAL DESCRIPTIVE REMARKS:
Patient has probably been of fair mental capacity: appears intelligent: is well nourished & extremely restless, inclined to fight: Examination difficult. Gross incoherence of speech: talks constantly: Makes senseless rhymes: Is in an acute maniacal condition

Personal and Medical History of Henry Skelinski

Ended His Own Life.

Sioux Falls, S. D., Special, Oct. 13.—The coroner's jury at Brookings has found that Henry Schelinski was not murdered, as had been suspected, but committed suicide. An almost empty bottle of morphine was found near the body, and it has been discovered that the poison was bought at Aurora. The suicide is twenty-three years of age. He came to this state from Minnesota, where he was confined in the insane asylum at Rochester, being released last July and coming here in August.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 9½ WEIGHT, 157½ lbs NUTRITION, Good
WOUNDS OR ABNORMALITIES, Condition of Skin, Clear
TONGUE, Tremors, Coatings, Quite Heavy yellow Coat Promptness Movement, prompt
PUPILS, Equality, Yes Size, Dilated
Response Light, Excessive Accommodation, Excessive
SIGHT, ✓
HEARING, ✓
COORDINATION, Arms, } not tested: appears impaired.
Legs, }
TREMORS, Hands, Yes Tongue, quite marked
Facial Muscles, no General, no
REFLEXES, Patellar, not tested
Other
ARTICULATION,
Slurred, lisps
Hesitating,
FACIAL EXPRESSION,
✓
SENSIBILITY,
✓
HEART, rapid: somewhat weak
Slightly irregular: no murmurs noted.
LUNGS,
Seem good

EXAM. URINE, Nov. 11 96.
Color Yellow.
Sp. Gr. 1030.
Reaction Acid.
Character Clear.
Albumen None.
Sugar None.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,	Rec'd Sept	Constipated,	Irregular,
APPETITE, Good,		Medium,	Poor,
SLEEP, Good,		Poor,	Irregular, recently & sleepless
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,
Father or Pat. Relations, father State & be peculiar.
Brothers or Sisters, also one brother

Personal and Medical History of Henry Shelinski

BEBBEY, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 44514

Residence, Steele Co. Minn

Date Admission, 20th July 1896

Admitted by D. A. T. Colbourne Hour, 7 3/4 PM

How Sent, W. B. Chadwick. Jof P. Steele County

Sex, Male

Age, 21

Civil Condition, Single

Children,

Age Youngest Child,

Occupation, Farmer

Degree Education, Common School

Profession Religion, Yes. Lutheran

Habits, not intemperate

Nativity, Steele Co. Minn. (Parents born in Germany)

Physicians Committing, J. H. Adair and A. B. Stewart

Correspondents, None given on papers

No. for Year, 282

Insane Relatives, None

Cause Exciting, Unknown

Cause Predisposing, not stated

Form, Acute mania

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Will injure others: has threatened suicide.

Date of this Attack, July 1st 1896

Duration, about 16 days

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 21

Time of Leaving, May 20. 1897

Time in Hospital, 10 months

Result, Discharged Nov. 20. 1897 Recovered.

THERE IS A CLASS OF
Who are injured by the use of coffee. There has been placed on all the grocers' shelves a new preparation called GRAIN-O. It is made of pure grains, that when prepared as per directions, delicate stomach can receive it and not a particle of distress will follow, in fact it does them much good. Every one who tries it can tell it from coffee, and but few can detect it in the cup. It does not cost over ¼ as much. It may drink it with great benefit. 15 cts.

EXAMINATION ON ADMISSION.

Edly D. Herzog 7/7/96. **MENTAL CHARACTERISTICS.**

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

MEMORY:
- Past Events, Poor
- Recent Events,
- Special Subjects,

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

REASONING POWER:
- Ordinary Subjects, Complete Confusion
- Own Mental State,
- Special Subjects,

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

DELUSIONS:
- Systematized or Not, Unsystematized
- Special Subjects,
- Transitory or Not, Transitory, Yes.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
- Coherent or Incoherent, Incoherent
- Voluble or Reticent, very voluble

GENERAL DESCRIPTIVE REMARKS:
Patient has probably been of fair mental capacity: appears intelligent: is well nourished & extremely restless, inclined to fight: Examination difficult. Gross incoherence of speech: talks constantly: Makes senseless rhymes: Is in an acute Maniacal condition

Personal and Medical History of Henry Shelinski

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 9½ WEIGHT, 157 lbs NUTRITION, Good

WOUNDS OR ABNORMALITIES, Condition of skin, clear

TONGUE, Tremors, Coatings, Quite heavy yellow coat Promptness Movement, prompt

PUPILS, Equality, Yes Size, Dilated

Response Light, Excessive Accommodation, Excessive

SIGHT, ✓

HEARING, ✓

COORDINATION, Arms, Legs, } not tested: appears impaired.

TREMORS, Hands, Yes Tongue, quite marked

Facial Muscles, No General, No

REFLEXES, Patellar, not tested

Other

ARTICULATION,

Slurred, lisps

Hesitating,

FACIAL EXPRESSION, ✓

SENSIBILITY, ✓

HEART, rapid: somewhat weak Slightly irregular: no murmurs noted.

LUNGS, Seem good

TAKEN,

EXAM. URINE, Nov. 11 '96.
- Color Yellow
- Sp. gr. 1030
- Reaction Acid
- Character Clear
- Albumen None
- Sugar None

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,	Constipated		Irregular,
APPETITE, Good,		Medium,	Poor,
SLEEP, Good,		Poor,	Irregular, no contty sleepless
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,

Father or Pat. Relations, father Dead & Insane

Brothers or Sisters, also one brother

Personal and Medical History of *Henry Shelinski*

1896

This patient was brought here by Deputy Sheriff M. A. McAndrews, attended by August Kroger, with following history. Patient is in apparently good physical condition. No history of insanity or heredity. This is 1st attack: Symptoms manifested in that he has been restless and disturbed since July 4th 1896. The disease seems increasing: not variable: no rational intervals. Derangement now shown by his having delusions of Grandeur. He is disposed to injure others: has not attempted suicide, but has threatened to suicide: is of destructive 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. He has not been restrained or confined. Cause of the disease is unknown: no medical treatment. Patient is evidently suffering from acute mania, with exaltation.

July 29 On admission, was put on C. (G.H.N. Rft. Complexion light: hair light: eyes blue: Condition of skin good: no marks scars or bruises noticed: Is clean: noisy & restless: was brought, strapped). Summary 14 days record. Patient admitted at 7.30 PM on July 31st Given bath. Temp. 100 P. 100 Resp. 30. Very restless & did not sleep any during night. Ate nothing for breakfast & had to be held. Trans. to Infirmary at 10 AM in a very excited, raving condition: was held by four nurses. Fed through tube 1 qt. malted food, & 1 oz. salts. Was put in restraint at 10:20 AM, restless & noisy most all day. Habits filthy. Ate nothing all day. Slept 7 hrs. at night. Aug 1. Taken out of restraint at 9 AM. Slept most of day: Very quiet when awake: Given bath. Appetite good: Habits clean: Behavior good. 2d Very quiet all day: Talks incoherently at times: Appetite good: Sleeps well. 3d Has been very quiet all day. reads most of time: Appetite good: Habits clean: Bowels regular: 4th Up & out of doors this PM. Behavior good. 5th Up on ward all day. Works on ward: Wants to go home: Appetite good: Bowels regular: Habits clean: Has complained some of headaches but not so much of late. Aug 8 Has been up on ward since July 31. Works some. Appetite good: Bowels regular: Habits neat & clean: Talks freely & quite rationally. Says he is well & wants to go home.

Aug 30 to Apr 30 97 Summary Nurses Notes by Dr. Phelps. Aug 30 Up & about ward most of work. Is reading some: Is still incoherent. Sept 24 Visited by father, was abusive in talk. Taken out against advise of physicians. Has been maniacal in behavior & is slightly excited. Put upon 6'. Is restless, talkative & progressive. Oct. 1 Wt. 176. Nov 2 160th Seems to be improving some. Dec. 1 Quiet & well behaved of late. Acts & talks rationally. Apr. 30 Has been working with carpenter of late, Is quite well behaved in every way. Seems to have improved very much. May 1 97 Wt. 171th, Talks quite rationally at present. Is slightly foolish in talk but is very well behaved.

May 16 Given parole. 20 Eloped.

Discharged.

Personal and Medical History of

Personal and Medical History of August C. Gieske

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4455.

Residence, 84. E Curtis St. St Paul, Minn.

Date Admission, 21st July 1896.

Admitted by D. Herzog Hour, 6 45 P.M.

How Sent, Benn Davis, Court Commr. Ramsey County

Sex, Male

Age, 32

Civil Condition, Single

Children,

Age Youngest Child,

Occupation, Stone-Cutter

Degree Education, Common School.

Profession Religion, Yes. Lutheran

Habits, not Intemperate

Nativity, Ill. Illinois (Parents born in Germany).

Physicians Committing, G. Stanton & V. J. Hawkins

Correspondents, Herman Gieske (brother) 84 E. Curtis St. St Paul

No. for Year, 283.

Insane Relatives, none

Cause Exciting, Do not Know

Cause Predisposing, Epil

Form,

Accompanying Bodily Disorder,

Suicidal or Not, —

Date of this Attack, Epilepsy

Duration, several

No. of Attack, not 1st (during past — past)

No. of Admissions, 1st

Age First Attack, about 17. (?)

Time of Leaving, October 19 — 1901.

Time in Hospital, 5 yrs 2 mos 14 ds

Result, Died: Status Epilepticus

ASSAULTS A DOCTOR.

August Gieske Is Violent at the Rochester Asylum.

August Gieske, who was committed to the insane asylum Tuesday, became violent when he reached the hospital in Rochester, and assaulted one of the doctors of the institution, kicking him in the mouth and splitting his lip. As soon as the straps were taken from Gieske's hands by Deputy Sheriff Johnson he flew into a passion, declaring that the officers of the hospital were about to kill him and that they hired the deputy sheriff to bring him to the place of slaughter. A young physician was the first to come within his reach. It was with great difficulty that he was finally overcome by the officers.

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps 9/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Somewhat confused.

Quick or Sluggish, Very sluggish.

MEMORY:

Past Events, Rather Poor

Recent Events, Rather Poor

Special Subjects, Rather Poor

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Dull.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient very slow to answer quite dull. No delusions or incoherence appear, but a dullness that is hard to get through to get information. Answers slow & at times uncertain. No very reliable information.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, None formed - very slow & dull.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of August C. Gieske

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

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

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, ragged edges Fair Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size, dilated

Response Light, Accommodation,

SIGHT, Normal.

HEARING, "

COORDINATION, Arms,

Legs,

TREMORS, Hands, None Tongue, None

Facial Muscles, " General, "

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal.

LUNGS, Normal.

TAKEN,

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 56 Fm 665 R. a. 34 Bm. a. 19 Aut. p. d. 15.8 Tr. d. 13 Bm. d. 12.5

HISTORICAL, Has had fits since small boy? Has about 2 fits a day.

LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Living

Father or Pat. Relations, Living Healthy

Brothers or Sisters,

Personal and Medical History of August C. Gieske

BERGET, FIDLAR & CHAMBERLIN, DAVENPORT, IOWA

Whole No. 4455.

Residence, 84 E Curtis St. St Paul, Minn.

Date Admission, 21st July 1896.

Admitted by D. Herzog Hour, 6 1/2 PM.

How Sent, Benn Davis, Court Commr. Ramsey County

Sex, Male

Age, 32

Civil Condition, Single

Children,

Age Youngest Child,

Occupation, Stone-Cutter

Degree Education, Common School.

Profession Religion, Yes: Lutheran.

Habits, not Intemperate

Nativity, Elgin, Illinois: (Parents born in Germany).

Physicians Committing, G. Stanton & V. J. Hawkins

Correspondents, Herman Gieske (brother) 84 E Curtis St. St Paul

No. for Year, 283.

Insane Relatives, none

Cause Exciting, Do not Know

Cause Predisposing, Epilepsy

Form,

Accompanying Bodily Disorder, Epilepsy

Suicidal or Not, — Not —

Date of this Attack, Epilepsy, Since 17 years

Duration, Several years —

No. of Attack, Not 1st (During past 7 years)

No. of Admissions, 1st

Age First Attack, about 17. (?)

Time of Leaving, October 19 — 1901

Time in Hospital, 5 Yrs 2 mos 14 ds

Result, Died: Status Epilepticus

EXAMINATION ON ADMISSION.

Exam. by R. M. Phelps 9/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Somewhat confused.

Quick or Sluggish, Very sluggish.

MEMORY:

Past Events, } Rather Poor

Recent Events, }

Special Subjects, }

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Dull.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient very slow to answer - quite dull. No delusions or incoherence appear, but a dullness that is hard to get through to get information - Answers slow & at times uncertain. No very reliable information.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, None formed - very slow & dull.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of August C. Gieske

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

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

FORMALITIES, None.

Coatings, Ragged edges Fair Luminae Promptness Movement,

Equality, Equal. Size, Dilated

Response Light, Accommodation,

WRIGHT, Normal.

HEARING, "

COORDINATION, Arms,

Legs,

TREMORS, Hands, None Tongue, None

Facial Muscles, " General, "

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal.

LUNGS, Normal.

TAKEN,

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 Com 66.5 Nose 3.4 Bin.a. 14 Aur.p.d. 15.8 Fr.d. 13 Bin.d. 12.5

HISTORICAL, Has had fits since small boy? Has about 2 fits a day.

LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Living

Father or Pat. Relations, Living healthy

Brothers or Sisters,

Personal and Medical History of *August C. Gieske*

1899

This patient was brought here by Deputy Sheriff Emanuel Johnson, attended by Herman Gieske, with following history. Patient is in fair physical condition. No history of consanguinity or heredity. This is not 1st attack; others occurred during last 4 years; duration a week to 10 days. Has not been in hospital. First symptoms manifested by Epilepsy, since 18 years. Disease seems increasing; variable, & rational intervals no more: since 3 years, the Epilepsy manifested itself a mania. Derangement now shown in the subject to kill members of his fathers family and himself. Has not attempted suicide. Is destructive of clothing. No peculiarities had been previously shown: no history of intemperance. Has been subject to Epilepsy. He has not been restrained or confined. Cause of the Disease, do not know. Has been treated by all so-called Epileptic remedies. Is now restless & dont answer questions.

July 21 On admission, was put on B1. (G.H. Ward) Complexion dark: hair brown: eyes gray: Some marks on right ear: Scar on right wrist, caused by hand-cuffs: pimples all over back: Is clean. behavior not good: wants to fight.

Aug 3 Nurses Notes (Summary) Received on ward July 21 at 7.30 P.M. via Navy & pugnacious condition was held by nurses until bed time. Behavior has been changeable was very troublesome & noisy up to July 25th talking a great deal & incoherently. During that time had delusions, - said someone was going to kill him & that the food was poisoned: Had eight very hard convulsions on 23rd & 24th, & each day. Since 27th has been very quiet. Sits on hall, goes out with crowd. Speaks only when spoken to: Answers questions fairly well. Is slow to comprehend & also slow in actions. Bromide given 3 times daily. Cathartics occasionally. Sleeps fairly well all the time. Appetite poor from date of admission until 27th Refused meals occasionally. Since then has been eating well. Bowels fairly regular all the time.

Aug 5 '99 to Jan 31 '99 Summary Notes (Nurses) by Dr. Phelps. Patient very quiet. Seems to be improving July 29 Still rather restless at times & at others quiet & stupid. Aug 30 Patient has convulsions every few days, sometimes two in a day, & is on the whole rather slow & stupid.

Feb 1 No change. Is stupid & at times irritable. Jan 31 Unchanged in any respect.

May 1 '99 Wt. 135.# July 31 Has frequent convulsions & is more dull mentally & is more quite thoroughly demented. It is impossible to have any conversation of value with him. At times is somewhat irritable: Jan 31 '99 Intervening notes show no change of importance. Feb 1 - July 31 '99. (Dr Wamous) Wt. 178.# Is pugnacious & somewhat troublesome. Is an epileptic demented. Feb. 11 Had a convulsion. Feb 12. Fell to floor cutting nose & causing it to bleed. Feb 22 Struck in mouth when coming up stairs. When on ward spit out a tooth. Complained of being kicked in back but on examination no bruises found.

Feb 24. Had convulsion. May 9 Has convulsions, sometimes they occur almost daily. July 10 Trans. to Infirmary. Apparently in stupor Has having frequent

Personal and Medical History of *August C. Gieske*

convulsions. July 11 Had 18 convulsions. June 14 Visited by mother. June 17 Remained quiet all day & became much better June 19 Dressed & upon ward. Seems mask but prefers to be up.

June 26. Complains of pain says he has hamorrhoids. Found to have rectal abscess which was opened & dressed. June 30. Goes out with patients each day. Has gained in strength & seems much better. Aug 1 - Jan. 31 1900 (Dr Chapple). Sept. Wt 139

1900 - Jo - Has had epileptic convulsions averaging 2-3 per week. Is quite dull & confused mentally. occasionally talks quite rationally. Memory very poor. Neat in habits inclined to be pugnacious & irritable at times. Appetite & sleep good: Does no work. Feby 1900. Wt 135.# P 74. May 30. No change noted. July 31. No change of importance during period: has had frequent "Epileptic Seizures" & is growing more stupid & demented. Becomes much confused & excited, at times, and has "pugnacious spells". Rather untidy in habits & very inactive. Does no work - appetite good: bowels regular: Sleeps well. Aug 21. Transferred to W. Limbs swollen & painful: has difficulty in walking Sept 4 Up, on ward: is somewhat improved, physically. Sept 5 Transferred to B1 — Jany 31/1901 Dementia gradually increasing: Has frequent Severe Convulsions and is much Confused: very Stupid & sluggish in his habits Easily angered & pugnacious at times. Feby. Wt 135.# May 1. Wt 131 "Aug 1. Wt 130"

1901 Jan 31 Feby 1 Oct 1 Has had quite frequent and severe convulsions, during year. Is failing mentally and physically: becoming quite weak and unsteady. Oct 17. Transferred to 7W.

17 very dull; confused: Has frequent Convulsions - Oct 18. 62 - Convulsions.

18 10 Convulsions. Failed rapidly & Died at 4.05 P.M.

19 Diagnosis — Status Epilepticus

Dies

Personal and Medical History of William H. Elliott

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4457.
Residence, Grant, Minn.
Date Admission, 24th July 1895.
Admitted by Dr. Koenig Hour, 6:45 PM.
How Sent, E. G. Butts, Jr. P. Washington County
Sex, Male
Age, 28
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farmer
Degree Education, Common School
Profession Religion, Yes. Catholic.
Habits, Not Intemperate
Nativity, Stillwater. (Parents born in Ireland)
Physicians Committing, W. H. Pratt and B. J. Merrill
Correspondents, William Elliott (father) Stillwater Minn

Family Physician B. J. Merrill Stillwater Minn

No. for Year, 285.
Insane Relatives, None
Cause Exciting, Possibly from effects of that.
Cause Predisposing, Not given
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Has threatened Suicide
Date of this Attack, on July 22d
Duration, 2 Days
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 28
Time of Leaving, Mar. 9. 1898
Time in Hospital, 1 yr. 7 mo. 13 d.
Result, Discharged Mar. 25, 1898. Improved.

EXAMINATION ON ADMISSION.

Exam by P.M. Phelps 7/29/95.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused ideas.
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: Patient peculiar in manner & confused in ideas though some answers sound clear. Can hardly rely fully on all of them. Says he had trouble with a man two years ago & has worried ever since. Has drank some. Confusion of ideas prominent.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS: Confused, delusive ideas,
Systematized or Not, seemingly getting worse.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of William H. Elliott

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft 3 in WEIGHT, 170½ lbs NUTRITION, Good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Promptness Movement, Prompt.
PUPILS, Equality, Equal Size, Rather small.
Response Light, Poor Accommodation,
SIGHT, Good he says.
HEARING, Good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Seem fairly steady Tongue, do
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION, Good.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Normal.
LUNGS, Normal.
Arteries - Normal
OPHTHALMOSCOPIC EXAM.,

TAKEN,

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

CRANIAL MEASUREMENTS, Circ. O. 59½ Circ. V. 68½ N. to a. 38½ Bin. a. 38 Ant. p. d. 20½ Trans. d. 16½ Bin. d. 13 F. L. 13.3
HISTORICAL, Says had Pox - ? Visited by Dr Merrill + Med. Galen institute 67 E 3rd St. Drinks hard at times
LENGTH OF INVASION, "2 years" Says ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any.
Mother or Mat. Relations, living - healthy.
Father or Pat. Relations, Living healthy.
Brothers or Sisters, 4 brothers + 4 sisters 1 brother circ sick chills.

Personal and Medical History of William H. Elliott

1896

This patient was brought here by Deputy Sheriff G.W. Smith, attended by Otis Audsam, with following history. Patient is in apparently good physical condition. No history of consanguinity or heredity. This is 1st attack; symptoms manifested on July 22d: irrational and incoherent speech: did not sleep. The Disease seems increasing: not variable: no rational intervals: Derangement now shown in that nothing definite to be gained with him, except some love affair, which the family say does not exist in fact. Patient is not disposed to injure others. Has not attempted but has threatened suicide: no filthy or destructive habits. About 2 weeks ago, was working in the field & was affected by extreme heat: was sick & did not work for 2 days. There is no history of intercurrance: no diseases: had injury to eye and head, 2 years ago: no after effect from head injury. Is has not been excited or confused. Cause of the Disease, possibly, from effect of heat. No treatment: On personal examination nothing learned, except as above: could not get anything coherent or rational from him. Was quiet & pleasant: would endeavor to answer questions, but became confused, before completing a sentence: appearance & manner, those of an insane person.

July 21 to Aug 7

On admission was put on B3 (G.A.N. Hosp. Complexion dark: hair brown: eyes gray: condition of skin good: has small red spot on back. Is clean: restless & noisy).

Nurse's Notes (Summary) Patient came on ward B3 at 7th July 21st was given bath. Was noisy & troublesome during night & was inclined to be pugnacious. Is restless & noisy at times during day. Out with crowd. Temperature on arrival 100 Pulse 90 Resp. 21. Appetite good. July 22 Restless & noisy during day. Has delusions - thinks people are calling him insulting names & becomes very excited at times. Talks incoherently July 23 Very restless & noisy during day thought he had done someone a great wrong. Sleeps fairly well.

July 24 Becomes very excited & violent this afternoon. Wanted to attack patient whom he thought insulted him. Taken to B1 at 12 M. Returned to infirmary at 2 P.M. Is very restless. was given hot bath with cold cloths to head & put to bed. Slept most of afternoon. Talked very irrationally. Has delusions - thinks some one has done him a great wrong & he is cutting him to pieces. July 31 Quiet most of day: talks to himself. Is troubled with piles Aug 1 Seems to have some thing on his mind that troubles him a great deal. Is quieter. Talks rationally at times but still has delusions: walks floor in room some. Aug 3. Weight 155 lbs Very quiet, reads some. Habits clean Aug 5 Has been upon ward all day: Apparently improving: Habits clean: Behavior good & sleeps well.

Aug 19th to Apr 30th 97 Summary Nurses Notes by Dr. Phelps. Aug 19 Out walking. Has behaved rather better than usual today. Aug 26 Is rather restless & somewhat troublesome. Sept. 1 Rather bad in behavior today, occasionally strikes at nurses. Is now upon sick ward. Sept. 23. Visited by sister. Has been very restless & rather inclined to fight. Oct. 1 Has been up on ward for several days past altho is still somewhat restless. Has delusions in regard to other patients. Oct. 7 Does not speak of his delusions

Personal and Medical History of

1897

but is somewhat peculiar. Jan 13 Trans. to A' Has been very quiet most of time Apr. 30 Is at present working in dining room: Seems at times a little silly in behavior and a little foolish in manner but does not talk about his delusions.

May 4 Wt. 178# July 31 '97 Talks in a childish way & at times seems a little dazed. In general, however, mental state is quieter & the delusions which he had at first are not so prominent. Mch 1 '98 Eloped today. He has not changed very much and at times has been rather stupid but manner has been that of fair intelligence

Discharged.

Personal and Medical History of Gust Larson

BERGET, FISCHER & CHAMBERS, DAVENPORT, IOWA.

Whole No. 44158.
Residence, St Paul Minn
Date Admission, 25th July 1896.
Admitted by D. Phelps Hour, 6 PM.
How Sent, Benn Davis, Court Commr. Ramsey County
Sex, Male
Age, - 35 -
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Laborer
Degree Education, Common School
Profession Religion, Yes: Episcopalian
Habits, not Intemperate
Nativity, Sweden: (Parents also born there)
Physicians Committing, Geo. J. Hanley and V. J. Hawkins
Correspondents, no friends or relatives known by Deputy

No. for Year, 286.
Insane Relatives, None
Cause Exciting, Syphilis
Cause Predisposing, Chronic
Form,
Accompanying Bodily Disorder, Syphilis (?)
Suicidal or Not, Not
Date of this Attack, 5 Years ago
Duration, - 5 Years (off & on?)
No. of Attack, 1st
No. of Admissions, 1st Time (was in hospital, Danville Ills?)
Age First Attack, - 30 -
Time of Leaving, Apr. 26. 1900
Time in Hospital,
Result, Transferred to Hastings (OK PM)

EXAMINATION ON ADMISSION.

Exam. by R. H. Herzog & D. McPhelps July 25th 1896

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Rather slow & confused.
Quick or Sluggish,

MEMORY:
Past Events, Apparently fair.
Recent Events, " "
Special Subjects, " " except delusions.

PERCEPTIVITY:
Alert or Dull, Rather dull &
Correct or Illusive, Incorrect.

REASONING POWER:
Ordinary Subjects, Not very bad.
Own Mental State, Poor - & delusions of persecution
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Had catarrh for years sickly about a week. Has always been a laborer Has had delusions of persecution for years. Says eye trouble is of long standing since childhood - Denies having contracted syphilis. Scars on chest are suspicious - superficial small circular unpigmented. Pat

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, & mildly.

DELUSIONS:
Systematized or Not, People after him & lick him since
Special Subjects, 9 yrs. He went with another fellows girl &
Transitory or Not, made him angry - but someone told him
HALLUCINATIONS: after him - Hears them say they
ILLUSIONS: They will kill him - day & night

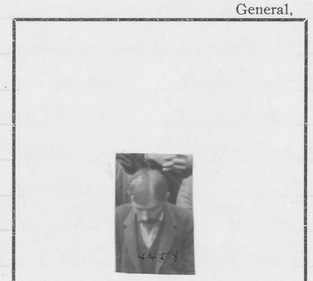
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,
on injections of Mercury & Potassium Iodide. Some dementia but understands quite readily.

Personal and Medical History of Gust Larson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft 1 in WEIGHT, 175 lbs (Usual 190) NUTRITION, Some loss of flesh.
WOUNDS OR ABNORMALITIES, Scars like shots on chest & abdomen. Discoloration on back - Pt. says all made by an electric shock
TONGUE, Tremors, Fine. Coatings, light gray. Promptness Movement, Prompt.
PUPILS, Equality, Very unequal. Size, R. much dilated - left normal
Response Light, Right will not Accommodation, R. will not.
SIGHT, Left eye fair - cant see much with right.
HEARING, Fair.
COORDINATION, Arms, Rather slight impairment
Legs, Same.
TREMORS, Hands, None of note. Tongue, Fine tremors
Facial Muscles, None General, None -
REFLEXES, Patellar, 1-2 slight. EXAM. URINE,
Other
ARTICULATION, Good
Slurred,
Hesitating,
FACIAL EXPRESSION,



SENSIBILITY,
HEART, Fey slight systolic murmer at apex soft & blowing - Sounds somewhat weak Size somewhat enlarged. Regular Apex beat 5th interspace, nipple line.
LUNGS,
Some retraction over Rt. clavicle
Sounds - Fairly good but quick.
OPHTHALMOSCOPIC EXAM., TAKEN,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular, rather
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Rather Poor, on account of headache & worry.	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. 56 (Cm.) 55¾ Nas. a. 36 Ena. 33.3 Aut. p. d. 19.7 Transv. d. 15.7 Bimd. 13 Fac. l. 12.5
HISTORICAL, Had scarlet fever in South Dakota - Syphilis denied - Denies staying with prostitutes - Drinks very rarely at times - Does not get drunk Smokes & chews - Has headaches - Bad in night - mostly on top of head. Married for 9 years for City of Mpls. Ry. worker.
LENGTH OF INVASION, 2-3 years (?) ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any.
Mother or Mat. Relations, Living - about 70 - Has rheumatism -
Father or Pat. Relations, Living at 70 Healthy - a farmer Some consumption among cousins
Brothers or Sisters, 2 brothers & 3 sisters - all healthy so far as known

Personal and Medical History of *Gust Larson*

1896

This patient was brought here by Deputy Sheriff Mr. Horst, with following history. Patient is in fair physical condition. No history of consanguinity or heredity. This is 1st attack: was in Hospital at Danville, Ills, malaria. Recovery: first symptoms of this attack manifested 5 years ago: persecution. Disease seems increasing: not variable: no rational interval. — Derangement now shown in that he thinks that people are chasing after him, at night, to kill him. Patient is not disposed to injure others, nor suicidal, no filthy or destructive habits. — As to any previous peculiarities &c, don't know. There is no history of intemperance nor of any severe disease &c or head injury. He has not been restrained or confined. Suppose cause of the disease is Syphilis. No treatment. He now has a stupid or typhoid expression.

July 25 On admission, was put on B^{3} (G.H.N. Kpt. Complexion dark: hair brown: eyes brown: Condition of skin, not good: large veins in left leg and some in right ankle; has light colored blotches on chest, skin in back, dressed in places, caused by Electric belt. Is dirty: behavior good).

Aug 8 Nurses Notes (Summary) Patient has been very quiet & orderly since coming on ward. Tends strictly to his own affairs. Appetite has been good; Bowels regular & has slept very well. Talks very little to anyone. Answers questions rationally & intelligently. Aug 5th was quite restless & excited all day; seemed very desirous to go home. Aug 6th continued restless all morning, became quiet after dinner. Said nothing concerning his delusions until Aug 8th when he refused to take medicine, saying we were trying to kill him & were giving him poison: Cried & raved loudly & tugged to get away. Has been on medicine 3 times a day since admission.

Aug 18th to Apr 30 99 Summary Nurses Notes by Dr. Phelps. Aug 18 Attempted to escape: Has been rather melancholy & nervous of late. Sept 1st Wt. 167. Sept 25 Seems to grow more & more depressed. Oct 1st Wt. 160 lbs. Is becoming very melancholy. Jan 1 Has been receiving shower baths for some time, seemed somewhat brighter during December but is quite depressed now. Apr. 30, Wt. 149½ lbs. Was quite quiet & depressed up to April first when he became silly & laughing at intervals. May 1st 97 Wt. 179 lbs. July 31st 97 Patient has been working outside some lately. Seems to have gained in health and talks in a fairly rational way, but is rather slouchy in general appearance. Jan. 31st 99 Condition does not change very much: Has worked a good deal of late: Laughs to himself. Answers questions quite intelligently. General appearance rather dull. Feb 1st to July 31st 99 (Dr Wilcox.) Wt. 181. Feb 5 Refuses to work in Kitchen Feb 8. Went to work in laundry. March 17 Struck by J. Brikke. General condition good: Is working in bakery. July 3 Trans. to A'- July 15. Abscess on right hand opened & dressed. Aug 2nd 99. Wt 170. P 74. Quiet & well behaved: frequently talks to himself while working. Aug 27. Has been out Camping: returned to-day. Nov 2. Works in tailor Shop. Dec 2 Dec 28 1900 Jan 1 to Apl 1st 00 Sick in bed - one day - Dec 28. Had trouble with a patient & struck him over head. Transferred to B' 13 Bay for 4 hours. Dec 29 Works in centre dining-room - Jan 1st 1900 Works in barn; behavior good; Apl 1st 1900. Continues about the same; mentally & physically. Apl 26th 1900 Transferred to Hastings Hospital.

Personal and Medical History of

Personal and Medical History of Adolph Fasenmeyer

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4459

Residence, St. Paul. Minn (3 weeks).

Date Admission, 25th July 1896 -

Admitted by Dr Phelps Hour,

How Sent, Benn Davis, Court Constr. Ramsey County

Sex, Male

Age, -58-

Civil Condition, widowed

Children, Three

Age Youngest Child, —

Occupation, Farmer

Degree Education, Common School

Profession Religion, Yes. Catholic

Habits, not intemperate

Nativity, Germany (Parents also born there)

Physicians Committing, John B. Brinkhall and J. Dhage

Correspondents, sister-in-law in Court - unknown by Supt

No. for Year, 287

Insane Relatives, brother insane in Germany

Cause Exciting, also mother - Heredity -

Cause Predisposing, Heredity & previous attack

Form, Chronic Mania.

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, not

Date of this Attack, 3 weeks ago

Duration, 3 weeks

No. of Attack, 2nd -

No. of Admissions, 1st Here (was at Independence, Iowa)

Age First Attack, about 55.

Time of Leaving, May 26. 1897

Time in Hospital, 10 mo. 1 day

Result, Improved. Discharged 5/28/97

Sent to Independence, Iowa
per Dr on May 26-1897

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps & W.H. Herzog 7/25/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused & incoherent

Quick or Sluggish, Active.

MEMORY:

Past Events,
Recent Events,
Special Subjects, } Seems good in general but statements wandering.

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects,
Own Mental State,
Special Subjects, } Fair Imp.

GENERAL DESCRIPTIVE REMARKS: A garrulous, somewhat exalted chronic mania. Talks incessantly if allowed - easily excited, rather incoherent - ideas not correct. Health fairly good. Some dementia with fairly well systematized delusions. Says wife is intimate with a millionaire in Cedar Rapids

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Somewhat.

Special Subjects, Infidelity of wife

Transitory or Not, Fixed.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION: Considerable incoherence

Coherent or Incoherent,

Voluble or Reticent,

Rapids & shuts him up in asylum - Somewhat emaciated & restless.

Personal and Medical History of Adolph Fasenmeyer

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6in WEIGHT, 136 lbs NUTRITION, Good.

WOUNDS OR ABNORMALITIES, Condition of skin good for age.

TONGUE, Tremors, Coatings, quite heavy Promptness Movement, Good.

PUPILS, Equality, Equal. Size, Normal.

Response Light, Normal Accommodation, Normal.

SIGHT, Good Slight opacity

HEARING, "

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None Tongue, None

Facial Muscles, " General, "

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Sounds quite exaggerated. Apex beat 6" interspace - 1/2 in right nipple line. Regular. Sigt somewhat enlarged.

LUNGS, Normal.



TAKEN,

Arteries - Temporals somewhat stiff. Radials slightly also.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Long. Ch. 53 Ext. 64 Fr. a. 33 Bin. a. 34 Antp. d. 175 Trans. d. 15.3 Bin. d. 14 Fac. l. 12.2

HISTORICAL, "Been sick" Drank a good deal in old country. denies drinking much now.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") None Crazy.

Mother or Mat. Relations, Healthy — died when he was 5 years old.

Father or Pat. Relations, " died at 78

Brothers or Sisters, 4 brothers - 3 dead - 1 high school teacher

Personal and Medical History of *Adolph Fasenmeyer*

1896

This patient was brought here by Deputy Sheriff E. Johnson, with following history. There is no history of consanguinity. Has a brother insane in Germany, also mother, insane in Germany. This is not 1st attack: one occurred 3 years ago; lasted 3 years: was in hospital at Independence, Iowa: Improved; seemed rational only 3 days after leaving hospital. First Symptoms of this attack manifested 3 weeks ago, just after leaving hospital; began to quarrel with daughter-in-law. The Disease seems increasing; not variable: no rational intervals: Derangement now shown by being very talkative; rambling; uses inelegant language, on all occasions. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. Previously had been very talkative. There is no history of intemperance, nor of any severe disease or a head-injury. As above stated he was in Independence Insane Asylum. Supposed cause of the disease is heredity. Only gave treatment at above hospital (Independence). Pt is, now, excited, talkative, always in the move.

July 25 On admission, was put on B3 (G.H.N.Rpt. Complexion light: hair gray: eyes blue: Condition of skin good: small tumor on right side of chest. Tongue: Behavior good: is very talkative).

Aug 8 Nurses Notes (Summary) Behavior restless, noisy & troublesome most of the time. Is constantly talking, asking questions & telling about his past life. He is always asking privileges & promises to keep quiet but soon forgets & becomes noisy again using very abusive & profane language most of time. Appetite is very good: is never satisfied with allowance. Complains because he has to eat on hall & without knife & fork. Bowels regular. On medicine from 28th to 31st. Does no work on ward. Makes hair chains & works a great deal of the time both on hall & while out with crowd. Average amount of sleep 6 hrs +.

Aug 8/96 to Apr 1/97 Summary Nurses Notes by Dr. Phelps. Patient rather well behaved on the whole but extremely talkative, abusive & at times profane. Sept 1st Wt. 150 Lbs. Oct. 1st 154 lbs. Conduct remains unchanged. Is at times mildly maniacal but usually is stupid. At times is unreasonable & abusive. Jan 1 Wt. 162 lbs. No change in mental condition. Apr 1st Physical condition good. No special change of any kind. May 1 '97 Wt. 162 lbs. Patient has a muddy exalted manner & talk, in which there is not so much of well defined delusion as a general slight incoherence & exaggeration of everything he talks about. Mischievous in behavior: at times excited & violent. May 26 Sent to Iowa to-day, it having been ascertained that he was a resident of that State.

Discharged

Personal and Medical History of

Personal and Medical History of Fred Quimby

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4468.
Residence, Kenyon Village, Minn
Date Admission, 1st August 1896 -
Admitted by D. C. B. Bay Hour, 6.45 P.M.
How Sent, Axel Haller J.P. Goodhue County
Sex, Male -
Age, - 38 -
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Farmer
Degree Education, Common School -
Profession Religion, not a church member
Habits, not intemperate -
Nativity, Minnesota. (Parents born in New Hampshire)
Physicians Committing, C. Jacking and A.W. Jones
Correspondents, none given in papers -
Mernida Quimby Stanyan Minn.

No. for Year, 1.
Insane Relatives, Yes. Sister
Cause Exciting, not known.
Cause Predisposing, heredity possibly
Form, Paranoia
Accompanying Bodily Disorder, none mentioned -
Suicidal or Not, - not -
Date of this Attack, six years ago
Duration, - Six Years -
No. of Attack, 1st.
No. of Admissions, 1st.
Age First Attack, - 32 -
Time of Leaving, Jany 14 - 1903
Time in Hospital, 6 years. 5 mos 13 ds
Result, Died: Chronic valvular heart & Disease with Erysipelas.

EXAMINATION ON ADMISSION.

Exam. by. P.M. Phelps 10/10/96.

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: Patient seems a quiet chronic Paranoiac - Talks along rapidly & as matter of course, with delusions. He is the great I Am. existed from beginning. Never was born.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS: Confused state - Is the great "I Am"
Systematized or Not, Had no parents - Lived before
Special Subjects, anybody was born.
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Fred Quimby

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, ——— NUTRITION, Good.
WOUNDS OR ABNORMALITIES, None. Skin - Good
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size,
Response Light, Accommodation,
SIGHT, Good
HEARING, Good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Normal. Tongue, Normal
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred, } Good.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Heart beats very irregular 150 down to 90.
LUNGS, Good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Long. d. 19.7 (v.m. 36.5 H. oc. a. 38.5 Bm. a. 35.5 Ant. p. d. 19.9 Trans. d. 15 Bim. d. 14. Fac. length 12.5
HISTORICAL, Is incoherent cannot get information.
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, Sister here

Personal and Medical History of Fred Quimby

1896

This patient was brought here by Deputy Sheriff P. J. Lundquist with following history. Patient is in poor condition. No history of consanguinity: patient is insane. This is the 1st attack; has not been in hospital: first symptoms manifested six years ago: talked incoherently: disease appears to be increasing: not variable & no rational intervals in the last two years: there did not occur at regular intervals. Derangement now shown by his being in constant fear of personal violence. He has threatened to injure his father: not suicidal: no filthy or destructive habits. No particulars as to any peculiarities &c having been previously shown. No history of intemperance, nor of any severe disease &c or head injury. He has not been restrained or confined. Cause of the disease, not known: was treated by a Doctor in Mantorville; no particulars. On personal examination, physique is good. There is fear of personal violence & poisoning. Thinks he is married and has a large family: seems harmless.

Aug 1 On admission, was put on B3. (G.M.N. D.M. Complexion dark: hair black: eyes brown; condition of skin good: has a large mole on neck. Is dirty: behavior good).

Aug 1- (Nurses Notes Summary) Patient received on ward, Aug 1st at 7:30 P.M. Given bath. Talked a great deal when spoken to: Irrational: Habits clean: behavior good. Patient of a melancholy disposition, talks very little & irrationally: Delusions are very prominent: Habits clean & quiet. When indoors sits quietly in one place with his face toward the wall: Temperature has ranged from 99 to 100.4: Appetite has been good: Bowels regular: Sleep good: Has no physical ailment, except rise of temperature, & makes no complaints: Today (Aug 14) has seemed a little brighter but resumed his stupid condition toward evening.

Sept 1896 to Apr. 1897 Summary of Nurses Notes by Dr Chapple. Sept 1. Patient sits in one place most of the time: is very cranky. Physical condition good: Wt. 164 lbs. Jan 1 165 lbs. Feb 5. Trans. to B3. Wt. 166. Always quiet & apparently somewhat stupid in manner. Feb 19. Trans. to annex. Apr. 30 quiet, at times foolish & silly. Does no work. May 1 '97 Wt. 167#. July 31 Health good: Works a little: Is always quiet: Does not talk much: Full of delusive ideas. Jan 31 '99 At present is doing no work: Is dull, childish & inactive altho appears to have considerable mental ability. D. Feb 1. J.

Feb 1 - July 31 '99. Wt 164. Appetite good: Behavior & habits good: Has delusions.

Aug 1 - Jan 31 1900. (Dr Chapple) Wt. 163½# Aug 18 & 19. Visited by sister & by a friend. No change during period. Health & behavior very good. Is quiet & cleanly. Worked in kitchen a few days but is usually inactive: Quite demented & irrational: Cleanly in habits. Does not speak unless addressed.

to 1900

Jany 31

Feby 1 - July 20 - 31 Aug 1 Wt 158#. Pst. July 20. Vaccinated; result good. July 31. No change: health good: Works in kitchen: habits quite tidy; very quiet & well-behaved. Talks some to self but will not converse with others; except to answer questions. Will not let anyone touch him, if he can help it. Seems to have a "delusion of uncleanness" of some sort. Aug 1 Wt 162½ Sept 10. Transferred to D3.

Personal and Medical History of Fred Quimby.

1899

Jany 31 Very little change: works in kitchen; habits tidy: very demented: talks some to himself, but avoids conversation: has peculiar delusions about greeting people. Quiet & well-behaved.

1900 Jany 1 to Jany 31 Wt 173½#. May 1. 163# Aug 1. 163# Nov 1. 169#. Pulse 80. Good health, during year: worked regularly as an extra kitchen-hand: very quiet: never speaks unless addressed: avoids others: very peculiar: habits tidy.

Aug 19. 1902 (Dr Chapple) Upto date patient has been in apparent good health, & working in the kitchen. Today transfered to D W. Complains of severe abdominal pains - a distention - Operated upon by Dr. Mayo for intestinal obstruction - Made good recovery from operation. Sept. 13. Given his clothes. Sept. 30. To Annex. Oct 19 To D. W. Symptoms of heart failure. Has constant oedema - put on heart tonics. Nov 6 Is somewhat improved. Given clothes today. Nov. 12 Difficult respiration; swelling of limbs: put to bed. Jan. 14-03 Expired today, at 8:50 P.M. Has been failing gradually with Mitral disease - became very distressed & oppressed for breath - a few days ago developed facial erysipelas - altho same infection is thought resulting from rapid exhaustion.

Personal and Medical History of Edward Burns.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4472
Residence, Stewartville, Minn.
Date Admission, August 5th 1896
Admitted by Dr. W.H. Herzog Hour, 12.30 p.m.
How Sent, Thomas Fraser Judge of Probate Amsted Co.
Sex, male
Age, 25 years.
Civil Condition, single
Children, none
Age Youngest Child, —
Occupation, Laborer.
Degree Education, common school
Profession Religion, Roman Catholic
Habits, addicted to morphine
Nativity, Minnesota (parents both born in Ireland.
Physicians Committing, John Grosvenor Roes & Chas. T. Granger.
Correspondents,

No. for Year, 5
Insane Relatives, none
Cause Exciting, morphinism
Cause Predisposing, unknown
Form, Morphinism, functional insanity
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, 22 years.
Time of Leaving, June 22. 1897
Time in Hospital, 10 mo. 17 da.
Result, Discharged - June 22-97. Recovered

EXAMINATION ON ADMISSION.

Exd by Dr Herzog 8/6/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, clear
Quick or Sluggish, fairly quick
MEMORY:
Past Events, seems good
Recent Events, do.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, fairly alert
Correct or Illusive, correct.
REASONING POWER:
Ordinary Subjects, good.
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, yes.
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, None Noted,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, coherent
Voluble or Reticent, fairly voluble.

GENERAL DESCRIPTIVE REMARKS: Patient talks fairly rationally on all subjects. Probably understates the extent of the morphinism. Says 'has taken morphine one year, never more than 10gn a day, always had physician give the drug.' However he is much scarred and brought a syringe with him. Says acquired the habit by taking it for rheumatism. Had acute articular rheumatism went to Hot Springs in 1894 - to Mt Clemens in 1895. Late, confessed going to Hot Springs on account of syphilis. Has probably low of fair mental grade but is effeminate & 'babyish'. Is very much run down but shows no definite symptoms of insanity on first examination.

Personal and Medical History of Edward Burns

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. 9 3/4 in. WEIGHT, 120½ lbs. usual weight 150. NUTRITION, poor.
WOUNDS OR ABNORMALITIES, scar of operation in groin 1 year ago. legs & forearms covered with hypodermic needle scars and with ulcers with rupia like crusts.
TONGUE, Tremors, considerable Coatings, large & flabby clean Promptness Movement, somewhat slow.
PUPILS, Equality, yes Size, normal
Response Light, excessive Accommodation, excessive.
SIGHT, some impairment, has worn blue glasses.
HEARING, good
COORDINATION, Arms, some impairment
Legs, considerable impairment
} usual tests not made. has great difficulty in standing & in walking.
TREMORS, Hands, slight Tongue, considerable
Facial Muscles, no General, no.
REFLEXES, Patellar, 10 equal.
Other abdominal exaggerated, ankle clonus.
ARTICULATION, voice is effeminate.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY, hyperaesthesia
HEART, slight systolic mitral murmur 2nd pulmonic sound sharp sounds somewhat weak. apex beat very forcible in normal position, somewhat irregular
LUNGS, no marked physical signs
complains of pain & soreness.

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, yes at present	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, none last night	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, long ONSET GRADUAL OR SUDDEN, gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Mother died of heart disease previously rheumatic.
Father or Pat. Relations, Father living, well. uncle rheumatic, grandparents rheumatic,
Brothers or Sisters, 4 brothers living one is "nervous." one sister living well, one died "lung trouble"

Personal and Medical History of Edward Burns.

1896

This patient was brought here by Sheriff C. N. Stewart, with following history. Patient is in poor physical condition. No history of consanguinity or of heredity. This is the 1st attack. Has not been in hospital. First symptoms were manifested three years ago by incoherent speech and wandering from home. Disease appears to be increasing - is not variable and there are no rational intervals. Derangement is now manifested by becoming violent unless narcotized with morphine. Cannot be kept at home. Patient has shown no disposition to injure others, is not suicidal, filthy or destructive. Is addicted to morphine. No peculiarities predominant passions &c noted as being manifested before the accession of the disease. No history of severe disease, head injury convulsions &c. No restraint or confinement has been employed. The cause of the disease is supposed to be "Morphine". No treatment has been pursued. On personal examination — Narcotized during examination and quiet.

Aug 5th On admission was put on "Infirmary East". "G. H. M's Rept (Complexion dark Hair black Eyes brown, Skin fair condition. Scars & Ulcers from hypodermic injections, clean. Walks lame. Restless, wants morphine. appears weak)

Aug 18 Nurses Notes (Summary) Patient came on ward Aug 6th at 2 P.M. Given bath & put to bed. Temp. 100° Pulse 100 R. 28. Is very weak & restless. Talks some but somewhat incoherently & irrationally. Legs in very poor condition broken up with ulcers. they seem to pain him very much: dressed with Iodoform gauze & bandages. Behavior very good & quiet: Habits clean: Has been very restless: Restless up to 9 a.m. Aug 9th remainder of day rested fairly well: Complained toward evening of pain in stomach: Sleeps 8 hrs. on average. Complains of limbs paining him: Limbs dressed daily & seem to be improving. Patient calls continually for morphine Aug. 10-11-12 remained in bed - very much quieter: Out in roller chair on 13th Says he feels quite well but continues to call for morphine: Has complained of diarrhoea for several days past. Rests fairly well at night Last 36 hrs. has had 1/8 gr. morphine: Temp. has been slightly above normal most of time - highest mark 100 4 Talks a great deal - rational but statements cannot be relied upon.

Aug 26 to Apr 30 96 Summary Nurses Notes by Dr Phelps Aug 26 Had a fainting spell - Has had several so-called fainting spells during past week. Complains of pain around heart Opium has been gradually diminished. Is receiving strychnine in its place together with Bromides Oct 2 Patient up & about: Wt. 134 lbs, being an increase of 13½ lbs. for month. Assists some with work. Seems very much improved. Dec 12 Patient's weight 145 lbs. Sick 5 days & removed to Infirmary. During day developed facial erysipelas. Feb 20 Patient about well again & about as before sickness. Apr. 30 Patient is in fairly good health: Assists with ward work, attends chapel, & takes an in-

Personal and Medical History of

telligent interest in everything. May 1 97 Wt. 142th. Patient is quite neat & clean in habits & behavior: Talks freely in a fairly intelligent manner: Is rather easily excited, childish in many ways & generally unreliable. June 22 97 Went Home. No change -

Discharged

Personal and Medical History of John Alfred Johnson.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4474
Residence, Preston, Minn.
Date Admission, August. 5. 1896
Admitted by Dr. H.H. Herzog Hour,
How Sent, E.V. Farrington. Judge of Probate, Fillmore Co.
Sex, Male
Age, 25 years
Civil Condition, single
Children, —
Age Youngest Child, —
Occupation, Farm laborer
Degree Education, common school
Profession Religion, Lutheran
Habits, unknown
Nativity, Sweden, parents also born there
Physicians Committing, J.H. Phillipps and Henry Jones.
Correspondents,

No. for Year, 7.
Insane Relatives, unknown
Cause Exciting, unknown
Cause Predisposing, unknown
Form, subacute insanity
Accompanying Bodily Disorder, none given
Suicidal or Not, No.
Date of this Attack, Two months ago.
Duration, Two months
No. of Attack, 1st.
No. of Admissions, 1st.
Age First Attack, 25 years.
Time of Leaving, July 1. 1898
Time in Hospital, 1 yr. 10 m. 4 d.
Result, Discharged. Dec. 17. 1898 Recovered.

EXAMINATION ON ADMISSION.

Exam. by P.M. Phelps. 8/25/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, 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, "
GENERAL DESCRIPTIVE REMARKS: Acute - Has talked incoherently on the subject of religion a good deal of the time.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, ✓
Depressed,
DELUSIONS: Talks continually in a
Systematized or Not, confused way about
Special Subjects, religious subjects.
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of John Alfred Johnson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good
WOUNDS OR ABNORMALITIES, Condition of skin good.
TONGUE, ~~Tremors~~, somewhat flabby. Coatings, Clean. Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, ✓ Accommodation,
SIGHT, Normal.
HEARING, Good.
COORDINATION, Arms, Fair
Legs, "
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 7-8 Equal, EXAM. URINE,
Other
ARTICULATION, Good.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds extra loud & strong - Probably hypertrophied -
LUNGS, Good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Lare (a) 56½ Ear (b) 37.5 F.o.c.a 37.5 B'm.a 35 Aur.p.d 19.8 Fr.m.d. 15.9 B'd. 12.8 Fac. L. 12.
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any (2)
Mother or Mat. Relations, Living Healthy.
Father or Pat. Relations, Living - healthy - 63
Brothers or Sisters,

Personal and Medical History of John Alfred Johnson.

Personal and Medical History of

1896. This patient was brought here by Henry Nupson with the following history. Patient is in fair physical condition. No history of consanguinity or of heredity. This is the first attack: first symptoms were manifested about 2 months ago by religious excitement. Disease appears to be increasing. There are rational intervals which occur at any time. Derangement is now manifested by hallucinations, says he is a prophet, is continually preaching. No disposition to injure others, not suicidal or filthy or destructive. No previous peculiarities. No severe disease, epilepsy &c. No restraint or confinement. Cause unknown. No treatment has been employed. On personal examination "shows all the symptoms of acute religious mania."

Aug. 1896. Nurses Notes (Summary) Patient received on ward August 5th Appeared excited & was extremely noisy all PM. Did not go to sleep until sleeping dose was given. Has delusions, thinks he is a prophet sent to save sinners. Appetite good. Bowels regular. While out walking on 7th inst. became very noisy & stubborn; would not walk & was carried in by nurses. Delusions still quite pronounced. Continued noisy all day. 11th Appetite fair bowels regular. Sleeps well. Continues noisy & stubborn. Does everything possible to provoke nurses. Put on bromide 3 times per day. On 13th became very destructive while out, tearing his clothing, hat & shoes. 14th very noisy & excited all PM. 15th Some improvement, quiet & well behaved, also worked some on ward. 16th Presumed old habits, noisy & mean. 18th quiet to day. Appetite has remained good: bowels regular: Has slept well since admission.

Sept. 1896 to March 97. Summary Nurses Notes by Dr. Phelps Sept 1. Patient has been rather emotional & restless in behavior & not to be depended upon: Is mildly maniacal. Oct. 1. Wt. 141 lbs. Still rather restless & maniacal. Oct. 29 Trans. to B'. Nov. 1. Has to be kept in bed a good deal of the time & watched, behavior rather maniacal. Nov. 10 Trans. to Infirmary on account of rise of Temperature noted today. Has a swollen Knee. Nov. 16. Trans. to B' again. Knee has been treated with fomentations & has improved altho still somewhat lame. Nov 30 Still complains of pain: Temperature somewhat high. Trans. to Infirmary again. Dec 4 Trans. to B'. Has been very restless upon Infirmary. Knee is gradually improved until it seems quite well. Jan 3. Kept upon B'. Restless & maniacal. Feb. 28 Still maniacal & restless. Talks little.

May 1897 July 8 Wt. 153#. Patient is rather irritable & restless, full of vague delusions & mildly maniacal: Trans. to Infirmary: Secretly tried to choke himself. July 9 Lies quietly in bed: No prominent symptoms: Asked for a knife to cut throat. July 31 Temp. usually about normal: At times tries to choke himself: Aug 1 Is now up & about, Still thinks he is to be killed. Aug 22 Trans. to B3. April 1898 Patient seems to have improved until he is quite rational. Since first of year has made very little note of any delusions & talks quite brightly & well. July 1. 98 Sent home on trial. Has continued to be fairly rational in every way

Discharged.

Personal and Medical History of John Guiney.

EGBERT, FIELAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4477
Residence, Austin, Minn.
Date Admission, August 6' 1896
Admitted by Dr R.M. Phelps Hour,
How Sent, O.S. Washburn, Dep. Mower Co.
Sex, - Male -
Age, - 63 -
Civil Condition, - Widowed -
Children, - Two -
Age Youngest Child, —
Occupation, - Laborer -
Degree Education, - None -
Profession Religion, Yes. Catholic.
Habits, no history of intemperance.
Nativity, Ireland.
Physicians Committing, A.N. Allen & C.H. Johnson.
Correspondents, John Guiney Austin Minn telegraph

No. for Year, 10
Insane Relatives, Not known.
Cause Exciting, Fall from a car.
Cause Predisposing, — —
Form, Dementia senilis
Accompanying Bodily Disorder, Cranial bones seem depressed from fall.
Suicidal or Not - N.+

If John Guiney is
by sick or dies
please notify his
brother Patrick Guiney
Austin Minn.
Box 149.

Result, Died. Progressive
Bulbar Paralysis.

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps. 10/10/96 **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: Thoroughly demented & paretic in form. Supposably from the cranial injury.
Can give no information personally - too demented.

Dull demented
Simple organic.

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 John Guiney.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Somewhat poor.
WOUNDS OR ABNORMALITIES, Cranial deformity. Skin - only fair.
TONGUE, Tremors, Very tremulous Coatings, Promptness Movement,
PUPILS, Equality, Unequal - Size, left larger.
Response Light, very little Accommodation, slight.
SIGHT, Poor - Don't know how poor.
HEARING, Poor -
COORDINATION, Arms,
Legs,
TREMORS, Hands, Tremulous. Tongue, Tremulous.
Facial Muscles, possibly on action General,
REFLEXES, Patellar, Exag - 8 EXAM. URINE,
Other
ARTICULATION,
Slurred, Much
Hesitating, yes.
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Rhythm Normal Feeble 1st sound. Sounds palpitating at apex - weak at base. Size dilated.
LUNGS,
Sounds are good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, No	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Ears (L) 5.7 (R) 5.9 H. c.c. 5.1 Bim. a. 3.1 Circ. f.d. 18.4 Front. d. 1.4 Bim. d. 11.9 Fac. length 11.1
HISTORICAL, No information
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 John Guiney.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4777
Residence, Austin, Minn.
Date Admission, August 6' 1896
Admitted by Dr R.M. Phelps Hour,
How Sent, D.S. Washburn, Dep. Sheriff Mower Co.
Sex, - Male -
Age, - 63 -
Civil Condition, - Widowed -
Children, - Two -
Age Youngest Child, —
Occupation, - Laborer -
Degree Education, - None -
Profession Religion, Yes. Catholic.
Habits, No history of intemperance.
Nativity, Ireland.
Physicians Committing, A.N. Allen & C.H. Johnson.
Correspondents, John Guiney Austin Minn Telegraph

No. for Year, 10
Insane Relatives, Not known.
Cause Exciting, Fall from a car.
Cause Predisposing, — —
Form, Dementia senilis
Accompanying Bodily Disorder, Cranial bones seem depressed from fall.
Suicidal or Not, - Not -
Date of this Attack, About 15 months ago.
Duration, About 15 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, - 62 -
Time of Leaving, June 14. 1897
Time in Hospital, 10 mo 8 da.
Result, Died. Progressive Bulbar Paralysis.

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps. 10/10/96

MENTAL CHARACTERISTICS.

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

MEMORY:
Past Events, Dementia
Recent Events, senilis
Special Subjects, as

PERCEPTIVITY: organic.
Alert or Dull,
Correct or Illusive,

REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Thoroughly demented & paretic in form. Supposably from the cranial injury.
Can give no information personally. Too demented.

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 John Guiney.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Somewhat poor.
WOUNDS OR ABNORMALITIES, Cranial deformity. Skin - only fair.
TONGUE, Tremors, Very Tremulous Coatings, Promptness Movement,
PUPILS, Equality, Unequal - Size, Left larger.
Accommodation, slight.
how poor.

Tongue, Tremulous.
General,

REFLEXES, Patellar, Knee - 0
Other
EXAM. URINE,

ARTICULATION,
Slurred, Much
Hesitating, Yes.
FACIAL EXPRESSION,

SENSIBILITY,

HEART, Murmurs Valves Filling 1st sound. Sounds palpitating at apex - weak at base. Size Dilated.

LUNGS,
Sounds are good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, bins (L) 52 (cm) 59 h. occ. 31 Bin. a. 31 Aut. p. d. 184 Fronv. d. 14 Bin. d. 11.9 Fac. length 11.1
HISTORICAL, No Information
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 John Gurney.

1896

This patient was brought by Sheriff's Deputy John Johnson with following history: Is aged: Nothing known as to Consanguinity or heredity: This [2d] attack manifested about 15 months ago after a fall from a car when patient was found unconscious. Disease seems increasing, variable, no rational intervals: Derangement shown in loss of memory - has many vagaries: Is not disposed to injure others: No suicidal filthy or destructive habits: No previous peculiarities: History of intemperance not known Cranial bones seem depressed as though fractured at some time. Nothing known as to treatment, confinement or restraint. On personal examination - difficult to learn anything by conversation with patient examination of head as above: Commitment recommended as patient is dangerous to himself on account of wandering about & exposing himself to want of food & shelter or to accident. On Admission

Aug. 19 Nurses Notes (Summary) Patient received on ward at 7:30 P.M. on 6th Seemed quiet & well behaved. Physical condition fair. Skin in good Condition: Has ravenous appetite: Bowels regular: Stutters very badly when conversing: Eyes inflamed & maturated on rising in morning: Mental qualities very deficient: Memory very poor: During 1st week had temperature ranging from 99 to 100.2. Was transferred to A[t] on 12th but escaped through window & was brought back to B[t]. Habits have become more filthy & slovenly last few days: Patient seems quite feeble: Appetite remains good; bowels regular: Has slept very well past week: Mental condition unimproved.

Sept 1/96 to Apr. 30/97 Summary Nurses Notes by Dr. Phelps. Sept. 1 Patient weak feeble & aged. Is somewhat senile in appearance altho his trouble is paretic in form & the paresis is too excessive to go on simply to old age. Oct 10 Has become somewhat restless and is still feeble & paretic that he has hurt himself several times. Oct. 30. Has erysipelas of face starting in a place which he had bruised. Nov. 30 Now on sick ward, mostly on account of feebleness: Is demented, feeble & childish altho usually quiet. Dec. 16 fell out of bed: was visited by father Jan 31 Patient still feeble & demented: Has to be fed by nurses at times & at times falls out of bed. Apr 30 Wt. 140 lbs. At times refuses to eat & is very Depressed. May 1/97. Patient has been lying in a quiet dull way in bed. Wt. 107 lbs. Is thoroughly paretic. June 1/97 Wt. 96 lbs. Is growing more & more stupid. Has difficulty in swallowing: lies quietly in bed greater part of time. June 1st Died at 7:30 A.M. failure very steady and gradual & of the character of paretic changes. no convulsions noted.

Died.

Personal and Medical History of

Personal and Medical History of Olaf Bjornstad.

BURNET, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4479
Residence, Redwing, Minn.
Date Admission, August 7th 1896
Admitted by Dr. S. L. Phelps. Hour, 7 P. M.
How Sent, Axel Haller, Jap. Goodhue Co.
Sex, Male.
Age, 36.
Civil Condition, Married.
Children, 3.
Age Youngest Child, —
Occupation, Shoemaker.
Degree Education, Common School.
Profession Religion, Not a church member.
Habits, Not intemperate.
Nativity, Norway.
Physicians Committing, Galen Allen, & H. McKinstry.
Correspondents, Have given on papers.

No. for Year, 12.
Insane Relatives, Aunt on Mothers side.
Cause Exciting, Excessive worry.
Cause Predisposing, — —
Form, Melancholia Acute
Accompanying Bodily Disorder, Insomnia. weakness
Suicidal or Not, Not.
Date of this Attack, July 30th '96.
Duration, About one week.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 36.
Time of Leaving, July 16. 1897.
Time in Hospital, 11 mo. 9 d.
Result, Discharged Nov. 3. 1897 Improved.

EXAMINATION ON ADMISSION.

Exam. by. P.M. Phelps 8/10/96. **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:
Vague mental state. Has been depressed.

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

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Some white coating Promptness Movement, Prompt.
PUPILS, Equality, Equal. Size, dilated.
Response Light, rather slight. Accommodation, —
SIGHT, —
HEARING, Good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Not much Tongue, —
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION, Fair.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,

TAKEN,

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) 55.5 (fm) 66.5 Occ.a. 36 Bi.a. 35 Ant.p.d. 19.7 Fr.s.d. 15.2 Bi.d. 13.2 Fl. 13.6
HISTORICAL, Typhoid fever long ago — Stomach trouble — Operation for piles 1 yr. ago. Headaches often past yr. Drinks a little. Drinks sometimes
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, died asthma
Father or Pat. Relations, Living healthy. — Father's sister crazy.
Brothers or Sisters, has 3 children.

Personal and Medical History of Olaf Bjornstad.

1896

This patient was brought here by Marshall Eastrand with following history:- Patient in impaired physical condition. First symptoms of attack manifested by insomnia + fear of being killed: Disease appears increasing with rational intervals generally in evening + early morning: Derangement shown in religious remorse, reading socialistic books + fears of being poisoned: Is not suicidal, filthy or destructive or disposed to injure others: Was quick tempered + nervous before attack: No history of consanguinity father was a habitual drunkard: No severe disease or injury to head. Patient has been watched at night + treated by Dr. Juel. On personal examination shows mild looks, elevated temperature, quick pulse, + dilated pupils - fear of personal injury. On admission put upon Infirmary ward East.

Aug 7 '96 Nurses Notes (Summary) Patient received on ward at 7.30 PM. Given bath + put to bed. Very uneasy during night. Aug. 9th Thinks he is going to be killed, says he does not want to die now: Is very uneasy, out of bed often but is quiet: Does not sleep very well: Appetite good. Bowels irregular: Aug. 13 Since 10th has shown some improvement: Talks more rationally, delusions not so noticeable: Says he is not very well + wants to remain until cured. Appetite good: Bowels somewhat irregular: Out walking with crowd on 15th + 13th: Still restless at times:

Aug 20 Patient appears to be improving gradually: Habits so far have been clean + he has been quiet. Talks very rationally at times + at others will give away to delusions: Appetite very good most of time: Rests well at night Temperature has been but little above normal, highest mark 99.6.

Aug 31 '96 to Apr 30 '97 Summary Nurses Notes by Dr. Phelps. Oct 31 Patient rather irrational + depressed- Is afraid that people are going to kill him. Oct 31 Still worries about going home: Believes himself to be very sinful + unworthy

Jan 31 Very much depressed, at times irritable. Apr 30. Wt. 140 lbs. At times refuses to eat + at times very depressed.

May '97 Patient deluded and despondent, sobs and cries a good deal: Is, however, fairly intelligent in appearance + answers questions fairly intelligent

July '97 Remains about same. July 16 Went home this PM. little if any improvement in patient altho becoming somewhat cheerful upon learning that he could go home.

Discharged.

Personal and Medical History of

Personal and Medical History of Milton Talbot

BRIGHT, PIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4481

Residence, Helena, Mont. previous to Reinc dent to State Prison Jan 95

Date Admission, August 10th 1896.

Admitted by Dr. R.M. Phelps. Hour,

How Sent, E. G. Butts, Jay P. Washington Co.

Sex, -Male-

Age, - 25 -

Civil Condition, Single

Children, None.

Age Youngest Child, -

Occupation, Machinist.

Degree Education, - Common school.

Profession Religion, Not a church member.

Habits, Intemperate -

Nativity, Minnesota.

Physicians Committing, W.W. Pratt + D.L. Clark.

Correspondents, Sent given in Japan

No. for Year, 14

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, -

Form, melancholia acute

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, About 7 months ago.

Duration, About 7 months.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, -25-

Time of Leaving, Dec. 11. 1896

Time in Hospital, 4 m. 1 d.

Result, Discharged Feb. 9. 1898
Reconvened

EXAMINATION ON ADMISSION.

Exam. by Dr. Phelps 9/27/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Fairly clear

Quick or Sluggish,

MEMORY:

Past Events, Fair

Recent Events, "

Special Subjects, Confused as to time in prison

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Only fair.

Own Mental State,

Special Subjects, Somewhat poor

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS: None noted now except that

Systematized or Not, he thinks he was operated

Special Subjects, on + without any special

Transitory or Not, Evidence.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Had syphilis 4-5 years ago. Think had operation but on being questioned only knows that he was in pain in evening - they gave him drink of water + he knew nothing more until morning + found himself strapped to a board. Was treated as the Dr. once said to him he treated a case. Had had course of mercury previously. Had trouble with nose, throat, hair falling out + pain in abdomen. Thinks was crazy, must have been. Not so well now as has been at times, but not bad - Is weak + nervous. Think treated him badly. He refused to work once + they strung him up by hands + beat him on the head.

Personal and Medical History of Milton Talbot.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8½ WEIGHT, 152½ NUTRITION, Good.

WOUNDS OR ABNORMALITIES, Skin - good.

TONGUE, Tremors, Coatings, Clear. Promptness Movement, prompt.

PUPILS, Equality, Equal. Size, Normal.

Response Light, Good. Accommodation,

SIGHT, Good - Says eyes are weak - no glasses.

HEARING, Good

COORDINATION, Arms, Gone

Legs, "

TREMORS, Hands, Normal. Tongue, None

Facial Muscles, " General, "

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,



SENSIBILITY,

HEART, Normal.

LUNGS, Normal.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, 6. (h.) 55 (circ.) 66. Fro.a. 34.5 Bi.a. 36. Aur.P.S. 19.2 Fr.d. 15.5 Bi.d 13. T.L. 12

HISTORICAL, Had syphilis 5 yrs. ago. Doctored for 2 or 3 months + then went out to Helena Drinks some - Has been drunk several times.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any insanity.

Mother or Mat. Relations, living healthy

Father or Pat. Relations, Dead amputation of leg.

Brothers or Sisters, 7 sisters.

Personal and Medical History of Milton Talbot.

1896

This patient was brought here by Sheriffs Deputy D.G. Beebe from State Prison with the following history:- Is in fair physical condition: No history of consanguinity or heredity: This is first attack & first symptoms were manifested about 7 months ago by delusions in regard to his health - also in regard to his work, - imagined that he was about to die, also that persons were interfering with his work: heard noises that troubled him. Disease seems increasing variable with irregular rational intervals lasting 2 or 3 days at a time. Derangement now manifested in regard to health - thinks health is so imperfect that he has but a short time to live: hears noises when at work - or at night: No disposition to injure others; not suicidal, filthy or destructive: No evidences of previous peculiarity. Patient used liquor to excess for two or three years before commitment; No evidence of serious disease or head injury: Patient was in solitary (at State Prison) confinement for 3 weeks to no effect. Has received only general treatment for constipation, headaches etc. Cause of disease unknown. On personal examination - patient healthy in appearance. Physical condition does not correspond with what he claims for himself - Action in this cause found on evidence of witnesses. On admission put upon D^t (G.H.N. Rpt: Complexion fair: hair brown: eyes gray: skin good: Small scar on left limb. Is clean: Behavior good.)

Aug 23 Nurses Notes (Summary) Patient received on ward on 10th inst. Behavior has been very good both on ward & when out with crowd: Has given no trouble at all. Is a good worker, will do whatever is asked of him Says he is well pleased with the place: Has no desire to run away. Talks rationally on all subjects no delusions have been detected in talk or actions. Appetite good. Bowels somewhat irregular the first few days, an occasional cathartic given. Very regular of late. Slept very poorly first 2 or three nights, on 13th given Sleping dose: Since then has slept well: Neat & clean in habits & appearance.

Sept 1st to Dec. 11th '96 Summary Nurses Note by Dr Phelps Sept 1st 158 lbs. Quieted down quite rapidly after coming in. Behaves quite rationally & fairly well. Oct 1st Getting along nicely: Talks quite rationally Dec. 11 Eloped - was working in dining room. In good health - mental condition unchanged.

Discharged.

Personal and Medical History of

Personal and Medical History of Adolph Erickson

EGBERT, FIELAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4482
Residence, Scandia, Minn.
Date Admission, August 10' 1896.
Admitted by Dr. R.M. Phelps Hour,
How Sent, E.G. Butts, J of P. Washington Co.
Sex, -Male-
Age, -29-
Civil Condition, -Single-
Children, none -
Age Youngest Child, -
Occupation, Carpenter.
Degree Education, -Good Education-
Profession Religion, Not a church member.
Habits, not intemperate.
Nativity, Minnesota (parents Sweden)
Physicians Committing, E.B. Dulligh & G.E. Clark.
Correspondents, Bro. Alf. Erickson, Marnie Mills
Bro. Wm Ericson 2514 - 14th Ave S. Mpls (Goes out to work for Jacob Legve Byron 7/7-02)

No. for Year, 15.
Insane Relatives, None.
Cause Exciting, Business depression
Cause Predisposing, —
Form, subacute insanity
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not.
Date of this Attack, Aug. 3' 1896.
Duration, about 1 mo.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 29 yrs.
Time of Leaving, 7th July 1902
Time in Hospital, 5 yrs. 10 mos. 27 ds
Result, Improved. Dis'd. Jan 15/03 By B.of C.

Disg/a D.P.

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps 9/15/96

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: Thinks it all a mistake that he is here - Dont know what the mistake is. Didn't tell him he was crazy or anything about it. Seems weak & simple mentally. Quiet & composed.

Personal and Medical History of Adolph Erickson.

Adolph Ericson
Bro Alf. Ericson
Marnie Mills
Bro Wm Ericson
2514 - 14th Ave S.
Mpls
Goes out to work for
Jacob Legve
Byron -
7/7-02

July 9/02 per D.P.

33/353

ATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 168 NUTRITION, Fairly good.
Skin - good.
Coatings, Normal. Promptness Movement, good.
Size, Normal.
Accommodation, normal -

Tongue, Right
General, no.

EXAM. URINE,

Good.

Slurred,
Hesitating, rather slow.
FACIAL, EXPRESSION,
SENSIBILITY,
HEART, No murmurs - Bounds good. regular
LUNGS,



TAKEN,

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 (ms) 55.5 h. to a. 36.5 Bi. au. 36.5 Ant-p. d. 19.7 D. diam. 15.2 Bas. d. 13.5 Fl. 12.2
HISTORICAL,
LENGTH OF INVASION, long - ONSET GRADUAL OR SUDDEN, gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Dead - Out of head when sick - was nervous. died some him trouble
Father or Pat. Relations, " physical disease
Brothers or Sisters, 2 brothers - healthy

Personal and Medical History of Adolph Eric[illegible]

HERBERT, FIGLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4482

Residence, Scandia, Minn.

Date Admission, August 10' 1896.

Admitted by Dr. R.M. Phelps Hour,

How Sent, C. G. Butts, J. of P. Washington Co.

Sex, -Male-

Age, -29-

Civil Condition, -Single-

Children, none.

Age Youngest Child, -

Occupation, Carpenter.

Degree Education, -Good Education-

Profession Religion, Not a church member.

Habits, not intemperate.

Nativity, Minnesota (Parents Sweden)

Physicians Committing, C.B. Dulligh & G.E. Clark.

Correspondents, Bro. Alf. Erickson, Marine Mills
Bro. Wm Ericsson 3514 - 14th Ave S. Mpls (Goes out to work for Jacob Leyberg Mpls 7/96)

No. for Year, 15.

Insane Relatives, None

Cause Exciting, Busine[illegible]

Cause Predisposing, —

Form, Intoxicant

Accompanying Bodily D[illegible]

Suicidal or Not,

Date of this Attack,

Duration, ad[illegible]

No. of Attack,

No. of Admission

Age First Attac[illegible]

Time of Leavin[illegible]

Time in Hospital, 5 Yrs. 1[illegible]

Result, Improved. Disch[illegible]
By J. Bdf. C.

Insane by R.M.P. 9/15/96

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps 9/15/96

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: Thinks it all a mistake that he is here - Dont know what the mistake is. Didn't tell him he was crazy or anything about it. Seems weak & simple mentally. Quiet & Composed.

Personal and Medical History of Adolph Ericsson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 10 WEIGHT, 168 NUTRITION, Fairly good.

WOUNDS OR ABNORMALITIES, Scars - good.

TONGUE, Tremors, Coatings, Normal. Promptness Movement, good.

PUPILS, Equality, Equal - Size, Normal.

Response Light, normal Accommodation, normal -

SIGHT, Good

HEARING,

COORDINATION, Arms, Good.

Legs, "

TREMORS, Hands, No. Tongue, Slight

Facial Muscles, No - General, No.

REFLEXES, Patellar, Normal. EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating, rather slow.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No Murmurs - Bounds good. regular

LUNGS,



TAKEN,

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 (ms) 66.5 h. o.e.a. 36.5 Bi. Aur 36.5 Ant. p. d. 19.7 P. diam. 15.2 Bi. d. 13.5 Fl. 12.2

HISTORICAL,

LENGTH OF INVASION, long - ONSET GRADUAL OR SUDDEN, gradual.

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

Mother or Mat. Relations, Dead - Out of head when sick. - was nervous. died some kind trouble

Father or Pat. Relations, " physical disease

Brothers or Sisters, 2 brothers - healthy

Personal and Medical History of Adolph Erickson.

1896

This patient was brought here by Sheriff's Deputy G. W. Smith attended by George Stevens with the following history:- Patient in fair physical condition. No history of consanguinity or heredity. First symptoms manifested August 3 1896,- Had made threats to shoot several persons. Disease seems increasing, variable with rational intervals "as soon as you speak to him about his condition he flies off. Derangement now shown in thinking that people are down on him & are boycotting him. Patient has shown disposition to injure others. Is not filthy or destructive: no previous peculiarities shown: No history of intemperance in parents or self: No severe disease or head injury. Cause of disease supposed to be business depression: Patient has not been confined or restrained. No particulars concerning treatment notes. On personal examination- pulse regular; pupil eye normal; general appearance good. On admission put upon B's Gen'l Rpt. Complexion light: hair light: Eyes blue: Scar on leg. Is clean: behavior good)

Aug 3 Nurses Notes (Summary) Patient received on ward at 7 P.M. Aug 10th Temp. 97.8 Pulse 72 Resp 18. Appeared quiet & orderly. Talks rationally. Physical condition apparently good. Has been quiet & well behaved since admission: Assists with ward work: No delusions noticeable: Marked improvement mentally: Does not understand why he was brought here & of late has seemed anxious to go home: Appetite good: bowels fairly regular: Sleeps well: Very neat & clean in habits & dress.

Sept 1900 to Apr 30 1901 Summary Nurses Notes by Dr. Phelps. Sept 1. Neat & clean: Talks usually in a rational manner: Has a few paranoiac delusions. Oct. 1. Wt. 146 lbs. Jan. 1. Patient about same in every respect Wt. 175 lbs. Apr. 30 Delusions usually on religious subjects. Does not talk about them much. Appears intelligent - Appears fairly well. May 31 99 Wt. 174#

July 31 '99 Thinks that people are trying to oppress him & keep him here. Also that they are trying to poison him & put bugs & worms in food. Reads most of time. Talks on religious subjects: Most of time is quiet & agreeable so much so that patient does not know that he has delusions.

Jan 31 99 Intervening notes show patient as staying quietly here: Works out at times

Feb 1 to July 31 99 (Dr Watmough) Feb 1 Wt. 164. Pulse 70, Has delusions: Works in laundry: May 21 Had trouble with patient Hayden. Thinks he is being abused.

July 31 July 23 Refused to work in laundry. July 31. No noticeable Change in any way —

Aug 1/00 Aug 1. Wt 172 lbs. Aug 31. Behavior somewhat obstinate at times: Still shows delusions of persecution. He spends a good deal of time writing, reading Scriptures. Refused to work any longer in laundry. —

Nov 30 Nov 30. No special Change. Takes some interest in outside games. Feby 28. No change to report.

1900 April 26 April 26. Asked to present home. Continues reading Scripture. July 20. Vaccinated successfully.

July 20/00 July 21. Complains of some one putting paint on coat. July 31. No chang. Still holds delusions.

Aug 30 Neat & clean: works on ward. Nov 30. Still holds delusions of persecution: Spends time reading

Nov 30 and writing Scripture: refuses to work outside. Physical condition seems quite good. —

Personal and Medical History of Adolph Erickson

1901

Jan 31/01 "Thinks food is mixed with poison". June 31. No change to note, in patients' condition. —

Feby 1 Wt 170#. Pyx. May 31. General behavior good: Still holds "delusions of persecution" -

May 31 Spends considerable time reading & writing (Gets books & magazines from Library) - Reads

July 25 the Scriptures. Occasionally, complains of stomach trouble. July 25 Went out Camping.

31 Still out at Camp, at Nonoco - Aug 17. Returned from camp: to a/c Oct 1. Wt 167#

Nov 30 Condition about the same. Jany 31/02. Health usually good: behavior fair, though has delusions

1902 Jany 31 and, at times, easily excited: neat and tidy in habits: has worked some, of late, in the Laundry.

July 31/02 (Dr. Phelps) Patient has been quite well during year; appears rather hypochondriacal & full of queer ideas. Was ~~today~~ allowed to go out with a farmer to work for him during the summer. Is in fair physical Condition.

Personal and Medical History of Charles E. Furness.

ECKERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4483

Residence, St. Paul, Minnesota.

Date Admission, August 11 1896.

Admitted by Dr. R. M. Phelps. Hour,

How Sent, S. Fraser, J. of P. Olmstead Co.

Sex, -Male-

Age, -52-

Civil Condition, Married

Children, -3-

Age Youngest Child, —

Occupation, Land Commissioner of Great Northern.

Degree Education, Graduate Harvard College.

Profession Religion, Attends Unitarian church,

Habits, Not intemperate.

Nativity, Philadelphia, Pa. (Parents not known)

Physicians Committing, H.H. Richardson - E. Graham.

Correspondents, Mrs. C.E. Furness, St. Paul, Minn.

No. for Year, 16

Insane Relatives, None.

Cause Exciting, Some severe brain trouble.

Cause Predisposing, — —

Form, Dementia organic

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, 14 years ago.

Duration, 14 years.

No. of Attack, 1st
Was at Kirkbridges, Philadelphia Dr. Fowler Private

No. of Admissions, 2nd (Asylum near Camden N.J. since 1886)

Age First Attack, -38-

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Clear

Quick or Sluggish, rather quick.

MEMORY:

Past Events, fair

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

✓ Indifferent,

Exalted,

Depressed,

DELUSIONS: yes.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, Reticent.

GENERAL DESCRIPTIVE REMARKS: Patient in fair physical condition - quite fleshy - Mental condition:- Disinclined to talk, objects to being questioned. Becomes nervous and angry when asked about his relatives or his own condition Has delusions:- Says it is all known. Lots of this have been published etc, Declines to answer. Says he does not know what this institution is. Is probably much above average in mental development. Is very reserved in manner

Personal and Medical History of Charles E. Furness.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Clean. Promptness Movement, prompt

PUPILS, Equality, Equal Size, Normal.

Response Light, good Accommodation, normal.

SIGHT, Some impairment

HEARING, Good.

COORDINATION, Arms, Quite good

Legs, do.

TREMORS, Hands, slight Tongue, none.

Facial Muscles, some when agitated General, None.

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION, good.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, S. Sounds good - Apex beats regular.

LUNGS, Breath sounds feeble
Chest symmetrical
Expansion fair

TAKEN,

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,") No history given

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Charles E. Furness.

1896

This patient was brought here by Sheriffs deputy Alex R. Spul, with the following history: Patient in fair physical condition. First symptoms of attack manifested 14 years ago + patient has been confined in private hospitals ever since - manifested by Paresis - Disease seems stationary, no rational intervals: derangement now manifested by simple dementia. Patient shows no disposition to injure others, is not suicidal, filthy or destructive: No previous peculiarities shown: Disease caused by some acute brain trouble. has been confined + received treatment as above stated. On Personal examination - patient in state of apathy.

Aug 11/96 On admission put upon Infirmary East (Gtkn. Rpt. Complexion fair. hair dark: eyes brown. Skin in normal condition: Is clean: behavior quiet. Summary Nurses Notes by Dr. Phelps. Patient rec'd on Ward at 8 to Bm Aug 11 + given bath. Pulse 100. Seems rather unwilling to talk. Always appears to be thinking intently of something. Amuses himself by reading, playing solitaire, smoking etc.

Sept 30 No change whatever noticeable in patient: always appears in good health. Appetite good: Seldom speaks but answers intelligently at times. Wt. 225. seems rather dull + occupied with delusive ideas: Occasionally laughs to himself: has a parole. Apr. 30/97 At times rather sullen but usually as above described. May 1/97 Wt. 213 lbs. July 31/97 Patient quiet, in good health. Makes no trouble in any way to anyone. Has parole + does not appear to abuse it in any way: plays games + reads: occasionally will play cards with other patients. Is very uncommunicative, will very rarely talk, but seems to understand what is going on + has considerable general intelligence. Sept. 13/+ Jan 13/98 Visited by wife also May 27/98.

Jan 31/99. No special change during whole period in patients behavior: Seems thoroughly harmless + quiet. Feb 1 - July 31/99 (Dr Warnock) Patient quiet + well behaved: Has parole of grounds: goes to A 3 each morning to smoke: Remains in room in afternoon Mch 12 Visited by wife.

July 31 Appetite + behavior good. July 31/99. No change noticeable in patient, in any way. -

Aug 1/ 31 Wt 208 lbs Aug 31/99. Patient still has parole of grounds + generally stays out of doors, in morning.

Sep 1- Patients physical condition is good; mental condition shows no change. Sep 1/1900 Visited by wife.

Nov 30 1900 Nov 30/1900. Continues about the same, in every way. Neat + clean in habits. Has parole of grounds.

Jany 27 Jany 27/1900. Visited by wife. Apl 30/1900. No change in any way. Very quiet: seldom talks to any one; at times

Apl 30 talks some to himself + laughs foolishly. July 1/1900. Wt 221 lbs July 17. Patient vaccinated successfully.

July 1/17

Aug 30 Physical condition good: well behaved: seldom speaks to any one: rather sullen: (Aug 29. Visited by wife).

Nov 1/ 30 Out of doors, a great deal of the time. Nov 30. No special change to report in condition -

1901

Jan 31 Condition Continues the same. Feby 1. Neat + clean in habits: well behaved. Physical

Feby 1/ 28 Condition good: has parole. Feb 28 Visited by wife. Spends time playing "Solitaire"

July 31 and other Card-games. July 31. Condition shows no special change. Seems contented here.

Aug 1/ 31 Is quiet: usually well behaved: appears care-free, very quiet, harmless dementia: Plays solitaire

Sept 1/ 14 (with cards) a great deal; has parole. Sept 14. Visited by wife. Jany 1/02 Wt 208 lbs. Jany 31. Condition

Personal and Medical History of Charles. E. Furness

1901

July 31 Shows no change, in any way.

" 31 Patients condition is little changed. Weight has ranged from 198 lbs to 213 lbs. Health good - Always quiet; will rarely talk; behavior is very peculiar; has been visited twice by his wife during the year.

Personal and Medical History of Theodore L. Oakes.

BEGERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4486
Residence, St. Paul, Minn.
Date Admission, August 11th 1896.
Admitted by Dr. H. H. Herzog Hour,
How Sent, G. Willrich, Capt. Ramsey Co.
Sex, - Male -
Age, -38-
Civil Condition, - Married -
Children, None.
Age Youngest Child, -
Occupation, "Roomers"
Degree Education, - Common School.
Profession Religion, Not a church member.
Habits, Intemperate.
Nativity, Minnesota (Mother Canada, Father?)
Physicians Committing, J.B. Darling + J.C. Nelson.
Correspondents, wife.

No. for Year, 19.
Insane Relatives, Mother insane.
Cause Exciting, -
Cause Predisposing, "Not known perhaps heredity"
Form, Domestic alcoholic
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not attempted propensity active
Date of this Attack, Not stated.
Duration,
No. of Attack, 2nd (1st 1895)
No. of Admissions, 2nd (here once as inebriate + once as insane)
Age First Attack, -36-
Time of Leaving,
Time in Hospital,
Result,

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,

Disoriented

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS: Talks only vaguely of them
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Talks willingly + with fair clearness - but gives very little information. Says he + wife both quarrelled + struggled some - says of course he ought not but that of new make mistakes etc. She called in police + he was sent down here. Though appears bright yet is noted as sitting all day without any occupation or purpose absorbed in his own thoughts. Will move or speak readily on request with cheerful pleasantness. Never speaks much unless spoken to.

Personal and Medical History of Theodore L. Oakes.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, None. Skin - good.
TONGUE, ~~Tremors~~, Good. Coatings, Promptness Movement, Good
PUPILS, Equality, Equal Size, Some dilated.
Response Light, Accommodation,
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Quite tremulous Tongue, Steady
Facial Muscles, General,
REFLEXES, Patellar, ? Equal EXAM. URINE,
Other
ARTICULATION, Good
Slurred,
Hesitating,
FACIAL EXPRESSION,

TAKEN,

SENSIBILITY,
Arteries - Not notably impaired
HEART, good - some palpitation.
LUNGS,
Good

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE, Head seems extra large to rest to appearance	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ (h) 56.5 (t.m) 65.5 R. oc. a. 35 Bi. a. 37 Ant. p.d. 19.3 Trans. d. 16.5 Bi. d. 13.6 F. L. 13
HISTORICAL, Drinks only moderately
LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any except mother.
Mother or Mat. Relations, Insane - at St. Peter - died Cancer.
Father or Pat. Relations, Killed in war.
Brothers or Sisters, 1 brother living -

Personal and Medical History of Theodore C. Oakes.

1896

This patient was brought here by Sheriffs Deputy E J. Hoyt with the following history:- Is in fair physical condition. This is second attack,- first having occurred in November 1894 when patient was confined at this (Rochester) Hospital for 19 days & discharged improved. Disease seems increasing, variable with irregular rational intervals: Derangement now manifested on no particular subject but patient seems at times to brood & at others to laugh without cause when alone. No disposition to injure others shown- nor to filthy or destructive habits: drank to excess before accession of disease. No severe disease or head injury. Treatment & confinement in hospital as above stated. On personal examination- indifferent.

Note- as above stated patient was confined here in 1894 (November) & was again here on insane warrant from March 5th to July 16th 1896. (For particulars see Vol. 29 Fol. 145 No. 3918 & Vol 32 Fol. 105 No 4348)

Aug 24 Nurses Notes (Summary) Patient received on ward Aug. 11th. Appeared quiet & well behaved. Physical condition good. Appetite has been good since admission, bowels regular: has slept well. Habits neat & clean: Seems contented here. Very quiet & well behaved: Assists willingly with ward work: Goes out walking with crowd: When indoors stays in room most of time: Does not talk unless spoken to: At times laughs & talks to himself in a foolish manner: Acted very foolish while out walking on the 15th. No change in patient since admission.

Sept 1896 to Apr 30 97 Summary Nurses Notes by Dr. Phelps Patient about same. Wt. 154 lbs. Is quiet well- behaved. Appears to be pre-occupied by ideas probably delusive in character. Quiet. Behaves quite well, occasionally talks & laughs to himself. Apr 30 No change in any respect.

May 97 Wt. 162 lbs. July 31 '97 No change in any respect. Will sit or stand in one position for hours: talking & muttering to some unseen person. Will not talk about himself. Has a fairly intelligent appearance. Jan 31 99 No

1899 Jan-July 31 change of any kind during period. Jan 31- July 31 99. (Dr Simmons.) Is quiet & well- behaved: seldom speaks unless addressed. Habits clean & dress neat. Works in Center dining room. Wt 151 lbs. At times is despondent. Physical condition good. Aug 1 Wt 143 lbs. Aug 31 Quiet & well- behaved. Works in Centre Dining room, Daily: Seldom Speaks. Nov 30. Patient keeps about the same, mentally & physically. Still works-

Aug 1/31 Nov 30 1900 Jan 16 Jan 16. Had trouble with patient through the night: was transferred to B2 for the night. Apl 30. When

Apl 30 questioned, refuses answer - Simply "nods his head"- Appears somewhat melancholy & spiteful. Is quiet

July 9/20 and well- behaved: Habits neat & clean. July 9 Wt 146 lbs - July 20. Was vaccinated successfully.

- 31 July 31. Patient's condition continues about the same, all the time. He works regularly in dining- room.

Aug 30 Patient works faithfully in dining- room. Neat and clean in habits. Sept 2 Went Camping.

Sep 11 Returned from Camp. Nov 30. Condition shows no special change. Still works in dining- room.

1901 Jan 31 No change to report in patients' Condition. - Sept 1 Wt 140 lbs Pgo - July 31. Quiet & well-

July 31 - behaved: Seldom talks. Works regularly in C.D.R. - July 31. No apparent change, in

July 31 anyway. Clean & neat. Still works in C.D.R. regularly. Augs. Wt 139 lbs.

Personal and Medical History of Theodore C. Oakes.

1900

July 31 Patient quiet. Dull. Seldom talks: Is/Was demented: Behavior evidently controlled by delusions. Works regularly in Centre Dining room. Is clean and neat: health seems good.

" 31/03 Has changed none during the period. Quiet & well behaved; Dull. melancholly in manner; works regularly in C.D.R. Habits clean.

Personal and Medical History of Gustav Oldenroth

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4487
Residence, Rice Co. Minn.
Date Admission, August 17. 1896.
Admitted by Dr. R.M. Phelps. Hour,
How Sent, R.A. Mott. Jog. P. Rice Co. Minn.
Sex, - Male -
Age, - 27 -
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Laborer.
Degree Education, - Common school -
Profession Religion, Fr. Presbyterian
Habits, Some years ago used tobacco to excess.
Nativity, Germany.
Physicians Committing, Roscoe N. Jackson & J.S. Seeley.
Correspondents, Mrs. D.C. Whitman. Faribault, Minn. (Sister)

No. for Year, 20
Insane Relatives, Mother had nervous trouble for years
Cause Exciting, Inherited tendency to nervous disorder & Masturbation
Cause Predisposing, Probably heredity
Form, Involuntary insanity
Accompanying Bodily Disorder, Nervous prostration.
Suicidal or Not, Not. Fr. fears he may be tempted to -
Date of this Attack, Sick 3 years"
Duration, "
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 24.
Time of Leaving, June 17. 1897
Time in Hospital, 10 mo.
Result, Discharged Nov. 3. 1897. Improved.

EXAMINATION ON ADMISSION.

Exam. by H.H. Stuzo, M.D. 11/8/96

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed.
DELUSIONS:
Systematized or Not, Unsystematized
Special Subjects, Hypochondriacal -
Transitory or Not, Fixed
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Incoherent -
Voluble or Reticent, Quite voluble

Personal and Medical History of Gustav Oldenroth.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Considerably impaired.
WOUNDS OR ABNORMALITIES, Skin - dry. somewhat scanty -
TONGUE, Tremors, Coatings, light grayish coat Promptness Movement, Fairly prompt.
PUPILS, Equality, Equal. Size, Normal.
Response Light, Somewhat sluggish Accommodation, Somewhat sluggish.
SIGHT, Claims impaired -
HEARING, Good.
COORDINATION, Arms, Impaired.
Legs, "
TREMORS, Hands, Slight Tongue, Quite marked
Facial Muscles, None General, None.
REFLEXES, Patellar, 8 Equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating, Somewhat.
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs - Rounds Fairly strong - somewhat rapid.
LUNGS, Sounds seem good - Resp. shallow

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, at times loose -	Constipated,	Irregular,
APPETITE, Good,	~~Medium,~~ Capricious	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp., shallow	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, Formerly used much tobacco.
LENGTH OF INVASION, Long - ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, living - rather nervous.
Father or Pat. Relations, Dead - unknown cause.
Brothers or Sisters, 2 sisters - well.

Personal and Medical History of Gustav Oldenroth.

1896

This patient was brought here by Sheriff's Deputy B. J. Sheridan with the following history: patient in fair physical condition. This is first attack - patient has been sick somethin years. first symptoms manifested by Nervous prostration: Disease appears increasing - not variable - derangement shown by hallucinations, illusions, wakefulness & on religious subjects: Is not filthy or destructive: shows no disposition to injure others: No furious peculiarities, severe disease or injury to head. has not been confined or restrained - Sedatives & tonics gave temporary relief - On Personal Examination no further particulars noted.

Aug 12 '96 Nurses Notes (Summary) Patient was received on ward on Aug 12: was well behaved & quiet: Slept 3 hrs. Physical condition rather poor: Appetite poor: Talks quite rationally on all things except his ailments Aug. 15 Appetite has improved greatly but complains of difficulty in swallowing Aug 16th Continues to improve: Appetite good: bowels regular, Sleeps fairly well: Aug 18 Complained of heart burn: Thinks it was caused by eating cucumbers: Aug 20 Has continued to improve until this A.M. Complained of headache & ringing in ears: Ate light dinner & supper. Aug 25 No change in patient today. was put upon Medicine on 13th, Continued to date: Bowels regular: Has slept well during 14 days.

Sept 1 '96 to Apr 30 '97 Summary Nurses Notes by Dr. Phelps. Sept 1 Patient is noted as apparently improving somewhat since admission: Seems in good health. Wt. 137 lbs. Oct 31 Patient quiet & well behaved. Feb 28. Has been more dependant of late: Does not very often mention his delusions. Says that people threw him out of bed recently. Apr 30 Behaves quite well - thinks he is going to die soon. Has a pain in head. May 8 '97 Wt. 138½ lbs. Physical condition fairly good. Has hallucinations: - complains of noise in his ears. June 5 Wt. 142 lbs. Is irritable, & thinks that everyone is working against him. June 16 went home rather more quiet recently - no very marked change however, in general mental state.

Discharged.

Personal and Medical History of

Personal and Medical History of Michael Ryan. #2

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4493
Residence, St. Paul, Minn.
Date Admission, August 17, 1896.
Admitted by Dr. H.W. Herzog. Hour,
How Sent, J. Willrich, J. of P. Ramsey Co.
Sex, - male -
Age, not stated.
Civil Condition, Single.
Children, -
Age Youngest Child, -
Occupation, Gardener.
Degree Education, - Common -
Profession Religion, yes Roman Catholic.
Habits, Not intemperate.
Nativity, Ireland (Parents Ireland)
Physicians Committing, B.F. Paxton + J.G. McNamara
Correspondents, — Wm Abbott Eagle St. St. Paul.

No. for Year, 26.
Insane Relatives, None.
Cause Exciting, Not stated
Cause Predisposing, Not stated.
Form, Dementia Terminal
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, 2½ years ago.
Duration, 2½ years.
No. of Attack, Not stated.
No. of Admissions, 2nd
Age First Attack, Not stated
Time of Leaving, Dec. 16 - 1896
Time in Hospital, 3 mos. 29 da.
Result, Discharged May 5: 1897 Unimproved

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps 8/25/96

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: Was bothering a woman
Systematized or Not, with whom he was
Special Subjects, not acquainted - with
Transitory or Not, proposals of marriage.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Says he was "twice married" Didn't get service of church either time. Woman said he would have to go or she would. Admits that she did not want him. Talks vaguely "thought she ought to get married. had 4 or 5 children + husband dead" etc. etc. Seems a quiet, quiet marked dementia - quite symmetrical. Probably from alcoholism.

Personal and Medical History of Michael Ryan. #2

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, Condition of skin fairly good.
TONGUE, Tremors, Normal. Coatings, Promptness Movement, prompt
PUPILS, Equality, Equal. Size, Normal.
Response Light, - Accommodation, —
SIGHT, Says good
HEARING, Fair.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Some slight Tongue, Some slight
Facial Muscles, " General, "
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION, Fair.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Seems normal.
LUNGS, Fair


4493

TAKEN,

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) 55½, (fm) 66 N.s.a. 35 Bi.a. 35 Ant.p.d. 19.3 Trans.d 15.3 Bi.d. 13.3 Fach 1.2
HISTORICAL, Used to drink hard. not much lately.
LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Dead dropsy.
Father or Pat. Relations, Father insane nearly all his life - always lived on farm. Is now dead.
Brothers or Sisters,

Personal and Medical History of Michael Ryan. #2

This patient was brought here by Deputy Sheriff E. J. Horst, with the following history: Is in fair physical condition: This is not first attack, patient having had others "at various times in several years" of temporary duration. Disease seems stationary, variable, with irregular rational intervals. Is irrational on subjects in general. Patient has shown no disposition to injure others, is not suicidal, filthy or destructive. No history of heredity or of intemperance in self or parents: No severe disease or head injury: Cause of disease not stated. Patient has served two terms in work house. On personal examination no further particulars noted

Note Although not mentioned in Commitment papers - this patient was here in this (Rochester) hospital from Oct. 25'93 to Apr. 16'94 when he was discharged improved (For particulars see. Vol. 25 Pol. 201. No 3530)

Aug 30 Nurses Notes (Summary) Patient received on ward Aug 7 at 7.30 P.M. Quiet & well behaved: Physical condition good. Temperature very slightly above normal most of time since admission highest mark 99° Appetite good. Bowels regular: Sleeps well. Habits clean Behavior quiet & orderly: Is very industrious when on ward: Talks very little & starts when spoken to. Is rational but seems nervous & fidgety when conversing. Goes out with crowd every day. Seems rather anxious to go Home.

Oct 19 to Dec 19 Summary Nurses Note by Dr Phelps. Oct 1 Wt. 180 lbs. Patient quiet & quite well behaved. Shows a little mild dementia. Dec 16 Eloped from dining room. Has been somewhat ill-tempered of late & has a great many delusive ideas but does not often talk about them.

Discharged.

Personal and Medical History of

Personal and Medical History of J. Nelson (or Nels J. Nelson)

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4495
Residence, Racine, Minn.
Date Admission, August 18' 1896.
Admitted by Dr C B Eby. Hour, 1:50 P.M.
How Sent, S.S. Washburn, J of P. Mower Co.
Sex, — Male —
Age, — 34 —
Civil Condition, Married.
Children, — 3 —
Age Youngest Child, ——
Occupation, Farmer.
Degree Education, — None —
Profession Religion, Yrs Lutheran.
Habits, Quite intemperate.
Nativity, Minnesota (Parents Norway)
Physicians Committing, A.W. Allen & E.H. Washburn.
Correspondents, —

No. for Year, 28.
Insane Relatives, Not known.
Cause Exciting, "Stopping drinking"
Cause Predisposing, Not known.
Form, Acute alcoholic
Accompanying Bodily Disorder, Weakness, dizziness.
Suicidal or Not, Not.
Date of this Attack, has been sick for 3 months
Duration, "
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 34
Time of Leaving, Jan. 8. 1897
Time in Hospital, 4 mo. 21 da.
Result, Discharged May 5-97. Improved

EXAMINATION ON ADMISSION.

Exam. by Dr. P. M. Phelps 8/25/96 **MENTAL CHARACTERISTICS.**

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

MEMORY:
Past Events,
Recent Events, } Can't tell Talks little
Special Subjects,

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

REASONING POWER:
Ordinary Subjects,
Own Mental State, } Poor all through.
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Appears fairly healthy. Has long been considerably disturbed. Is rather dull in answering questions. Seems defective. Is quiet, indifferent, dull. Seems dull, not silly.

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

DELUSIONS:
Systematized or Not, } Can't tell - Dull. Talks
Special Subjects, } almost none.
Transitory or Not, } Acts slowly.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, — WEIGHT, — NUTRITION, —
WOUNDS OR ABNORMALITIES, — Condition of skin good.
TONGUE, ~~Tremors,~~ broad, flabby. Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Accommodation,
SIGHT, —
HEARING, —
COORDINATION, Arms, Fairly good
Legs, "
TREMORS, Hands, Slightly tremulous Tongue, Slight
Facial Muscles, General,
REFLEXES, Patellar, Equal. - 3 EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds fair
LUNGS, Fair

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ. (a) 54½ from 68 N. oc. a 57 Bin. a. 34½ Aur. Bd. 19.7 Diam. a. 15 Bm d. 12.4 Fac. l. 13.2
HISTORICAL, Statements not very reliable.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Not healthy
Father or Pat. Relations, Dead.
Brothers or Sisters,

Personal and Medical History of J. Nelson.

1896

This patient was brought here by Sheriff's Deputy C.C. Prince attended by T.J. Townsend with the following history:- Patient is in fair physical condition - As to Consanguinity nothing known. Patient has been sick for 3 months - has dizzy spells. Disease seems increasing, is variable with irregular rational intervals - has violent spells. Derangement shown in chasing wife about house & yard, frightening his family & neighbors: he has shown disposition to injure wife: is not suicidal or filthy: is destructive in that he broke windows of house. No peculiarities previously shown beyond intemperance: No severe disease or injury to head: Patient has not been confined or restrained: has been prescribed for but refuses medicine. On personal examination - It is very difficult to get answers to questions which he evidently understands - he admits "feeling strange in his mind" feeling dizzy etc. Commitment recommended because he is unsafe to be at large.

Aug 9 Nurses Notes (Summary) Patient received on ward Aug 19 at 4 PM. Quiet & stupid in appearance: Talked very little. In good flesh Temp. 99⁶ Appetite good: Bowels regular: Slept poorly first few nights: Has averaged between 5 & 6 hrs. since then. Is quiet & stupid in behavior answers questions rationally but does not converse with anyone: Is slouchy in habit & dress. Goes out daily with crowd: Whether indoors or out always sits quietly in one place.

Oct 1896 to Jan 1897 Summary Nurses Notes by Dr Phelps. Patient usually sits quietly in one place, is rather well-behaved & does not talk of his delusions Dec 1st Is rather stupid & slouchy. Does not often speak unless spoken to. Jan 1 Ment Cond - No change.

Discharged.

Personal and Medical History of

Personal and Medical History of Henry Walter.

DORCAT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4498
Residence, Welch, Goodhue Co. Minn.
Date Admission, August 20th 1896
Admitted by Dr H.H. Herzog Hour,
How Sent, Axel Hallen, J.of P. Goodhue Co.
Sex, - Male -
Age, - 33 -
Civil Condition, Single
Children, - None -
Age Youngest Child,
Occupation, Farmer.
Degree Education, - Common School -
Profession Religion, Yes German Lutheran
Habits, Not intemperate
Nativity, New York (Parents Germany)
Physicians Committing, Geo. C. Milne. & Dearborn.
Correspondents,

No. for Year, 31.
Insane Relatives, None.
Cause Exciting, Masturbation.
Cause Predisposing, Not stated.
Form, Imbecile
Accompanying Bodily Disorder, Pain in back, Constipation.
Suicidal or Not, Not.
Date of this Attack, Three or four years ago.
Duration,
No. of Attack, Not first. (All on Attendant RMO)
No. of Admissions, 1st
Age First Attack, about 29.
Time of Leaving, Nov. 16. 1897
Time in Hospital, 1 yr. 2 mo. 27 d.
Result, Discharged Under Peterson Law. Unimproved. 11/16/97

EXAMINATION ON ADMISSION.

Exam. by R. W. Phelps. 8/22/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Sluggish.
MEMORY:
Past Events,
Recent Events, } Fair.
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Talk is distinctly feeble-minded. Admits couldn't learn much. Drawling speech. No delusions drawn out but reason + statements very feeble. Apparently always a feeble minded person almost deserving name imbecile. Hung around house lately + they could not see to him.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, None drawn out.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal — Henry Walter.

Rochester State Hospital.

Henry Walter
Patient.

Order for Discharge of Patient
Under Law 1897.

Filed NOV 8 1897 18
J K Bray
Dr

HEIGHT, 6ft
WOUNDS OR A
TONGUE, Trem
PUPILS, Equalit
Respon
SIGHT,
HEARING,
COORDINATIO
TREMORS, Han
Faci
REFLEXES, Pat
Other
ARTICULATIO
Slurred,
Hesitating, d
FACIAL EXPRE
Apraxia n
SENSIBILITY,
HEART, Pal
LUNGS, Slightly more

MISSION, CONTINUED.
RACTERISTICS.
50 now 140 NUTRITION, Nutrition
Condition of skin good.
Promptness Movement, Fairly prompt.
Size, Normal.
Accommodation,
Tongue,
General,
EXAM. URINE,
TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Didn't learn easily at school. No severe diseases. Doctor said had diabetes 6 mo. ago.
LENGTH OF INVASION, Says he has always been so ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies heredity
Mother or Mat. Relations, Living - Rheumatism.
Father or Pat. Relations, Dead Dropsy.
Brothers or Sisters, 1 brother living.

Office Secretary Board of Trustees,

MINNESOTA * STATE * HOSPITALS * FOR * INSANE.

Copy

On filing the certificate and report of the Physicians of the Rochester State Hospital for Insane, upon an examination of Henry Walter *a patient committed to said Hospital from the County of* Goodhue *and received there on the* 20th *day of* August *1896, recommending the discharge of said* Henry Walter *on the ground* he has no harmful tendencies. Dementia rather slight. could probably earn his living.

Ordered, that said patient, Henry Waltise *, be and hereby is discharged from the said Rochester State Hospital, under the provisions of Chapter 212, General Laws Minn. 1897; and that the Secretary of said Board forthwith notify the Judge of Probate of said* Goodhue *County, and send a copy of this order to the Medical Superintendent of said State Hospital.*

Dated Nov 1st *1897*

Johan Colemann
J. H. Block
P. H. Titus
Trustees.

Hung around house lately & they could not see him.

Personal and Medical History of Henry Walter

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6ft + WEIGHT, Usually 160 Now 140 NUTRITION, Nutrition

WOUNDS OR ABNORMALITIES, Condition of skin good.

TONGUE, Tremors, — Coatings, — Promptness Movement, Fairly prompt.

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Normal.

HEARING, "

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Sluggish EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating, draws slightly.

FACIAL EXPRESSION,

Arteries normal.

SENSIBILITY,

HEART, Palpitates considerably

LUNGS, Slightly more


4498

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Didn't learn easily at school. No severe diseases. Doctor said had diabetes 6 mo. ago.

LENGTH OF INVASION, Says he has always been so ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Living - Rheumatism.

Father or Pat. Relations, Dead Dropsy.

Brothers or Sisters, 1 brother living.

1896

This patient was brought here by Sheriff P.J. Lundquist with the following history:- Patient is in fair physical condition - No history of consanguinity or heredity: This is not first attack patient having had others several years ago of several days duration. First symptoms manifested by being morose & sullen: Disease seems increasing, is violent. Patient imagines that something is building in his body, also that something is talking within him. Derangement also manifested in delusions about his health; he imagines the cause of his illness to be that "Jesus Christ & God are within him & tearing his insides out of him. Patient is not suicidal or destructive; no disposition to injure others: shows disposition to filthy habits: Previous peculiarity a "silent habit or disposition to be alone": No history of intemperance in parents or self: No severe disease or head injury: Patient has not been confined or restrained & has received no treatment. On personal examination He has pain in the back (in lumbar region), constipation, tremulous tongue, disposed to be sleepy & indolent. pulse rapid.

Sept. 3 Nurses Notes (Summary) Patient received on ward Aug 20th Given bath. Slept well during night. Appeared quite rational: Is quiet & orderly. Has had slight rise of temperature. Goes out daily with crowd: Works none on ward: Walks have a great deal: Talks none unless spoken to. Appetite good: Bowels regular: Behavior good: Apparently no delusions Sleeps well. Makes no complaints.

So Summary Nurses Notes by Dr Phelps Rather simple minded & apparently
Apr 30 quite imbecile in character, No special delusions: Quiet & well behaved. No change Apr 30 '97. Weight averages about 136 lbs.
May 1/97 Patient works in kitchen every day, quiet & well-behaved. Answers questions quite well, tho feebleminded. July 29 Complains of pain in stomach: seems somewhat sickly of late: Placed upon Infirmary. July 30 Was found to have extreme constipation, better of late. Aug 30 Does a little work on ward, usually rather stupid & melancholy: Nov. 16 Sent out under Peterson Law: Quiet & well-behaved, has been coughing some of late.

Discharged.

Personal and Medical History of John Mullen #2

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4499
Residence, Freeman, Minn.
Date Admission, August 21st 1896.
Admitted by Dr. R.M. Phelps. Hour,
How Sent, Herman Blackmer, Jap P. Freeborn Co.
Sex, Male.
Age, 24.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Farmer.
Degree Education, limited.
Profession Religion, Catholic
Habits, Not intemperate.
Nativity, Minnesota (Parents Germany)
Physicians Committing, J.N. Basel + J.A. Blackmer.
Correspondents,
Dr. L.A. Medge, Albert Lea, Minn. Family physician.

No. for Year, 32.
Insane Relatives, None.
Cause Exciting, Masturbation.
Cause Predisposing, Probably previous attack.
Form, Confusional insanity
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, About a week ago.
Duration, About a week.
No. of Attack, 2nd (only one distinct lucid interval before this)
No. of Admissions, 2nd
Age First Attack, About 21
Time of Leaving, Feb. 20. 1899
Time in Hospital, 2 yr. 5 m. 30 d.
Result, Discharged Aug. 9. 1899
Improved

EXAMINATION ON ADMISSION.

Exam Aug 22/96 by RM. Phelps M.D.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Not clear.
Quick or Sluggish, Fairly quick
MEMORY:
Past Events,
Recent Events, } Fair.
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State, } Poor - Feeble-minded.
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Talks willingly + in seeming honesty. but wanders. Talks silly. Feebleminded. Appears a defection. Either Congenital or lack of development.

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 John Mullen.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, —
WEIGHT, —
NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES, —
Condition of skin good.
TONGUE, Tremors,
Coatings, Fairly clean except for tobacco
Promptness Movement, Prompt.
PUPILS, Equality, Equal.
Size, Normal.
Response Light,
Accommodation,
SIGHT, Good.
HEARING, Good
COORDINATION, Arms, Good
Legs, "
TREMORS, Hands,
Tongue,
Facial Muscles,
General,
REFLEXES, Patellar,
EXAM. URINE,
Other
ARTICULATION,
Slurred, Not very clear
Hesitating,
FACIAL EXPRESSION,


4499

TAKEN,

SENSIBILITY,
Arteries - good.
HEART, No murmurs.
Sounds - Palpitate
LUNGS,
Fair.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Long.(h) 56 Trans 65 N. oca. 36 Bin a. 34½ Aut. p.d. 19.5 Fronto. d. 15.6 Bizyg. 13.1 Fac. l. 12.3
HISTORICAL, Used to drink at times. Has been drunk twice.
LENGTH OF INVASION, Long. indefinitely ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, living - Does foolish at times Uncle not right
Father or Pat. Relations, Dead.
Brothers or Sisters, 1 sister all right

Personal and Medical History of John Mullen #2

1899

This patient was brought hrn by Sheriffs deputy - Henry English: accompanied by William Lowe:- Patient is in fair physical condition:- First attack occurred about 3 years ago when patient was in this (Rochester) hospital from October 20'93 to March 20'94 + left improved - First symptoms of present attack manifested about a week ago by strange actions Disease appears increasing, variable with irregular rational intervals - Derangement genral - on no particular subject. Patient has shown no disposition to injure others; is not suicidal, filthy or destructive: No history of heredity - or intemperance in self or parents; nothing known as to Consanguinity No severe disease or injury to head: Has taken medicine often to no effect - + has been confined as above stated - during previous attacks. On personal examination patient talks + acts like an insane person. Says "I think I am insane + want to go to the hospital."

Aug 21 Nurses Notes. (Summary.) Patient received on ward at 7:30 PM. given bath: body very dirty: Acts + talks foolishly Aug 28 Has been no change in patient since admission: Works on ward: Appetite good: Bowels regular: Seems contented here: Complains of difficulty in passing urine. Habits slouchy.

Sept Patient complained of diarrhoea: Medicine given Sept 4 No change noted in patient since day of admission: Appetite good. Bowels regular: Habits fairly clean. Behavior good.)

Oct 1'98 to Apr 30'99 Summary Nurses Notes by Dr. Phelps Seems to be growing more Habits rather slouchy. Since coming in behavior silly - Physical health fairly good. Oct 31 Has a trick of washing his shoes with a hair brush. Apr. 30 Patient has kept in about the same silly + feeble-minded way. Does some work. Wt. 189 lbs.

June 1'99 Wt. 176 lbs. June 26. Trans. to Infirmary: Complains considerable of pain in bladder: July 8 Seems contented to lie quietly in bed: and his complaints seem to be largely imaginary, at least no obvious symptoms are found to corroborate them. Sept. 1 Has been on Infirmary, today transferred to Bd 20 Trans. again to Infirmary; Seems to be failing somewhat: Has complained a good deal all the time; Temp. practically normal: No special symptoms. Jan 31'99 Patient has been up + about the last few months: Staid a long time in bed on Infirmary the second time: At times still complains. Temp. at one time 102, As a rule, however, it is normal + no symptoms found corresponding to his complaints. Feb 1 Quiet + well-behaved. Seldom speaks if not addressed: Habits clean: + dress neat. Feb 20 Went home with uncle.

Discharged.

Personal and Medical History of

Personal and Medical History of Battiste Angelo.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4500

Residence, Not known. (Found on train at Union Depot St Paul)

Date Admission, August 21st 1896.

Admitted by Dr. A. McPhelps Hour,

How Sent, G. Willrich, Jr of P. Ramsey Co.

Sex, - Male -

Age, - 27 -

Civil Condition, - Single -

Children, —

Age Youngest Child, —

Occupation, Laborer.

Degree Education, Common school.

Profession Religion, Yrs. Catholic.

Habits, Not known.

Nativity, Italy (Parents Italy)

Physicians Committing, J. Okage + Jno B. Brimhall.

Correspondents,

No. for Year, 33.

Insane Relatives, Not known.

Cause Exciting, Worrying over money & trying to get back to Italy

Cause Predisposing, Not known.

Form, Mania acuta

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not known.

Date of this Attack, Found on train Aug 20 - would not get off.

Duration, Not known.

No. of Attack, Not known.

No. of Admissions, 1st

Age First Attack, Not known

Time of Leaving, Apr. 26. 1900

Time in Hospital,

Result, Transferred to Hastings.

A.C. Pm

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 Battiste Angelo.

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, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,



SENSIBILITY,

HEART,

LUNGS,

TAKEN,

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 Battiste Ruglo.

1896.

This patient was brought here by Sheriffs Deputy Chas. Richon with the following history. Patient is in fair physical condition. Nothing is known concerning consanguinity; heredity or history of intemperance as patient was found on board train at Union depot St. Paul would not get off. Disease appears increasing, not variable & with no rational intervals: patient thinks he was robbed of money etc - has shown no disposition to injure others nor to filthy habits but is destructive of clothing: Nothing known as to previous peculiarities; severe disease or injury to head. He has been confined in county Jail for 24 hours. has received no treatment On personal examination patient tears clothing, shoes, etc., keeps eyes closed, calls loudly to imaginary persons.

Aug 24 Nurses Notes (Summary). Received on ward in a filthy & untidy condition. Extremely noisy one hour in early morning.

Sept 3 Very troublesome in behavior first two days & somewhat noisy. was in a stupid & stubborn spell. Given bath by order of Dr. Herzog, which seemed to revive him & bring him out of spell. Since then has been fairly well behaved. Has delusions, - says folks are coming to see him, tells nurses to let them in at a stated time. Appetite good: Bowels fairly regular all the time. Habits clean but untidy in dress. Is sleeping on floor: makes no trouble, sleeps well, averaging over 6 hrs. per night. Minds well when spoken to: Is very restless & uneasy. Last two days complains of head & says he is not so well as he was.

Sept 1896 to Apr 30 97 Summary Nurses Notes by Dr. Phelps. Talks in a fairly rational manner, altho at times depressed. Says he feels better. Has delusions about losing money. Works a little on ward. Sept 30 Seems to have improved. Does not mention delusions: Health has been good. Wt. 158½ lbs. Has been working some in Laundry. Oct. 11 Attempted to Escape & was taken from laundry. Nov 1 Wt. 165½ lbs. Very quiet & agreeable. Has delusions: Talks very little unless addressed. Dec 17 Rather melancholy in way of sitting around ward. Seems to be growing dull & stupid. Jan. 1 Wt. 159 lbs. No change. Feb 1. Walks up & down hall: Talks little, at times prays during the day. Wt. 158 lbs. April Wt. 160 lbs. Does not improve mentally. May 1st Condition unchanged. May 1897 Wt. 170 July 31 97 Works in dining room. General health good: Has a good many delusive ideas. Jan 31 99 Patient seems to have become somewhat more demented: Talks to himself: Climbs in windows: Is somewhat restless: Works some in dining-room at times. Feb 1 - July 31 99 (Dr Wanous) Wt. 161 lbs Quiet & has little to say. Feb 7. Trans. to Annex. May 20 Visited by friends. General condition unchanged. Aug 1 - Jan 31 1900 (Dr. Chapple) Wt. 163 lbs No change during period. Health fairly good: Habits cleanly: Works regularly on ward: Does not talk unless spoken to - Seems thoroughly demented. Actions very peculiar. ——

Jan 31 1900

April 26 No change & note & above notes still hold good. Wardsday, transferred to Hastings Asylum.

