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

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Version 3
August 20, 2018

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Egbert, Gideon & Chambers.

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Personal and Medical History of

Personal and Medical History of

Personal and Medical History of Mary Maxwell.

GIBERT, FIELDS & CHAMBERS, DAVENPORT, IOWA

Whole No. 4608
Residence, St. Paul, Minn.
Date Admission, December 15' 1896.
Admitted by Dr Hartzog Hour, 6.45 P.M.
How Sent, G. Milnich J. of P. Ramsey Co.
Sex, Female.
Age, —
Civil Condition, Widowed
Children, Three.
Age Youngest Child, 19 yrs.
Occupation, Housewife.
Degree Education, Common School.
Profession Religion, Presbyterian.
Habits, Not intemperate.
Nativity, North Ireland, (Parents Ireland)
Physicians Committing, Jno B. Darling - E Eugene Briggs
Correspondents, Hugh Maxwell. 188 E 10th St. St. Paul Minn - or cp Yuxa Bros.

No. for Year, 141
Insane Relatives, A sister.
Cause Exciting, Not known.
Cause Predisposing, Not known.
Form,
Accompanying Bodily Disorder, Anaemia & sleeplessness
Suicidal or Not, Not
Date of this Attack, 2 months ago.
Duration, about 2 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, —
Time of Leaving, Apl. 1. 1897
Time in Hospital, 3 mo. 16 da.
Result, Died. Tuberculosis Pulmonales

EXAMINATION ON ADMISSION.

Exam. by P.M. & St. Phelps. Dec. 17'96.

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS:
Systematized or Not, Many & varied.
Special Subjects, Thinks that everything is drugged
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Mary Maxwell.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in. WEIGHT, 130 lbs. NUTRITION, Pale.
WOUNDS OR ABNORMALITIES, None. Scar on right hand from vaccination.
TONGUE, Tremors, Coatings, slight White Promptness Movement,
PUPILS, Equality, Equal. Size,
Response Light, Normal. Accommodation, Normal.
SIGHT, Uses glasses.
HEARING, Seems impaired.
COORDINATION, Arms, Impaired.
Legs,
TREMORS, Hands, Considerable Tongue, Slight.
Facial Muscles, of lips General, all over.
REFLEXES, Patellar, both diminished
Other about 2+
ARTICULATION,
Slurred, slightly.
Hesitating, very. & slow.
FACIAL EXPRESSION,
SENSIBILITY,
Arteries - seem normal.
HEART, No Murmurs. Sounds strong
Palpitation
Symmetry chest. Fairly good.
LUNGS, Fairly good - Sounds normal.

EXAM. URINE, Dec. 25/96
Color, Reddish - yellow.
Character, Cloudy - flaky deposit.
Reaction, Alkaline
Sp. gr. 1030
Quan. 24 hrs. XX ℥j.
Albumen. Trace by Tourets.
Sugar. None.
Microscop. Large quantity Amor. urates & ammonium urate. Pus, bladder & vaginal epithelium & mucus bands.

GYNÆCOLOGICAL EXAM., 12/23/96 Menopause passed. Uterus retroverted & bound forward left side by adhesions
MENSTRUATION, Does laceration - Cystic degeneration of cervix Very foul discharge - External genitals normal
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ. (G) 55 (m) 63 N. to a. 35 Bi-a. 33 Ant-p. d. 19 Trans. d. 14.3 Bi. d. 11.7 Fac. l. 11.8
HISTORICAL, Headache & vertigo at times.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, living
Father or Pat. Relations, living
Brothers or Sisters,

Personal and Medical History of Mary Maxwell.

This patient was brought here by Sheriff's deputy, E. J. Horst, attended by Mrs. Preston in fair physical condition with the following history: No information as to Consanguinity. First symptoms of this (1st) attack appeared about 2 months ago when patient was greatly excited at night & feared being killed: Disease appears increasing & is variable patient usually being quiet during daytime. Derangement manifested by great sleeplessness & fears of being killed: Not disposed to injure others: Not suicidal: No disposition to filthy or destructive habits: No history of intemperance in parents or self: has suffered from grass anaemia. Has not been confined or restrained: has been given Tonics & Constructives On personal examination no further particulars noted.
On Admission put upon B.W. (5 ft 4½ Ppt Complexion dark: hair brown faitly gray. Eyes blue: condition of skin normal: Small scar on right hand: slight eruption on abdomen. Is clean: behavior quiet: talks sensibly at times but seems absent minded & has delusions.)

1896 Dec. 31. Condensed Fourteen Day Record: Patient during first week showed a temperature practically normal: Is, however, extremely melancholy: Was awake all of the first night: very noisy & fought room mate Next day was very excited, tried to bite her own fingers: was held in bed most of the day: Imagined there were drugs in her food and medicine: On the 17th was up on the ward but very noisy & restless: During rest of week was steadily noisy and restless in a manner resembling some what agitated melancholia: was also fed with tube, since second and third day, as had refused nearly all of preceding meals. During second week fed with tube steadily; was steadily quite restless and incoherent: was willing to talk some but was agitated, restless & depressed. Original Records Preserved.

1897 Jan. 3. Summary Nurse's Notes by Dr. L. L. Phelps:- Appetite fair: takes tonic: gym: treatment given: Jan 30: Is now slightly agitated & melancholy: put upon salt baths, & electrical treatments: Fe. 8'97 Gym. treatment, salt baths & electrical treatment continued: Mar. 10'97 Has recd gym. treatment steadily: Mar. 10 For several days past has been fed with tube: Mar. 15 - Sick in bed: fed with tube: Mar. 16 In bed: fed with tube: expectorates a great deal: Mar. 23 Bowels usually constipated: Quite noisy at times: worries a great deal: Transf. to Inf. & put to bed: coughs & expectorates a good deal: restless & noisy: Mar. 25: Seemed very much exhausted: complains of pain in lungs: Mar. 27 Resp. seems very difficult: coughs & expectorates a good deal: Mar. 28: Refuses solid food invariably: Has bed sores: complains of pain in back: Apr. 1st Died. Failed very rapidly & became very much exhausted toward the last.

Died

Personal and Medical History of

Personal and Medical History of Helena Swanson (or Svensson)

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. H609

Residence, Town of May Washington Co. Minn.

Date Admission, December 15th 1896.

Admitted by Dr. H.H. Herzog Hour, 6th P.M.

How Sent, E.G. Butts J. of P. Washington Co.,

Sex, -Female-

Age, -66-

Civil Condition, -Married-

Children, -2-

Age Youngest Child, 24 yrs.

Occupation, Housewife.

Degree Education, -None-

Profession Religion, Swedish Lutheran.

Habits, Not Intemperate.

Nativity, Sweden.

Physicians Committing, B.J. Merrill & W.H. Pratt.

Correspondents, --

No. for Year, 142.

Insane Relatives, Not known

Cause Exciting, Unknown

Cause Predisposing, Previous attacks.

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, Aug. 15 '96.

Duration, Since Aug. 15 '96.

No. of Attack, Has had several.

No. of Admissions, 1st

Age First Attack, About 49.

Time of Leaving, Mar. 2. 1878

Time in Hospital, 1 yr. 2 mo. 15 da.

Result, Died. Pneumonia.

EXAMINATION ON ADMISSION.

Exam. by R.M. & L.L. Phelps Dec. 17 '96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Very sluggish

MEMORY:

Past Events, Impaired

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull, Very dull.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Impaired in every way.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Will not talk. Resists everything. Scolds in swedish. Is afraid that she is going to be hurt - Very dull. Seems to realize very little - appears to have many delusions. Talks to herself

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 Helena Swanson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. WEIGHT, 92 lbs. NUTRITION, Impaired

WOUNDS OR ABNORMALITIES, Skin Normal.

TONGUE, Tremors, Coatings, None. Promptness Movement,

PUPILS, Equality, Equal Size,

Response Light, Accommodation,

SIGHT, Impaired - Eyes are poor

HEARING, Seems impaired.

COORDINATION, Arms,

Legs,

TREMORS, Hands, None. Tongue,

Facial Muscles, General, None.

REFLEXES, Patellar, EXAM. URINE, Jan. 5 '97

Other color Reddish - yellow

ARTICULATION, character Clear

Slurred, Reaction Alkaline

Hesitating, Amt. 24 hrs. V ℥

FACIAL EXPRESSION, Sp. gr. 1026

Albumen None

SENSIBILITY, Sugar None -

Arteries. Slight atheroma. Amt. urea. 200 gr. 24 hrs.

HEART, No murmurs. Sounds fair Microscop. Large quantity Amor. urates a few pus corpuscles & bladder epithelium.

Regular.

LUNGS, Region Chested. Sounds Normal TAKEN, —

Percussion note hyper-resonant

GYNÆCOLOGICAL EXAM., 12/31/96 Uterus retroverted & atrophied - Laceration of cervix & perineum - Retrocele - some haemorrhoids -

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, very. Irregular,

APPETITE, Good, Medium, Poor, very

SLEEP, Good, Poor, v Very restless. 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 Helena Swanson (or Swenson)

This patient was brought here by sheriffs deputy Frank Carlson attended by Mrs Hegstrand in poor physical condition. No history of consanguinity: Patient has had several attacks of insanity during past 17 years. has never been confined or restrained. First symptoms of present attack manifested August 15th by delusions that neighbors were trying to kill her two sons & that her house & the neighbors were to be burned. Disease seems increasing: not variable & with no rational intervals during this last attack. Her main delusion now is that her house & the houses of neighbors are to be burned. She wanders about night & day neither eating nor sleeping Not disposed to injure others: Not suicidal filthy or destructive. Nothing known as to heredity or intemperance in self or parents: or as to previous peculiarities. No severe disease or head injury: Cause of disease unknown: Has received no treatment. has not been confined or restrained. On personal examination unable to converse with her. Excited & voluble in speech - pulse & temperature normal. On admission put upon B.W. (G.H.& Rpt. Complexion dark: hair brown partly gray: eyes blue: skin normal: No marks, scars or bruises. Is very dirty: Behavior excited: does not speak english.)

1896
Dec 28 Condensed Bourneeds Day Records:- Admitted December 15: 1896. Resisted having temperature taken but indications are that it was normal: Appetite was good & patient regularly refused medicine & was quite resistive: Talks little English and it was rather hard to manage her: Slept only a portion of the night as a general rule: During second week slept somewhat better, but was in general rather stubborn and dull. Original Record Preserved

1897
Jan 5 Summary Nurse's Notes by Dr. S.L. Phelps: Yesterday had slight convulsion: seemed to have partial paralysis of left side for short time: was put to bed: Able to be up & about to-day: Mentally very demented & feeble: Habits clean: appetite fair: Feb 12 About the same mentally & physically: Mar 15 Appetite fair: goes riding & walking: bowels constipated: takes cathartics. Mar 24 Visited by Son: June 97 Eats & sleeps well: no mental change: July 29 Left eye swollen & very red: hot applications: July 30 Eye still much inflamed & swollen: July 31 Obliged to lance swelling on eye: washed & dressed anti-septically: Aug 2 Eye is better: mental condition unchanged Continued by Dr. P.M. Phelps. Nov 30 99 Patient rather more quiet than she has been but at times: at times scolds noisily: Ht 64 Wt. 85.#

Feb 7 Patient seems to be failing some: Pulse weak & rapid: Trans. to Infirmary. Temp. found to be 103.8 Mch 12 Patient died at 7:45 P.M. Temp. kept up more or less to the last & was very weak & exhausted No very prominent symptoms.

Died

Personal and Medical History of

Personal and Medical History of Celia Slocum

(Or. Anna R. Slocum al. Rocelia Slocum)

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4610

Residence, Austin, Minn.

Date Admission, Dec. 16' 1896

Admitted by Dr. A. F. Kilbourne Hour, 7 P.M.

How Sent, S.S. Washburn, J. of P. Mower Co.

Sex, -Female-

Age, -54- (Says 45)

Civil Condition, Divorced - (says single)

Children, None

Age Youngest Child, -

Occupation, House Keeper

Degree Education, Good Common School.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, New York. (Father Ky. Mother Vermont)

Physicians Committing, Ch. Washburn & Ch. Johnson.

Correspondents, - -

No. for Year, 143.

Insane Relatives, None.

Cause Exciting, Not stated

Cause Predisposing, Previous attacks.

Form, Manic Chr-

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, 1st given

Duration, not stated.

No. of Attack, 3rd

No. of Admissions, 2nd Here was once at St Peter.

Age First Attack, 33 about.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam by RM + JL Phelps Dec. 17'96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Somewhat impaired.

Quick or Sluggish,

MEMORY:

Past Events, Probably impaired

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects,

Own Mental State, Impaired.

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Talks almost constantly about herself. Says she thinks she is crazy.

EMOTIONAL STATE:

Normal, Calm, Somewhat excited.

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS: of sight.

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Celia Slocum.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 2 in. WEIGHT, 104 usually 111 NUTRITION, Somewhat impaired.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, White coat Promptness Movement, Sluggish.

PUPILS, Equality, Equal. Size, Normal.

Response Light, Sluggish Accommodation, sluggish.

SIGHT, Impaired.

HEARING, Slightly impaired.

COORDINATION, Arms, Normal.

Legs, Normal.

TREMORS, Hands, None. Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Prompt.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Slight atheroma

HEART, No murmurs. Rounds Normal

LUNGS, Breath sounds normal. Chest symmetry good.

EXAM. URINE, Dec. 30'97.

Color Reddish yellow.

Character Cloudy.

Reaction Acid.

Sp. Gr 1026.

Albumen None.

Sugar None.

Amt. in hrs. XX oz

Microscop. Triple phosphates - a few pus corpuscles - Oxalate of lime - Amorphous + mucine bands.

TAKEN,

GYNÆCOLOGICAL EXAM., 1/7/98 Menopause passed 3 or 4 years. Uterus slightly retroverted - not freely movable slight adhesions at left side some diathesis. Slight hæmorrhoids otherwise normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Long (A) 53½ (Cm) 59½ N. oc. a. 35 Bi. a. 34 Ant. p. d. 17.7 Transv. d. 14 Bi. d. 10.8 F.L. 11.8

HISTORICAL, Had Influenza. - Vertigo

LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN, 2nd Com.

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

Mother or Mat. Relations, died Typhoid Pneumonia.

Father or Pat. Relations, living 96 yrs.

Brothers or Sisters, Healthy.

Personal and Medical History of Celia Slocum.
(Anna R. Slocum or Rocelia Slocum)

This patient was brought here by Sheriffs deputy George Sutton attended by Mrs. Slocum. in fair physical condition - with the following history. No history of consanguinity: This is apparently 3rd attack of insanity: In 1875 Patient was taken to St. Peter & remained there 9 years - & in 1887 was brought to this (Rochester)[x] hospital where she remained 2 years. Disease appears increasing: is variable with rational intervals: Patient is not inclined to injure others: is not suicidal, filthy or destructive: No history of heredity or intemperance in parents or self: No severe disease or head injury: Patient has received no treatment outside of hospitals Commitment recommended as "it is reasonably certain by her threats or otherwise that she has dangerous tendencies or uncontrollable propensities toward crime. On Admission put upon B'W. (G.H.N. Rpt. Complexion dark: hair gray: Eyes gray: skin normal: No Marks, Scars or Bruises So clean: behavior quiet: Talks sensibly: has delusions but hides them.)

[x] Note (See further particulars Rec. Vol. 2 Fol. 35 & Vol. 8 Fol. 24 No. 1464)

1896 Dec. 17 Condensed Fourteen Day Record:- Patient admitted Dec. 16-1896. Temperature normal: appetite good & general bodily health unaffected. Patient is a chronic case, having been in this condition for years and was once a patient here: Her behavior is rather quiet and unobtrusive for the most part, and talks considerably to herself: has many delusions and queer ideas: has some dementia.

1897 Original Record Preserved.

Jan 8 Summary Nurse's Notes by Dr. S. L. Phelps: Appetite good: bowels constipated: talks to herself a good deal: when addressed will answer questions fairly well. Takes care of her room and also helps in dining room: May '97 At times talks rather incoherently to herself: otherwise very quiet & agreeable: Appetite good: sleeps well: physical health fairly good: works some on ward: Aug '97 Tidy in personal appearance: Appetite fair: bowels generally constipated: Has delusions & is always talking to herself. Continued by Dr. W. Phelps, Nov 13/97. Visited by brother: Is quiet & dull with some delusions which she has had for many years. Nov 26/98 Patient unchanged in any essential respect. Still on A2.

Dec 1-98 - Aug 31/99 Cont by Dr. Bobs. Physical condition very good: Appetite fair: bowels regular: sleeps well: Takes outdoor exercise: Assists with work in dining room & on hall. Has delusions: Mch 30-31 Frequently complains of pain in ears. Ears treated: Receives medicine. Occasionally quarrels with other patients Talks & scolds a great deal to herself.

Sept 1- Feb 28/1900. (Dr Heyerdahl) Neat: Appetite fair: Takes some outdoor exercise: Irritable at times: talks a great deal & mutters to herself: Expresses delusions: Jan 19- Wt. 110 #. Mch 1- Nov 31 (Dr. Heyerdahl) Neat. Bowels regular: Is quite irritable most of time: Scolds considerably: Takes regular out door exercise July 17 Vaccinated unsuccessfully. Occasionally

Personal and Medical History of Celia Slocum.

goes to town to do shopping: Nov. 16. Wt. 109 #. Sept 1 - Feb 28 1901 General health good. Feb 28 Wt. 104 #. Mar. to June 1901 General condition remains unchanged both mentally and physically, May 30 Wt. 106 #.

June to Sept. Patient shows no change in general condition Aug. 30 Wt. 105 #.

Sept. to Dec. Patient is in good general health, eats and sleeps well and takes out of door exercise, talks a great deal to herself, has hallucinations of hearing, scolds to herself, complains that she is not treated well, bowels somewhat constipated requiring occasional cathartics, neat in habits and appearance, occupies herself with sewing. Nov. 30 Wt. 104 #.

Dec to Feb 1st '02 No change. Wt about 106 #.

Personal and Medical History of Julia b. Pheris (or Pherin)

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4611
Residence, Faribault, Minn.
Date Admission, December 18th 1896.
Admitted by Dr. R. M. Phelps. Hour, 7 P.M.
How Sent, P. A. Mott Jail Rice Co.
Sex, Female.
Age, 30 yrs.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Book-Keeper.
Degree Education, Graduate St. Marys.
Profession Religion, Episcopal.
Habits, Not intemperate.
Nativity, Quebec. (Parents Canada)
Physicians Committing, D. W. Cool + F. M. Rose.
Correspondents, mother.

No. for Year, 144.
Insane Relatives, None.
Cause Exciting, Nymphomania.
Cause Predisposing, Previous Attack.
Form, Primary Dementia
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, 1890. (recov fully reported)
Duration, Since 1890.
No. of Attack, 1st Continuous.
No. of Admissions, 2nd.
Age First Attack, about 26
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. Dec. 19 by R. M. + A. L. Phelps. **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, Illusive.
REASONING POWER:
Ordinary Subjects, Impaired.
Own Mental State, "
Special Subjects, Much "
GENERAL DESCRIPTIVE REMARKS: Patient was here once before. A case of developmental insanity - said to have heredity from mother who yet was now in asylum.
Patient has a quite pure dementia in form. Talks + behaves a good deal at random. Is

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Many + Varied.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,
Intelligent in form + yet has little mental power.

Personal and Medical History of Julia b. Pheris.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 in. WEIGHT, 98 lbs. Usually 105 NUTRITION, Fairly good
WOUNDS OR ABNORMALITIES, None. Skin Normal.
TONGUE, Tremors, Coatings, Slight coat. Promptness Movement,
PUPILS, Equality, Equal. Size, dilated.
Response Light, Accommodation,
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms, Normal
Legs, Normal
TREMORS, Hands, None Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, Much exag.
Other ankle Clonus.
ARTICULATION,
Slurred, Normal
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries Normal.
HEART, No murmurs. Sounds Normal Regular.
LUNGS,
GYNÆCOLOGICAL EXAM., 12/23/96 Normal - Uterus retroverted bound by adhesions.
MENSTRUATION, Regular
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Jan. 1 '97.
Color Light Yellow.
Character Cloudy.
Reaction Acid.
Sp. gr. 1010
Albumen None.
Sugar None.
Microscop Amor. urates. Bladder + vaginal cells. several fat globules

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

CRANIAL MEASUREMENTS,
HISTORICAL, No bad habits
LENGTH OF INVASION, years - indefinitely ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Very Nervous rather demented.
Father or Pat. Relations, died consumption 35 yrs.
Brothers or Sisters, Each healthy.

Personal and Medical History of Julia b. Pheris.

This patient was brought here by Sheriff's deputy Mrs. Pheis, attended by Miss Mortenson. in fair physical condition with the following history: No history of consanguinity, heredity or, intemperance in parents or self. Patient never fully recovered since discharged from this institution* in 1895: Disease seems nearly stationary. Not curable: With no rational intervals: Derangement manifested by lack of interest in life & all its duties & violent temper: Patient frequently attacks her mother: Is not suicidal: Previous peculiarities not noticable was reticent & uncommunicative. No severe disease or head injury: Has not been confined since leaving this institution; has received tonics & quieting medicine On personal examination is listless, lacks interest.

* Note. (For further particulars see Vol. VI Folio 89 No. 3132.)

On admission put on A'N. (Gen'l Rept. Complexion - hair light brown: Eyes gray: skin normal: No marks, scars or bruises noticed: Is clean; behavior quiet: Talks sensibly)

1896. Dec. 31. Condensed Fourteen Day Record - Patient in ordinary bodily health, with no especial physical ailment: Has been Low Before Each is about the same as at her Previous Stay: Is in appearance rather feeble minded or demented, being rather silly with a good many queer ideas: Is able Lowered & answers questions fairly well.

1897 Original Record Resumed. J.B.

Jan 13 Summary Nurse's Notes by Dr. Phelps: - Very careless about her room and bed: Also at times irritable & quarrelsome with her room-mate: Gyn. treatment given every other day: Mar. '97 Very untidy in personal appearance & dress bowels regular: appetite good: sleeps well: Has many delusions: June '97 No change

Aug. Quiet in behavior: Appetite good bowels regular: many delusions: Gyn. treatment continued steadily: Continued by Dr. P.M. Phelps. Nov 30 '97 Rather silly, Talks to herself. Has very many peculiar ideas: Is rather obstinate: Is receiving gynaecological treatments. Feb. 23 Wt. 98# Sept 1 '98 Patient about the same in every respect.

Dec 1 '99 - Aug 31 '99 Cont. by Dr. Bibb. General health quite good: Requires laxatives: Has been receiving gyn. treatments - discontinued May 7th. Clean in habits altho careless in appearance. Receives tonic. Menstr. regular. Has many delusions & talks very incoherently: Usually quiet when not disturbed but is sometimes very irritable.

July 24 Visited by Sister - Imagines she has hemorrhages

Sept 1 - Feb 28 1900 (Dr Heyerdale) Nov. 27. Irritable: Remains in room a great deal: Takes exercise untidy in appearance but neat in habits: Occasionally scrubs skin from hands & face: Appetite good: Sleeps well: Jan 15 '90#.

Mch 1 - Nov 30 1900. Dr. P.M. Phelps. Menstruates regularly: Very irritable at times: Appetite good: bowels regular: washes herself a great many times during day using soapsuds at times & skin often red & irritated: July 21 Vaccinated: Does no work.

Oct 7. Visited by sister: Nov 24 Wt. 100# Dec 1. - Feb 24 1901 General health good

Personal and Medical History of Julia b. Pheris

Feb 24 1901 Wt. 93# Mar. to June 1901 No change in either mental or physical condition May. 29 Wt. 95#. June to Sept. July 30 visited by her mother, No change in her general condition Aug. 29 Wt. 89#.

Sept to Dec. General health good, eats & sleeps well, bowels constipated requiring daily cathartic, takes out door exercise, does not assist with the work, neat in habits and appearance, likes to sit in her room a great deal, is very irritable. Nov. 30 Wt. 92#.

Dec. to Feb. 1-03 No change. Wt about 92#.

Personal and Medical History of Eliza Lockwood

REGENT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4614
Residence, St. Paul, Minn.
Date Admission, Dec. 22nd 1896
Admitted by Dr. H. H. Herzog Hour, 6.45 P.M.
How Sent, G. Wellrich Jr. Sheriff Ramsey Co.
Sex, Female.
Age, 78. (says 89)
Civil Condition, Widow.
Children, four.
Age Youngest Child, 35.
Occupation, none.
Degree Education, Common school.
Profession Religion, Methodist.
Habits, Not intemperate.
Nativity, Connecticut Father N. Hamp. Mother Mass.
Physicians Committing, J. Ohage & Arthur Sweeny.
Correspondents,

No. for Year, 147
Insane Relatives, None.
Cause Exciting, Senility.
Cause Predisposing,
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, Gradual.
Duration, Not stated.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack,
Time of Leaving, Nov. 28. 1897
Time in Hospital, 10 mo. 29 d.
Result, Died Senile failure

EXAMINATION ON ADMISSION.

Exam. Drawn by P.M. & H. Phelps

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Illusive.
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects, Much impaired
GENERAL DESCRIPTIVE REMARKS: Very feeble. Incoherent in talk. Will not answer questions intelligently. Does not realize her condition.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Seems to have many & varied
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Very dull, feeble & slow.
Voluble or Reticent,

Personal and Medical History of Eliza Lockwood.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft. 9 in. WEIGHT, 94½ lbs. NUTRITION,
WOUNDS OR ABNORMALITIES, Skin - dry & pigmented brown.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Accommodation,
SIGHT, Impaired.
HEARING,
COORDINATION, Arms,
Legs, Very unsteady & feeble on feet.
TREMORS, Hands, None Tongue,
Facial Muscles, " General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating, Rather slow.
FACIAL EXPRESSION,
SENSIBILITY,
Arteries marked atheroma
HEART, No murmurs.
Sounds feeble
Top shoulder higher & somewhat larger than right - Lungs in fairly good condition.
LUNGS,
TAKEN,

EXAM. URINE, June 29/97
Yellow
White flaky deposit
XX
1010
Alkaline
None
None.
Large amt amor. urates & sodium urates - a few pus corpuscles - a few bladder cells.

GYNÆCOLOGICAL EXAM., 12/28/96 Uterus retroverted & atrophied - external genitals normal.
MENSTRUATION, Menopause passed.
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ(h) 53½ (r.m)61 N.oo.a.33 Bin.d.32 Ant.p.d.18.6 Transv.d.14 Bin.d.12½ F.L.10.8.
(Head) Longitudinal depression about 2 in. long, 1½ above either side ac. protuberance. Skull very ~~HISTORICAL~~ irregular. Circular scar on top of head as if had been cut.
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 Eliza Lockwood.

This patient was brought here by Sheriff's Deputy P. C. Haas attended by Miss Akins. in poor physical condition, with the following history:- No history of consanguinity, heredity or intemperance in parents or self. This is first attack: came on gradually. Patient has been in C & C. hospital St. Paul. Disease appears increasing: variable with rational intervals occasionally. She believes she is being starved & has delusions that a female patient is her son Percy & assaults other patients. Has shown no disposition to injure others Is unable to care for herself. No previous peculiarities manifested. No severe disease - has recently injured scalp by a fall. No treatment pursued. On personal examination is generally senile & talks irrelevantly. — — — On admission put upon Ward W. C.H.H. Cot. Complexion dark: Hair gray: Eyes blue: Skin normal: Sexual cavities in skull: Large scar on front part of head. Is clum left shoulder higher than right: Very nervous & irritable: Has delusions.

1896 Dec. 30. Condensed Fourteen Day Record:- Patient is an old lady who was taken away by her relatives at the end of ten days as they desired to keep her at home: Showed no especial bodily ailment or trouble of any kind except that of progressive senile dementia, being quite demented, talking to herself and having incoherence of speech: She imagines that someone is going to poison her. Was on B4 most of the time. Original Record Returned. Went Home. Dec. 30. '96.

1897 June 14 Summary Nurse's Notes by Dr. S. E. Phelps: Paid to-day: Old & very feeble: very demented: realizes very little: eats & sleeps well: bowels regular: takes out door exercise: Is very helpless: July 11: Was sitting in rocking chair this p.m. & fell to the floor, striking left side of head & bruising it quite badly: July 12 Quite weak: July 14 Transf. to Inf.-Quite noisy at times: unable to keep her in bed: always asking for something to eat: July 30 Fell out of bed this morning: bruised face very badly: Recd quite a cut on forehead: Aug 15: Very hard to keep her in bed: Aug. 18 Sitting up most of time to-day: Aug 30 T 98: P. 100. R. 34: Very feeble & demented: Sept. 30 Nurse's Notes:- Very untidy & also very destructive: appetite good: bowels regular: noisy at times: Oct 2: Unrestraint most of time, as unable to keep her in bed: Fell on floor & received cut on forehead - also face quite badly bruised. T 98.8 P. 70. R. 20. Nov. 1 T 99 P. 80 R. 27. Very restless & noisy: has to be kept in restraint to prevent falling out of bed: complains of feeling dizzy when up: Nov. 2 T 98.8 P. 78. R. 24 Nov. 7 Seems very stupid: slept most of day. T 98 P. 76 R. 22. Nov. 13 Very noisy most of day: back bathed with alcohol: Has small sore on back: Dressed with vaseline & boracic acid: T 97.8 P. 68 R. 22. Nov. 14 Seems very stupid: cheyne Stokes respiration: some difficulty in talking: Nov. 16 T 99 P. 80 R. 27: Unable to take any solid food: very restless & noisy most of day. bed sore dressed:

Nov. 17 Failing considerable the past few days: pulse weak: Nov. 18 unable to swallow: T. 100. P. 100 R. 30. Noisy most of day: very noisy during night.

Personal and Medical History of

Sept. 6 hours: Nov 19 Did not take much nourishment: very restless: pulse weak. T. 99.8 P. 108. R. 30. Taken out of restraint at 8:00 m. Resp. Cheyne Stokes: Very noisy till 1: a m. Died at 1:35 a. m.

Died.

Personal and Medical History of Rieka Degner

ROBERT, FOLEY & CHAMBERS, DAVENPORT, IOWA

Whole No. 4615
Residence, Vivian, Wascca Co. Minn.
Date Admission, December 21 1896.
Admitted by Dr. H.H. Herzog. Hour, 8 45 P.M.
How Sent, G.A. Nilson, J. of P. Wascca Co.
Sex, Female
Age, 56
Civil Condition, Married.
Children, 7
Age Youngest Child, 13
Occupation, Housewife (Husband farmer)
Degree Education, Common school.
Profession Religion, Lutheran.
Habits, Not intemperate.
Nativity, Germany (parents Germany)
Physicians Committing, F. P. Foehler & H. J. Young.
Correspondents, Mrs. Degner, Vivian, Minn.
Changed to. Minnesota Lake 3/7/97

No. for Year, 148
Insane Relatives, No.
Cause Exciting, Not known
Cause Predisposing, Not known.
Form, Melancholia, agitated.
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not
Date of this Attack, about week ago
Duration, about one week.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack,
Time of Leaving,
Time in Hospital,
Result, Died

EXAMINATION ON ADMISSION.

Exam. Dec. 21/96 by R.M. & Dr. Phelps.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Impaired.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Illusive.
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Struggles & resists constantly - Seems afraid. Refuses to talk - Will not answer questions - So restless that a thorough examination can not be made.

EMOTIONAL STATE:
Normal, Calm, Very restless
Indifferent,
Exalted,
Depressed,
DELUSIONS: Many & varied.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Incoherent, rep.
Voluble or Reticent,

Copy of Notice for hearing petition of William J. Degner for appointment of Guardian for Rieka Degner received Dec. 2' 1899. & filed with commitment papers MES

Rieka Degner.

ON, CONTINUED.

RISTICS.

NUTRITION, Good
condition dep.
Promptness Movement, Will not shake.
Normal.
mmodation, sluggish

HEARING, Seems good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Not tested.
Facial Muscles,
REFLEXES, Patellar,
Other
ARTICULATION, Can not tell
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Too restless to examine.
LUNGS, Cannot examine.
GYNÆCOLOGICAL EXAM., 12/31/96 Uterus retro-verted & bound by adhesions - perineum lacerated - slight cystocele & rectocele.
MENSTRUATION, Menopause passed
OPHTHALMOSCOPIC EXAM.,

Tongue,
General,

TAKEN,

EXAM. URINE, Dec. 30 '97
Color Yellow.
Character Cloudy.
Reaction Alkaline
Sp. gr. 1018
Albumen Trace by Sauers.
Sugar None.
Quant. 24 hrs. Not 3.
Microscop. Large quant. pus - Bladder & vaginal epithelium & amorphous urates.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, Refuses to eat.
SLEEP, Good,	Poor,	Irregular, Very restless - Resists constantly.
PULSE, Weak	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Cannot make exam. of head.
HISTORICAL, Says she never was sick before
LENGTH OF INVASION, Acute attack of 1 wk - 2 years previous ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denied.
Mother or Mat. Relations,
Father or Pat. Relations, Dead.
Brothers or Sisters, Husband paralyzed 3 years ago.

Personal and Medical History of Rieke Drgner

ROBERT, PICKARD & CHAMBERS, DAVENPORT, IOWA

Whole No. 4615

Residence, Truman. Waseca Co. Minn.

Date Admission, December 21 1896.

Admitted by Dr. H.H. Herzog. Hour, 8 45 P.M.

How Sent, G.A. Nilson, J. of P. Waseca Co.

Sex, -Female-

Age, -56-

Civil Condition, Married.

Children, -7-

Age Youngest Child, -13-

Occupation, Housewife (Husband Farmer)

Degree Education, Common school.

Profession Religion, -Lutheran.

Habits, Not intemperate -

Nativity, Germany (Parents Germany)

Physicians Committing, F. D. Foehler + H. J. Young.

Correspondents, Mrs. Drgner, ~~Truman~~, Minn.

Changed to. Minnesota Lake 3/7/97

No. for Year, 148

Insane Relatives, No.

Cause Exciting, Not known

Cause Predisposing, Not known.

Form, Melancholia, agitated.

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not

Date of this Attack, about week ago

Duration, About one week.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack,

Time of Leaving,

Time in Hospital,

Result, Died

EXAMINATION ON ADMISSION.

Exam. Dec. 22/96 by F.M. + Jos. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

Struggles + resists constantly - Seems afraid - Refuses to talk - Will not answer questions - So restless that a thorough examination can not be made.

EMOTIONAL STATE:

Normal, Calm, Very restless

Indifferent,

Exalted,

Depressed,

DELUSIONS: Many + varied.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Incoherent, resp.

Voluble or Reticent,

Personal and Medical History of Rieke Drgner.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, — WEIGHT, — NUTRITION, Good.

WOUNDS OR ABNORMALITIES, Skin - condition dry.

TONGUE, Tremors, — Coatings, — Promptness Movement, Will not show.

PUPILS, Equality, Equal. Size, Normal.

Response Light, Sluggish Accommodation, Sluggish

SIGHT, Seems good - Cannot test

HEARING, Seems good.

COORDINATION, Arms,

Legs,

TREMORS, Hands, Not tested. Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION, Can not tell

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Too restless to examine.

LUNGS, Cannot examine.

TAKEN,

EXAM. URINE, Dec 30 '97

Color Yellow.
Character Cloudy.
Reaction Alkaline
Sp-gr. 1018
Albumen Trace by Tsuncts.
Sugar None.
Quant. 24 hrs.
Microscop. Large quant pus. Bladder + vaginal epithelium + amorphous urates.

GYNÆCOLOGICAL EXAM., 12/31/96 Uterus retroverted + bound by adhesions - perineum lacerated - slight cystocele + rectocele

MENSTRUATION, Menopause passed

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, Refuses to eat.
SLEEP, Good,	Poor,	Irregular, Very restless - Resists constantly.
PULSE, Weak	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Cannot make exam. of head.

HISTORICAL, Says she never was sick before

LENGTH OF INVASION, Acute attack of 1 wk - 2 years previous ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations, dead.

Brothers or Sisters, Husband paralyzed 2 years ago.

Personal and Medical History of Rieke Degner.

This patient was brought here by sheriffs deputy G.H. Goodspeed attended by Wm. Degner (son) in poor physical condition - with the following history: Nothing known as to consanguinity. No history of heredity. First symptoms manifested about a week ago; ran away to neighbors. Disease appears increasing: Not variable: No rational intervals. Derangement manifested on no particular subject, is restless, nervous & wanders about or runs away from home: Not disposed to injure others not suicidal but is filthy & destructive: No peculiarities previously shown. No severe disease or head injury: Since commencement of attack (one week ago) has been watched: Has received medical treatment from Dr. Smith of New Richland. On personal examination, does not talk, lips dry, appears feverish, pulse rapid, vacant expression of eyes.

On admission put upon bed W (Gatch Cot Complexion dark: hair brown: eyes gray: Bruises all over body: Very dirty, restless & incoherent)

1897 Jan 4. Condensed Fourteen Day Record:- Temperature taken every day. The first week, normal: Patient showers & hair taken ~~sat~~ Three meals a day and that bowels were regular: was in behavior rather wild and was in restraint the first day of admission. Examination showed her to have a chronic chorea with a sort of agitated melancholia in behavior, the two seeming to be vaguely connected: After the first three or four days she began to quiet down & be a little more rational: is, however, very dull and demented. Original record preserved.

Feb. Summary Nurse's Notes by Dr. S.L. Phelps:- Salt baths given every other day: Quite demented & feeble: Mar. 2: Gen'l physical condition has improved a good deal: choreic movements very marked: Has been up & around ward most of time the past month: Now is quiet & well behaved: Apr. 22 Fought nurses quite violently: Seems to be growing worse mentally: Very stubborn & contrary: Gen'l health quite good:

July 6 Struck by another patient: Received quite a bad bruise: July 14 Health seemingly not very good: Quite restless most of time: vomits a great deal: Very incoherent in talk: Has been losing flesh of late: mental condition unchanged. Continued by Dr. Rev. Phelps.

Nov. 29/97 Patient extremely choreic: so much so as to be rather helpless, altho she has considerable strength & can resist a good deal, yet tumbles about & is apt to hurt herself. Is quite thoroughly demented & rather untidy.

Nov. 1/98. No change in any special respect. Is growing somewhat worse rather than better. Jan 1'99 - Aug 31'99 Cont. by Dr. Bibb Physical health impaired: Appetite very good: bowels regular: Is untidy in habits & appearance & very resistive.

Sept 1- Feb 28'1900 (Dr. Heyndale) Does not talk: Sits on bench all day: Habits dirty: Eats & sleeps well: Bowels regular: Resists being bathed: Jan. 15 Trans. to B2.

Nov 1- Aug 31'1900. (Dr. Linton) Troublesome when bathed: Habits dirty: Fed on tray: Appetite good: Sleeps well: Takes outdoor exercise: Nov. 10 Struck by M. Hinds & face

Personal and Medical History of Rieke Degner.

bruised: March 14. Kicked by M. Johnson: Head & back bruised. July 21. Vaccinated. Sept 1- Feb 28'1901- (Dr Heyndale) Dirty & resistive: Kept in bay & fed on tray: Quite restless: General health good: Sleeps well: Bowels regular: No epileptic attacks during period - Nov 30. Wt. 124½#. Jan 27'1901 Received slight cut on forehead: cause unknown: healed without difficulty: General health good. Jan 27 wt. 124½#.

Mar. to June 1901. No change in mental or physical condition, May 29 Wt. 127#. June to Sept. Patients general condition remains unchanged Aug. 31 Wt. 124#. Sept. to Dec Does not converse, is violent, strikes other patients, will throw dishes, is kept in bay, fed on a tray. General health good, eats and sleeps well, takes out door exercise, very dirty in habits and destructive, has choreaform movements of head and limbs. Nov. 30 Wt. 122#.

Dec to Feb 1-03 No change. Wt about 121 #.

Personal and Medical History of Nellie Donovan

DUBUQUE, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4616

Residence, St. Paul, Minn.

Date Admission, December 21 1896.

Admitted by Dr. H.H.Herzog Hour, 6 45 PM.

How Sent, G. Willrich & Jas P. Tansey Co.

Sex, Female.

Age, 33

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, None.

Degree Education, Can read & write.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, St. Paul, (Father Canada, Mother Ireland)

Physicians Committing, M. J. O'Brien & Arthur Sweeney.

Correspondents,

No. for Year, 149

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing,

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Years ago.

Duration, Several years.

No. of Attack, 1st

No. of Admissions, ~~2nd~~ 1 (House of Good Shepherd)

Age First Attack, —

Time of Leaving, Jan. 22. 1899

Time in Hospital, 2 yr. 1 mo. 1 da.

Result, Died - Tuberculosis Pul.

EXAMINATION ON ADMISSION.

Exam. Dec. 23/96 P.M. - Dr. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, —

Quick or Sluggish, —

MEMORY:

Past Events, Seems impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Partially illusive.

REASONING POWER:

Ordinary Subjects, Impaired.

Own Mental State,

Special Subjects, Impaired.

GENERAL DESCRIPTIVE REMARKS:

Feeble-minded, silly. Says they sent her here because she was not quite right.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS: Rather delusional ideas.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Nellie Donovan.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in WEIGHT, 134½ lbs. NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None. Condition of skin fairly good

TONGUE, Tremors, Coatings, Yellow. breath bad Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Sluggish Accommodation,

SIGHT, Seems good.

HEARING, Seems good

COORDINATION, Arms, Fair

Legs, Normal.

TREMORS, Hands, Some fine tremors. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, both about 6 of

Other

ARTICULATION, Prompt

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries normal.

HEART, No Murmurs. Regular

Strength sounds normal.

LUNGS, Sounds normal. C. symmetry normal

TAKEN,

EXAM. URINE, Jan. 5'97.

Color Yellow.

Character Cloudy.

Reaction Neutral

Sp. gr. 1015

Albumen None.

Sugar None.

Quant. 24 hrs. L ½ ½.

Microscop. Amor. urates + sodium urates - Bladder + Vaginal cells - + oxalate of lime.

GYNÆCOLOGICAL EXAM., 12/23/97 Uterus normal position external genitals normal.

MENSTRUATION, Regular but at times painful.

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 (m.) 62 N. oc. 34 Bi. a. 33½ Ant. p. d. 19 Trans. d. 14.8 Bi. d. 17.8 Fac. l. 10.8

HISTORICAL, Says has had dyspepsia. - headaches + dizzy spells.

LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN, Gradual

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

Mother or Mat. Relations, dead.

Father or Pat. Relations, died tumor stomach.

Brothers or Sisters, 3 brothers oldest irritable + surly 1 sister - fairly healthy.

Personal and Medical History of Nellie Donovan

This patient was brought here by Sheriffs deputy E. J. Horst attended by Miss Akers. in fair physical condition. with the following history: No history of consanguinity or heredity: Has been generally foolish, inconsequential & uncontrollable for several years: Disease appears stationary: not variable: with no rational intervals. Derangement manifested by general imbecility with inability to take care of herself & occasional outbursts of violence: No disposition to injure others: not suicidal: Is generally neglectful & has destroyed clothing: Has been in this condition for 10 or 12 years: No severe disease: Injury of head when 13 years old: No particulars as to intemperance: No treatment pursued: No restraint or confinement except as stated (House of Good Shepherd) On personal examination shows general evidence of weak mindedness. On admission put upon B.W. (Gen. Pop.) Complexion dark: hair black: eyes gray: Condition of skin normal: No marks or scars noted. Is very dirty: behavior quiet Answers questions sensibly but laughs a great deal & acts silly.)

'97 Jan. 3. Condensed Fourteen Day Record:- Temperature Taken first week normal, appetite good and habits normal: Behavior & general appearance show her to be quite imbecile in type which is confirmed by her behavior during the first two weeks: Rather garrulous & silly: Rather restless & almost chronic in her manner of restlessness: No especial sickness or trouble. Original Record Preserved.

Jan. 13 Summary Nurse's Notes by Dr. S. L. Phelps:- Coughs & expectorates quite a good deal: menstr. regular: Jan 14 Transf. to Annex: quite imbecile in appearance & manner: Quit health fair: Apr. 14 Appetite fair: habits clean: quite noisy & restless: very silly: quite stubborn: works in laundry part of time: Health seems good:

July '97 Aug. Very noisy obstinate & disagreeable: talks incoherently: Still works in laundry. Lungs & heart exs amined:- Quit nutrition fair. Chest expansion good: percussion note normal: breath sounds normal: Heart sounds full & strong: pulse 72 & full. Continued by Dr. R. W. Phelps. Nov 23/97 Patient works in laundry most of the time. No especial impairment in patients health: Is somewhat poor & emaciated:

Feb 24/98. Has been having massage of late & has seemed in very good health.

Mch 27/98. Patient received on sick ward. Has quite well defined symptoms of consumption. June '98 Up on ward part of time: Rather obstinate in behavior very untidy in appearance. Dec 30 '98 Nurses notes kept during intervening period show patients condition to be slowly but steadily progressive: Is at present quite weak. Jan 22 '99 Patient died today. Has failed steadily, no unusual symptoms noted.

Died

Personal and Medical History of

Personal and Medical History of Clara M. Roberts.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4620
Residence, St. Paul, Minn.
Date Admission, Dec. 27th 1896.
Admitted by Dr. A.M. Phelps Hour, 6th P.M.
How Sent, G. Willrich Jap. Ramsey Co.
Sex, female.
Age, 23.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, None (Father mechanic.
Degree Education, High school.
Profession Religion, Catholic.
Habits, Not intemperate.
Nativity, Minn. (Father Canada- Mother Norway)
Physicians Committing, B.F. Paxton & R.S. Bale
Correspondents,

No. for Year, 153.
Insane Relatives, None.
Cause Exciting, Not known
Cause Predisposing, Not known.
Form, Mania Chron.
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, 1889
Duration, Since 1889.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 16 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. Dec. 27/96 by A.L. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Clear on most subjects but confused as
Quick or Sluggish, to her condition.
MEMORY:
Past Events, Seems good.
Recent Events, " "
Special Subjects, " "
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive as to her condition.
REASONING POWER:
Ordinary Subjects, Impaired.
Own Mental State, "
Special Subjects, "
GENERAL DESCRIPTIVE REMARKS: Has delusions about her own health. Thinks she has consumption. That she is very slender. That it is only a question of a short time until she will die. Was in very dirty & filthy condition when admitted. Is rather feeble-minded. Is 26 years old she says & appears about 16 or 18

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, slightly.
DELUSIONS:
Systematized or Not,
Special Subjects, Thinks she has been put under influence of
Transitory or Not, Chloroform.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Clara M. Roberts.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1 in. WEIGHT, 124 lbs. NUTRITION, Good Color good.
WOUNDS OR ABNORMALITIES, Scar on right arm from cut. Skin normal.
TONGUE, Tremors, Coatings, heavy yellow. Promptness Movement,
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT, Seems good.
HEARING, Good.
COORDINATION, Arms, Normal.
Legs, "
TREMORS, Hands, Fine. Tongue, None
Facial Muscles, None General, None.
REFLEXES, Patellar, Equal about ✓
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries - Normal
HEART, No murmurs. Sounds normal
after first normal position - Regular.
LUNGS, Somewhat stooped, Expansion fair
Breath sounds good. Seems to have cold in head
GYNÆCOLOGICAL EXAM., - bro 28 Retroverted & bound on left side by adhesions - external genitals normal
MENSTRUATION, Regular - normal -
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Jan. 6'97
Color Yellow.
Character Ropy deposit
Reaction Acid.
Sp.gr. 1018
Albumen None
Sugar Trace by Haines & Bismuth
Quan. 24 hrs. XX ℥.
Microscop. Amor. urates. a few pus corpuscles & bladder cells. a few fat globules.

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

CRANIAL MEASUREMENTS,
HISTORICAL, Catarrh for years. Sick in bed with rheumatism quite often during past year. Headaches often.
LENGTH OF INVASION, little over 1 year ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, died lung trouble 1 yr. ago.
Father or Pat. Relations, died 6 years ago - Bright's disease
Brothers or Sisters, 4 brothers healthy but drink. 4 sisters all healthy.

Personal and Medical History of Clara M. Roberts.

This patient was brought here by Sheriffs Deputy Pochet accompanied by Mrs Pochet; in fair physical condition - With the following history. No history of consanguinity first symptoms of insanity manifested in 1889: disease seems increasing: is variable with rational intervals at menstrual periods: Derangement manifested on all subjects Not disposed to injure others: Is filthy + destructive: No peculiarities previously shown. No history of heredity, or intemperance in self or parents: No severe disease as head injury: Has not been confined or restrained but has received treatment from several physicians. On personal examination - delusions are on all subjects - On Admission put upon. Br W (U.S.N. Ret. Complexion dark: hair brown Eyes brown: Condition of skin normal. Small scar on upper part of left arm. To say dirty: rather excited + incoherent)

1899
Jan 4. Condensed Fourteen Day Record: Admission Dec. 23rd. Temperature normal: Appetite Good: Habits regular: In behavior Quite silly + inclined to talk irrelevantly and in appearance is a type of adolescent insanity, tending toward a suggestion of imbecility: Has, however, considerable intelligence: Patient was rather restless, inclined to be noisy + stubborn, having hysterical spells of crying at times: During second week was rather worse than during first week: nothing very notable, however, occurred. Original Record Forwarded.

Jan. 30 Summary Nurse's Notes by Dr. S.S. Phelps:- Peculiar + adolescent case: Appearance indicates a chronic condition: speech rather incoherent + somewhat silly: Gen'l health fair: Feb 2. Has been working in laundry for about 3 weeks: Feb. 22 Very stubborn + impudent: Quite violent at times: incoherent in talk: does not work any: Appetite good: bowels regular: Mar '99 Very stubborn + impudent: incoherent.
Mar. 25 Attempted to run away while out walking: May 99 Picks her hands + face: Very careless about appearance: Habits dirty: menst. irregular: June 10 Tried to escape while out walking: July '99 Menst. regular. Quite stubborn + careless about habits Continued by Dr. Rhu. Phelps. Nov 29 '99 Patient rather dirty in habits: Is rather imbecile + troublesome in behavior: at times quite violent + resistive. Feb 28 99 Had a burn on right arm, has been burned several times + probably does it purposely.
May 29 99 Visited by sister: June 2 Trans. to T3. Sept 30 Trans. to Annex. Jan 2 '99 Remains about same: Has worked some at sewing: Rather quieter but still as demented as before. Feb 1 '99 - Aug 3 1899 Cont. by Dr. Bess. Physical condition fair: Appetite good. Sleeps well. Takes outdoor exercise: Is untidy in habits + destructive + violent at times: Often disagreeable + obstinate + very active: Often strikes other patients July 21 Trans. B' Is fed on tray. Sept 1 - Feb 28 1900. (Dr. Heyerdale) Works some in dining room: Appetite fair: Bowels constipated: Takes cathartics: Goes riding + walking Habits dirty fed on tray. Sleeps well +. Jan 17 Wt. 175#. Patient much disturbed. Rambles in talk a good deal. Mch 1 - Aug 31 1900 (Dr. Linton) Dirty in

Personal and Medical History of

habits: Violent + stubborn + resistive at times: General health good: Eats + sleeps well: Fed on tray. Menstruates regularly: Bowels regular: Takes outdoor exercise: July 21 Vaccinated. Sept 1 - Nov 30 1900 (Dr Heyerdale) does not talk: Kept in bay + fed on tray: General health good: Eats + sleeps well: Nov 20. Wt. 105 1/2#. Dec 1 - Feb 28 1900 General health good: No change. Feb 15 Wt. 102

Mar. to June 1901 No change in mental or physical condition, May 30 Wt 99#.
June to Sept.

Sept. to Dec., Very troublesome, destructive and violent, is incoherent in speech and very profane, kept in bay, fed from tray, general health good, eats and sleeps well, takes out door exercise, habits dirty, menstruates regularly. Nov. 30 Wt. 91 1/2 #.

Dec. to Feb. 1-03 No change. Wt. about 90 #.

Personal and Medical History of Gertrude Dorand.

SUBERT, FUGAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 46 773

Residence, Stillwater Washington Co. Minn.

Date Admission, December 7th 1896.

Admitted by Dr Le B. Eby Hour, 7.35 P.M.

How Sent, E. G. Butts. Dep. R. Washington Co.

Sex, Female.

Age, 24.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Housework (Father - boiler maker)

Degree Education, Common School.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Wisconsin.

Physicians Committing, W. H. Pratt - I. C. Schuck.

Correspondents,

Sister. (See office register)

No. for Year, 156

Insane Relatives, 2 maternal uncles.

Cause Exciting, Not stated

Cause Predisposing, Heredity.

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not. Except admits desire sometimes

Date of this Attack, Quite recent.

Duration, Short (?)

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 24.

Time of Leaving, Nov. 16. 1897

Time in Hospital, 11 ms. 8 da.

Result, Discharged under Peterson Law Unimproved - 11/16/97

EXAMINATION ON ADMISSION.

Dec. 26'96 by H. L. Phelps.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Somewhat confused -

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Fair but rather uncertain -

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull & partially illusive

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS:

Patient has always been sick since a child - At present is childish in manner - rather silly & decidedly weak-minded - Very slow of perception - Hesitates in answering questions.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, rather.

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Has delusive ideas -

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Shows decided loss of will power - Dull & slow to comprehend.

Personal a... Gertrude Dorand.

Rochester State Hospital.

Gertrude Dorand

Patient.

Order for Discharge of Patient

Under Law 1897.

Filed NOV 8 1897 18

J. R. Stout M.D.

...ISSION, CONTINUED.

...ACTERISTICS.

HEIGHT, 5...

WOUNDS OR ABN...

TONGUE, Tremors,

PUPILS, Equality,

Response

SIGHT, Ga...

HEARING, G...

COORDINATION,

TREMORS, Hands,

Facial

REFLEXES, Patell...

Other

ARTICULATION,

Slurred,

Hesitating, ✓ d...

FACIAL, EXPRES...

SENSIBILITY,

HEART, No Mur...

Regular but a little quick. Apex beat normal position.

LUNGS, See below.

NUTRITION, Fair but pale

Skin - Normal.

Promptness Movement,

Size, Normal.

Accommodation, Normal.

Tongue, Slight.

General, None

EXAM. URINE, Jan 3' 97.

Color Reddish yellow.

Character Cloudy - Ropy deposit.

Reaction Acid.

Sp. Gr. 1010

Albumen None.

Sugar None.

Amt. urea ~~1200~~ 380 gr. 24 hrs.

Amt. 24 hrs. XXX Z.

Microscop. Large amt. Amor. urates & Bladder & vaginal cells - Small amt. pus -

TAKEN,

GYNÆCOLOGICAL EXAM., 12/28/97 Uterus normal position Extensive erosion of os discharge - External genitals excoriated.

MENSTRUATION, Regular - Normal.

~~OPHTHALMOSCOPIC~~ Lungs - EXAM. Right shoulder much lower than left drooping Front protrudes outward much beyond right giving a deformed appearance to chest. Breath Sounds very shallow over both lungs. Percussion note dull. Chest expansion very much diminished.

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

CRANIAL MEASUREMENTS,

HISTORICAL, Scarlet fever or Diphtheria at about 11 yrs. Has always been sick a good deal.

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,

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 Gertrude Doran *a patient committed to said Hospital from the County of* Washington *and received there on the* 24 *day of* Dec *1896, recommending the discharge of said* Gertrude Doran *on the ground* that is unmarried, unintelligent enough to live quietly at home and has a home to go to.

Ordered, that said patient, Gertrude Doran, *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* Washington *County, and send a copy of this order to the Medical Superintendent of said State Hospital.*

Dated Nov 1 *1897*

John Clausen
J. H. Block
T. H. Titus
Trustees.

Personal and Medical History of Gertrude Doran.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in. WEIGHT, 118 lbs. NUTRITION, Fair but pale

WOUNDS OR ABNORMALITIES, None. Skin - Normal.

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Normal. Accommodation, Normal.

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None. Tongue, Slight

Facial Muscles, General, None

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating, ∓ dull

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs - sounds normal Regular but a little quick. Apex beat normal position.

LUNGS, See below.

GYNÆCOLOGICAL EXAM., 12/28/97 Uterus normal position Extensive erosion of os discharge - External genitals excoriated.

MENSTRUATION, Regular - Normal.

~~OPHTHALMOSCOPIC~~ Lungs - EXAM. Right shoulder much lower than left drooping front protrudes outward much beyond right giving a deformed appearance to chest. Breath sounds very shallow-over both lungs. Percussion note dull. Chest expansion very much diminished.

TAKEN,

EXAM. URINE, Jan 3' 97.
Color Reddish yellow.
Character. Cloudy - Copy deposit.
Reaction Acid
Sp. Gr. 1010
Albumen None.
Sugar None.
Amt. urea ~~xxxx~~ 380 gr. ℥ hss
Amt. ℥ hss. XXX ℥.
Microscop. Large amt. Amor. urates +
Bladder + vaginal cells - Small amt. pus -

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

CRANIAL MEASUREMENTS,

HISTORICAL, Scarlet fever or diphtheria at about 11 yrs. Has always been sick a good deal.

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,

This patient was brought here by James Doran. attended by Katherine Doran with the following history: Patient is in good physical condition: No history of consanguinity: Patient has been stubborn, intractable & sullen for some time but yesterday went to a neighbors & threw stone through window: disease seems increasing, variable with irregular rational intervals. Derangement manifested by delusions of persecution & a desire to commit suicide: Not disposed to injure others: Not filthy or destructive: Two maternal uncles died in Wisconsin Insane asylums: Patient was always a willful child: No history of intemperance in self or parents: No severe disease or head injury: Has not been confined or restrained: Has received no treatment: On personal examination Physical symptoms negative. Admits delusions of persecution & a tendency or desire to commit suicide.

On admission put upon B.W. (Gd. N. Pt. Complexion fair- hair red: eyes brownish gray: Skin normal: No marks or scars noted: 2 large bruises on right leg: Is clean: Behavior quiet: Talks very little: has delusions)

1897
Jan. 6. Condensed Fourteen Day Record shows Temperature normal and Appetite good throughout: Has been uniformly fairly quiet and well behaved: In addition: has very few wishes or desires out of the ordinary: Is cleanly & does some work Is mildly demented, yet able to answer questions fairly well on ordinary subjects: Upon her history must be put down as of an adolescent type. Original Record Preserved.

Jan. 30. Summary Nurse's Notes by Dr. S.L. Phelps:- Gyn. treatment given steadily every other day since admission: Salt baths & electrical treatment given: very quiet & pleasant in appearance: talks quite sensibly; appetite fair: sleeps well: keeps some with work:

Feb. 18 All treatments continued: Mental condition seems to improve: Mar. '97 Very quiet & pleasant in manner: works in employee's dining-room: May 19 Very agreeable although at times rather silly: usually talks quite sensibly: works some on ward: Still receives gyn. treatment: July 30 Treatments have been continued steadily: Menses regular: Aug '97 Has been very quiet & well behaved & quite sensible: Has been working every day. treatment continued: Beginning to feel quite anxious about going home.

Sept. 17 Nurse's Notes: Gyn. treatment continued 3 times per week: Oct. 13 menses regular: Nov. 14 Very quiet & agreeable: appetite fair: bowels regular: takes out door exercise: Does no work: gyn. & electrical treatment continued: physical health good: neat in habits & appearance. Nov. 16 Went Home.

Discharged

Personal and Medical History of Fredericka Graw.

EUBERT, FISCHER & CROMBERG, DAVENPORT, IOWA.

Whole No. 4678

Residence, Fairbault Co. Minn.

Date Admission, December 30' 1896.

Admitted by Dr. R. M. Phelps Hr Hour, 7 P.M.

How Sent, J. F. Winship, Jap. Fairbault Co.

Sex, Female.

Age, 65

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, - Has none.

Degree Education, - None.

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Germany.

Physicians Committing, J. N. Hurst + A. J. Finkler

Correspondents, About Graw. Minnesota Lake, Minn.

No. for Year, 161

Insane Relatives, Mother reported to have been insane

Cause Exciting,

Cause Predisposing, Former attacks + heredity.

Form, Incl. Chr.

Accompanying Bodily Disorder, Ulcers - feet in very bad condition

Suicidal or Not, Not.

Date of this Attack, August '96.

Duration, Since August 96.

No. of Attack, 2nd

No. of Admissions, 2nd

Age First Attack, 64 (?)

Time of Leaving, February 14 - 1903

Time in Hospital, 6 Yr 10 mos 15 Ds

Result, Died: Phthisis Pulmonalis Decubitus

EXAMINATION ON ADMISSION.

Exam. Dec. 30' 96 by R. M. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, } Last fair.

Recent Events, }

Special Subjects, }

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Incorrect.

REASONING POWER:

Ordinary Subjects, Poor.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Depressed.

DELUSIONS:

Systematized or Not, Partially - thinks she is an animal

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient was taken out by brother-in-law - Brought back as having another attack. Wanted to live like an animal. Her condition indicated that she had partially succeeded. Probably an imbecile - who recently has had 2 attacks of melancholia. Has deformities - fingers twisted away outward - foot affect outward from ankle + toes turned outward. Back humped + one shoulder higher than the other.

Personal and Medical History of Fredericka Graw.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Not very good.

WOUNDS OR ABNORMALITIES, Feet very bad again - ulcers - fissures + callous - deformed

TONGUE, Tremors, Normal. Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size,

Response Light, Accommodation,

SIGHT, Probably good.

HEARING,

COORDINATION, Arms,

Legs, Feet sore Probably good.

TREMORS, Hands, Not notable. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, 6 & 7 equal.

Other

ARTICULATION, German + always

Slurred, poor - Imbecile im-

Hesitating, Patient.

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

GYNÆCOLOGICAL EXAM., Normal condition.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Jan. 4' 97

Color Brownish red.

Character Thick - flaky

Reaction Acid.

Sp. gr. 1036.

Albumen None.

Sugar None.

Amt in 24 hrs V Z

Microscop. Large amount uric acid. Crystals; Amor. urates, Fat globules + mucus bands.

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

CRANIAL MEASUREMENTS,

HISTORICAL, No occupation except working out a little

LENGTH OF INVASION, Years probably feebleminded always + this an attack ONSET GRADUAL OR SUDDEN, Fairly sudden as to attack

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Fredericka Graw

This patient was brought here by Sandy McDonald, Sheriff, attended by Nephew About Graw. in fair physical condition, with the following history - Patient was in this (Rochester) Hospital from Nov 29'95 to July 19'96 + left unparoled: In August 1896 symptoms were again manifested by imagining she was an animal + running away: disease appears stationary: not variable + with no rational intervals altho at times she is nervous + at others quiet. Derangement manifested in trying to injure others, running away + screaming + at times imagining she is a calf. Is filthy but not destructive: Mother reported to have been insane. Previous peculiarities - had an excitable spell + yrs. ago. prayed + sang constantly for 2 months: No history of intemperance in parents or self: No severe disease or head injury: Has been confined here, as stated; + has received some treatment - not benefitted. No further particulars learned on personal examination. ——— ——— ———

*Note For further particulars see Vol. 30 Folio 25 No. 4259. ——— ———

On admission put on Bd 70 (5th Ward) Complexion dark: Eyes blue: hair light brown: Condition of skin normal: scars on both legs from varicose veins: ulcer on right leg + 2nd finger on right hand: Is very dirty: Feet + hands deformed: Is quite excited, crying + talking continually.

1897
Jan. 12 Condensed Fourteen Day Record:- Admitted Dec. 30.1896 for the second time: Came back again rather dirty, with her feet bound up and ulcerated, not so bad however, as at last previous Admission: It is stated that this is due to her persistent attempts to live like an animal, she thinking her self one and running out into the woods &c: Rather restless, but quieted down somewhat during the first two weeks. Somewhat melancholy in type: Had to be fed with tube: Several times during the latter part of the two weeks has imagined she was poisoned: Is shown to be of a type tending toward imbecility. Original Record Preserved.

Jan. 13 Summary Nurse's Notes by Dr. L. L. Phelps:- Admitted in a very filthy + neglected condition: both feet were very sore with deep fissures filled with dirt + filth: 2nd finger of left hand sore also: cried almost continually at first: imagined she was a wild animal + wanted to live in the woods: Feb. 10: Appetite good behavior quiet: quite agreeable: bowels regular: works in dining room: Mar. '97 still works: is very agreeable: Apr. 97 no change: July 97 works in dining room: eats and sleeps well: physical condition seems good. Continued by Dr. W. M. Phelps. Oct 5/97 Patient unchanged in every respect during last few months. Feb 15'98 Wt. 134# Apr. 6 Patient's feet are in very bad condition, very dirty, calloused + sore: Has worked some in dining room. June 15 '98 Has been melancholy of late; crying + troublesome. Disarranges beds: July 19 Trans. 6'. July 10 Working in dining room + very agreeable. Aug 28 Right knee swollen Liniment applied.

Personal and Medical History of Fredericka Graw.

1899
Oct 3 to 6 '98 In bed - complained of headache. Oct 7 Again up on ward: Is better:
Dec 31 '98 no change: Mch 1 - Aug 31 '99 Cared by Dr Bebb. General health fair: Appetite variable: receives special also tonic: Bowels constipated: Goes walking + riding: Assists at times in dining room: Reads papers + books: often complains of headache + pain in right leg. Sept 1 - Dec 28 1900 (Dr Heyndale) Works some in dining room: Appetite fair: Bowels constipated: Takes cathartics: Goes riding + walking: Has trouble frequently with sore on leg: Jan 13 Wt. 116.# Patient much disturbed remains in bed a great deal of time: Feb 28 Somewhat better: More quiet in behavior
Mch 1 - Nov 30 1900. Eats + sleeps well. Goes riding: Somewhat constipated: Behavior quiet: May 1 Visited by nephew. May 3. Going into spell: Refuses meals: Walks up + down hall crying. May 17. Still takes but little nourishment: Sits in room a great deal: May 28. Fed by nurses: June 1 - Has delusions in regard to food: July 13. Attempted suicide by tying apron around neck + bed: Trans. Bd. July 21 Vaccinated: Augs. Showing improving, but still resistive. Takes outdoor exercise Sept 14. Had diarrhea: Temp. 102. Trans. to Infirmary: During stay on Inf. highest temp. 103 5. Pulse 124. Kept on boiled milk diet with brandy. Given medicine to control diarrhea: Stools at times haemorrhagic, slimy + offensive. Quite restless part of time + at times disturbed + noisy: Sept 25. Temp + stools normal Trans back to ward. Appetite poor but went to dining room for meals: Bowels constipated: Untidy in habits: Cries + moans a great deal apparently from homesickness: Begs to be taken home: General health somewhat seems fair. Nov 16 1900 Wt 101 1/2#. Seems to be feeling well: Requires mechanical feeding at times: Dec 1 - Feb 28 1901 General health fair - appetite fair: At times has to be fed by nurses: Bowels constipated: Takes cathartics: Has special diet: Habits clean: Sits in one place all day long: Cries a great deal: Has a great desire to go home: Expresses no delusions: Feb 28 95#
Mar 1 - June 1 - 1901 No change in mental or physical condition. Does no work. May 28 Wt. 95#. June to Sept. Patient very melancholy, takes no exercise, does no work, answers questions intelligently, Sept. 9 Wt. 90 1/2#. Sept. to Dec. Nov. 3 was pushed from her chair on to the floor by another patient left leg and hip sprained was up on ward Nov. 16 but sits in a chair all day and refuses to take any exercise, is unable to walk.
Jan 1 to Feb 1, 1903. Physically in very poor condition: appetite poor: is fed with milk 3 times daily: bowels constipated: takes no exercise: does no work: untidy in habits and appearance: is very unhappy: cross a great deal: has many delusions: especially about her food: thinking that it is poisoned: is resistive when being bathed: Nov. 2 Wt. 91#. Patient failing rapidly: sleeps little. Feb. 13, 1903 patient died at 1:30 A.M. Cause Exhaustion in Senile Dementia.

Personal and Medical History of Mary Evans.

BIGELOW, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4644
Residence, Caledonia, Minn.
Date Admission, January 13' 1897
Admitted by P.M. Phelps, M.D. Hour, 4:30 P.M.
How Sent, Thos. Ryan. Jos. P. Houston Co.
Sex, female.
Age, - 28 -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, School teacher.
Degree Education, normal school.
Profession Religion, Catholic.
Habits, not intemperate.
Nativity, Minnesota - (Parents Ireland)
Physicians Committing, E.B. Johnson & W.W. Freeman.
Correspondents, Dr. Evans, La Crosse, Wis.

No. for Year, 177
Insane Relatives, None.
Cause Exciting, Neurasthenia Anaemia, Menorrhagia - At present it is amenorrhoea.
Cause Predisposing,
Form,
Accompanying Bodily Disorder, gives above.
Suicidal or Not, Not.
Date of this Attack, 1st Attack Oct. '95.
Duration, -
No. of Attack, 2nd
No. of Admissions, 2nd (St Sisters Hospital Lacrosse)
Age First Attack, 27
Time of Leaving, Apr. 19. 1897
Time in Hospital, 3 mo. 6 da
Result, Discharged Aug. 11. 1897 Improved.

EXAMINATION ON ADMISSION.

Exam by P.M. & H. Phelps 1/16/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish,
MEMORY:
Past Events, Seems good.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Fearful -
DELUSIONS:
Systematized or Not, Has delusive ideas - vaguely
Special Subjects, defined - Fears world is going wrong
Transitory or Not, Sat Earth & sun are coming together Etc
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Restless, nervous & anxious. Thinks it is a mistake that she was brought here. Thinks she is not sick. Says she thinks it must be a disturbance in the atmosphere - producing storms earthquakes, Etc. Worries about people talking about her - Suspicious & vaguely fearful of disasters. Implicates others as well as herself. Has confusional state of mind. Melancholy in character.

Personal and Medical History of Mary Evans.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3 in. WEIGHT, 109 lbs. NUTRITION, Slightly pale.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, Normal. Coatings, Promptness Movement, Prompt.
PUPILS, Equality, Equal Size, Slightly dilated,
Response Light, Prompt. Accommodation,
SIGHT, Good.
HEARING, Seems good.
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None. Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, Normal
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,

SENSIBILITY,
Arteries - Normal.
HEART, No murmurs - Sounds fair Apex beat normal. To regular.
LUNGS, Normal.

TAKEN,

EXAM. URINE, Feb. 4. '97.
Color Yellowish red.
Character Cloudy & flaky deposit
Reaction Acid
Sp. Gr. 1031
Albumen None.
Sugar " None.
Amt. 24 hrs. V 3.
Microscop. A few blood corpuscles, amor. urates & bladder & vaginal cells.

GYNÆCOLOGICAL EXAM, Jan 16 '97 Uterus normal position - External genitals normal.
MENSTRUATION, Irregular not very painful
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Headaches frequently Slight dizzy spells at times.
LENGTH OF INVASION, About 1 year ONSET GRADUAL OR SUDDEN, Gradual seemingly
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any knowledge of
Mother or Mat. Relations, Healthy
Father or Pat. Relations, Healthy before a fall he had
Brothers or Sisters,

Personal and Medical History of Mary Evans.

This patient was brought here by John Evans, attended by Mary Evans, in fair physical condition: with the following history:- No history of Consanguinity. First symptoms appeared in October, 1895 - Attack lasted about 6 months - patient was in Sisters Hospital at La Crosse + left improved - Patient incoherent in talk: Disease seems increasing: variable with irregular rational intervals: Derangement manifested on subject of solar system, cyclones etc. 1st derangement on religion. Patient not disposed to injure others; not suicidal, filthy or destructive: No previous peculiarities shown: No history of intemperance in parents or self: No serious disease or head injury. Patient was confined for 9 weeks in hospital at La Crosse. On personal examination it is learned that patient has not slept for 12 days. Shows confusion of ideas. On admission put upon B.E.C.H.R. Rpt. Complexion fair: hair brown: eyes gray: Condition of skin normal: No marks scars or bruises noted: Is clean: behavior quiet but restless: Talks sensibly.)

15-97
Jan 16. Condensed Fourteen Day Record. Admitted Jan. 13-97. Appetite was good: Temperature normal when taken: no especial bodily illness apparent, although she complained very much of weakness: Her description seems to be that of a purely hysterical type of behavior: Has crying spells that seem to trouble her, but no well defined delusions have been obtained, although her ideas are exaggerated + of a delusionary character. Original Record Preserved

Feb 1 Summary Nurse's Notes by Dr. S.L. Phelps. Massage given every other day: mental condition improving: much better contented: takes massage + salt baths: Gen'l health fair: Mar 1st Massage every other day: Has improved both physically and mentally: seems to talk sensibly: appetite good: sleeps well: takes some interest in work. Apr. 1: Massage given steadily. Apr 19 Went Home: Very much improved in mental condition: Talkes quite sensibly: Quiet in behavior: neat in habits + appearance: Gen'l Health good.

Discharged

Personal and Medical History of

Personal and Medical History of Augusta Aufang.

EBERT, FICLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4645
Residence, 656 Blair St., St. Paul, Minn.
Date Admission, January 14' 1897
Admitted by Dr. R.M. Phelps Hour, 7 P.M.
How Sent, G. Willrich, J. of P. Ramsey Co.
Sex, Female.
Age, — (Says 38)
Civil Condition, - Married -
Children, - 5 -
Age Youngest Child, 2 months.
Occupation, — (Husband Insurance Agent)
Degree Education, Ordinary.
Profession Religion, Catholic.
Habits, Not intemperate
Nativity, Germany. (Parents same)
Physicians Committing, J. Okage + G. Stamm.
Correspondents, none given in patients

No. for Year, 178
Insane Relatives, None.
Cause Exciting, —
Cause Predisposing, Previous attack
Form, Mania Chron.
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Never attempted - propensity active
Date of this Attack, not stated
Duration,
No. of Attack, 2nd (1st 9 yrs. ago. lasting 9 mo)
No. of Admissions, 2nd
Age First Attack, —
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam by R.M. + G.L. Phelps. Jan. 14 '97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, At times quite confused + at others
Quick or Sluggish, Clear.
MEMORY:
Past Events, Impaired.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Answers at random.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects, Impaired
GENERAL DESCRIPTIVE REMARKS: Rather confused + memory is uncertain. Talk is rather incoherent at present. At times talks sensibly.

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 Augusta Aufang.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. WEIGHT, 110 lbs. NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES, Skin - Normal.
TONGUE, Tremors, Coatings, Heavily coated - yellow Promptness Movement,
PUPILS, Equality, Equal. Size,
Response Light, Normal Accommodation, Normal.
SIGHT, Good
HEARING, Seems good
COORDINATION, Arms, -
Legs,
TREMORS, Hands, None. Tongue, None.
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Normal.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs.
Sounds normal.
LUNGS, Normal.

TAKEN,

EXAM. URINE, Feb. 6'97.
Color yellow.
Character. Cloudy - flaky deposit.
Reaction Alkaline.
Sp. gr. 1020
Albumen. Trace by Esbachs.
Sugar None.
Amt. in hrs. XXXIV ½.
Microscop. Large quantity bladder + vaginal epithelium - a few uric acid crystals + Amon. urates.

GYNÆCOLOGICAL EXAM. Jan. 19'97 - Uterus retroverted + bound toward right side. Cervix lacerated (transversely - laceration of perineum. Erosion of os - some endometritis. cystocele, rectocele.
MENSTRUATION, always irregular
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Complains of headache at times.
LENGTH OF INVASION, 2nd attack ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Nervous.
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Augusta Aufang.

This patient was brought here by J.P. Hendricks attended by her husband, in fair physical condition, with the following history:- Nothing stated as to consanguinity. First attack occurred about 9 years ago when patient was confined in this (Rochester) hospital from Dec 8'1888. to Sept. 27'1889. & discharged recovered. Her insanity is of a puerperal character is not variable, no rational intervals: She wants to kill herself & youngest child (7 mo. old) Derangement manifested by loss of memory & quarrelsome behavior: nothing stated concerning habits: No history of heredity or intemperance in parents or self: No severe disease or head injury: Has not been confined during this attack. No further facts learned on personal examination. On Admission put upon 3rd M. G.H.N. Ward. Complexion dark hair brown: eyes gray: No marks; scars or bruises noticed: Is clean: behavior quiet: is incoherent)

1897 Jan. 14 Condensed Fourteen Day Record: Admitted Jan. 14. Temperatures appeared normal during first week when taken: Appetite uniformly good: habits good: On admission was restless restless & talkative and cried for an hour or so during the night: Had been nursing child & breasts needed frequent attention: During first week is rather incoherent in talk, sleeping rather poorly, but upon the whole fairly quiet: During the second week talks rather more coherently, although at times cries, is melancholy and irregular in behavior: Complains at times of head ache. Original Record Preserved.

Feb 3 Summary Nurse's Notes by Dr. R.L. Phelps. Very melancholy, cries a good deal: does not sleep well: seems to worry a good deal over delusive ideas: Appetite poor: bowels constipated: receives Gyn. treatment every other day: Also receives electrical treatments and salt baths: Apr. Gyn. treatment, salt baths & electrical treatment continued during Feb, March & April: Very melancholy at times: cries a good deal: does very little work: is mischievous: Has delusions but at times will talk quite sensibly:

June No change: July 31. Very mischievous: bowels usually constipated: takes out door exercise: Gyn. treatments continued: also salt baths given 3 times a week: takes tonic: Aug 29. Gyn. treatments continued: no special change. Continued by Dr R.M. Phelps.

Nov 26/97 Has been receiving salt baths & gynaecological treatments: Is rather mischievous & troublesome Feb 4 98 Wt. 110# Still receiving gynaecological treatments

Apr 28 Visited by friends Aug 6 Wt. 110# Sept 1 Trans. to B3. Feb 15 99. Is working some on ward & is feeling somewhat better. (Cont. by Dr. R.A. Babb) Dec 26 98. (Omitted above). Had operation for rectal suspension & perineorrhaphy: Reaction good retained nourishment well: Was given Jan. 5 99 Abdominal stitches removed: Jan. 11 Remainder of stitches removed: Jan. 20 commenced to sit up: Jan. 21 To sit on ward most of day: menstr.: June 10 Neat in habits: careless in appearance: bowels regular: appetite good: assists with work: June 10

Personal and Medical History of Augusta Aufang.

1899 June 10 Visited by husband: June 17. Menstr. June 23 Trans. to B3. July 9 complained of cough: Aug 12 Menstr. Isolating & quite irritable: Is occasionally very disagreeable: Sept. 9: Attempted to strike nurses with broom: Is some what more melancholy of late: Still assists with work: Nov. 30 No special change: Assists with mending & other sewed work: When not occupied almost always sits in a corner on floor: can answer questions sensibly but is usually incoherent: attempts to throw articles out of window unless watched. Sept- Feb 28'1900. Dr Reynolds Sept 9. Very melancholy of late:

Nov 30 Takes out door exercise: Disagreeable at times: cries & is quite melancholy: Assists with work: Occasionally strikes other patients & talks more or less to herself. Jan 15 Wt. 113#. Feb 20 Easily excited: Works in dining room: Appetite good: Mch 1- Nov 30 1900 Incoherent & profane: Inclined to be violent. Apr. 11. Attempted to throw chair at patient Expresses many delusions: May 30 Assists with work: Neat: Appetite good: Takes out door exercise: Menstruates regularly: July 2 Vaccinated fought violently. Aug 26. Attacked nurses. In seclusion one hour:

Aug 26 Quite disturbed & inclined to be violent: Sept 21. Expressed delusion that she was stolen from husband & brought to hospital to be a slave to rich people. Dec 1- Feb 28'1901 Dr H.J. General health good. Assists with work. Feb 25 Wt. 111#.

Mar. to June 1901 Mar. 29 Patient shows no change in mental or physical health. Wt. 112½#.

June to Sept. Patients physical and mental condition remains unchanged. Aug. 29 Wt. 112#.

Sept. to Dec. Patient is neat in habits and appearance, general health good, bowels regular, takes out door exercise, assists daily with ward work, is agreeable if let alone, attends amusements, at times becomes very much disturbed mentally and violent, will then attack nurses and other patients, talks to herself a great deal. July 3. Patient became very angry at supper time rushed into the hall and knocked a patient down and fought nurses, was secluded. Nov. 30 Wt. 113#.

Jan to Feb 1, 1903. From Oct. 5th to 8th patient was confined to bed with an attack of dysentery: ordinarily physical condition is good: appetite good: bowels regular: sleeps well: menstruates regularly: takes exercise: assists with the ward work: neat in habits and appearance: at times scolds and is quite disagreeable on the ward: expresses some delusions: at times converses intelligently ordinarily is quiet: does not voluntarily converse: Nov 30th Wt. 105

Personal and Medical History of Mary A Silsbe

LUDDEN, FISCHER & DICKBERG, DAVENPORT, IOWA

Whole No. 4646
Residence, LeRoy, Minn.
Date Admission, Jan. 15' 1897.
Admitted by H.H. Herzog M.D. Hour, 4 P.M.
How Sent, A.S. Washburn, J. of P. Mower Co.
Sex, Female
Age, 59. (Says 55)
Civil Condition, Married.
Children, 2.
Age Youngest Child, 37.
Occupation, — (Husband Carpenter)
Degree Education, Can read & write.
Profession Religion, Methodist.
Habits, Not intemperate.
Nativity, Ireland (Parents Ireland)
Physicians Committing, E.A. Hinsdale & A.W. Allen M.D.
Correspondents, none given in papers -
Newton Silsbe, Leroy Minn Husband -
M.J. Hart M.D. Leroy Minn. Physician

No. for Year, 179.
Insane Relatives, None known
Cause Exciting, Paraplegia.
Cause Predisposing, Not known.
Form,
Accompanying Bodily Disorder, Paralysis.
Suicidal or Not, Not.
Date of this Attack, Had Stroke of paralysis in 1892
Duration, —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, —
Time of Leaving, Jan. 31- 1897.
Time in Hospital, 16 da.
Result, Died -
Cerebral Softening following Apoplexy

EXAMINATION ON ADMISSION.

Exam by Dr. H.L. Phelps Jan 16'97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Very confused & sluggish.
Quick or Sluggish,
MEMORY:
Past Events, Impaired.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects, Very poor
GENERAL DESCRIPTIVE REMARKS: Talks almost constantly but her speech is so thick can not understand her. Very helpless - Can not walk or stand - Right side Completely paralyzed for over a year - Very demented.

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

Personal and Medical History of Mary A Silsbe.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Impaired
WOUNDS OR ABNORMALITIES, Partial paralysis of right side.
TONGUE, Tremors, Coatings, Heavily coated Promptness Movement,
PUPILS, Equality, Equal Size, Slightly dilated.
Response Light, Accommodation,
SIGHT, Fairly good -
HEARING, Seems good.
COORDINATION, Arms, Paralysis of right side
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred, Very thick.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arthritis- No atheroma
HEART, No murmurs. Sounds normal. Regular.
LUNGS, Chest symmetry good Breath sounds normal.
GYNÆCOLOGICAL EXAM., Uterus somewhat atrophied & somewhat lacerated rectocele - laceration of perineum - / extension hemorrhoids.
MENSTRUATION, Menopause passed 5 yrs.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

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

CRANIAL MEASUREMENTS,
HISTORICAL, 6 Yrs. ago had stroke Paralysis & right side remained partly paralyzed. Previous to this had series of convulsions & left side has had slight convulsions since.
LENGTH OF INVASION, Long - several years ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Mary A Silsbe.

This patient was brought here by R. Maxfield attended by husband, Newton Silsbe, in poor physical condition with the following history: No history of consanguinity; Disease first manifested by paralytic stroke in 1894. Appears increasing: Is variable with rational intervals: Derangement manifested in thinking at times that part of the house has been sold & moved away - Cannot at times recognize her husband: No disposition to injure others; is not suicidal, filthy or destructive: No previous peculiarities shown: No history of intemperance in parents or self. No severe disease or head injury - except 2 strokes of paralysis: Has not been confined or restrained: has taken Strychnia & morphia: ———————
On personal examination - shown a condition of partial paralysis. Commitment recommended patient requiring constant attendance to guard her from accident & injury owing to her helplessness. On admission put upon B & M. (Gt. N. Ry.) Complexion fair: hair brown: Eyes blue: Condition of skin normal: No marks or scars noticed. Is clean: Right side paralyzed partially. Behavior quiet Is incoherent.

1897.
Jan. 27 Condensed Fourteen Day Record: Patient admitted Jan. 15-97. Temperature during first week showed slight rise, even the second week was occasionally above 100. This continued until the time of her death, which occurred Jan. 31 st. Upon admission was helpless from paralytic stroke & remained in bed all of the time: Speech was thick and it was very hard to understand her at all: She failed quite steadily during the last day or two, dying in coma: She lay rather noisily talking to herself the greater part of the time: Paralysis affected her throat & it was very hard for her to swallow and very difficult to make herself understood at all in talking.
Physicians Note: Patient was almost entirely paralyzed on her right side: was put to bed on admission and remained there until she died. (Original Record Preserved)

Nurses Note
Jan. 24. 6 a.m. T. 100. P. 80. R. 20.: 5 p.m. T. 98.7 P. 96. R. 20. Milk & gruel given: Tonic also given: Very noisy: slept one hour: Alcohol bath given.
Jan. 29 5 p.m. T. 101. P. 84. R. 22: Milk & gruel & also Tonic given: Slept well during night: Sponge bath given, back bathed with alcohol. Seems quite weak.
Jan. 30. 8 a.m. T. 100. P. 104. R. 46: Milk & Tonic given: very weak: Medicine given for diarrhoea: very stupid: Jan. 31: R. 50: Pulse very weak: Failing fast: Died 7:15.
Physicians Note:- Patient was almost entirely helpless: remained in bed during her entire time here: Speech was very thick so that it was quite difficult to understand her: Failed suddenly & died on Jan. 31st.

Died

Personal and Medical History of

Personal and Medical History of Mrs. P. N. Lilleskog

COBERT, TIDLOW & CHAMBERS, DAVENPORT, IOWA

Whole No. 4655	No. for Year, 188.
Residence, Cannon Falls, Minn.	Insane Relatives, Son died in Insane Asylum.
Date Admission, January 22 1897.	Cause Exciting, Don't Know.
Admitted by H. Stryker M.D. Hour, 6 to 1 PM.	Cause Predisposing,
How Sent, Axel Haller, Jos P. Goodhue.	Form, Chronic Dementia
Sex, Female.	Accompanying Bodily Disorder, None mentioned.
Age, - 57 -	Suicidal or Not, Not.
Civil Condition, - Married -	Date of this Attack, 7 or 8 yrs ago.
Children, - 3 -	Duration, 7 or 8 yrs.
Age Youngest Child, - Died at age 21 -	No. of Attack, 1st
Occupation, Housewife - (Husband Farmer)	No. of Admissions, 2nd
Degree Education, Common School.	Age First Attack, About 49.
Profession Religion, - None -	Time of Leaving,
Habits, Not intemperate.	Time in Hospital,
Nativity, - Sweden -	Result,
Physicians Committing, Jos. Anderson & F. W. Dunnet.	
Correspondents, Mrs L. O. Rapp. (daughter) Cannon Falls, Minn.	

EXAMINATION ON ADMISSION.

Exam by P. M. & L. Phelps. Jan 22/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Somewhat confused.

Quick or Sluggish,

MEMORY:

Past Events, Seems impaired

Recent Events, Quite "

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects, Impaired

GENERAL DESCRIPTIVE REMARKS: Answers at random. Incoherent & demented. Rather silly in manner. Very fleshy & strong physically.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Illusive ideas

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION: Dull -

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Mrs. P. N. Lilleskog

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7½ WEIGHT, 167 NUTRITION, Very good.

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size,

Response Light, Accommodation,

SIGHT, Slight Arcus senilis. Impaired uses glasses.

HEARING, Normal.

COORDINATION, Arms, Normal.

Legs,

TREMORS, Hands, None. Tongue, —

Facial Muscles, — General, None

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries - Normal.

HEART, No murmurs - Sounds normal Regular.

LUNGS, Normal.

GYNÆCOLOGICAL EXAM., Jan. 25 97 Uterus somewhat retroverted - Some hyperæmia of cervix & walls of vagina bleeds upon touch - External genitals excoriated.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

EXAM. URINE, June 7 '97

Color	Yellow
Character	Cloudy
Sp. gr.	1017
Reaction	Acidulous
Albumen	Trace by Tanrets.
Sugar	None -
Large Quantity Amor. urates oxalate of lime triple phosphates & few bladder cells.	

TAKEN,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Always well physically - In Insane Asylum in Minn. - some time ago. for 8 yrs.

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, Son died insane

Personal and Medical History of Mrs. P.N. Lillieskog.

This patient was brought here by Sheriffs deputy A.L. Lundquist, attended by Mrs. C. Lundquist, in fair physical condition with the following history:- No history of consanguinity. First symptoms manifested four 8 yrs. ago by irritablesome: disease appears stationary, is variable with no rational intervals: Ran away from home yesterday; Threatened injury to her Grandson. Is disposed to injure others: is not filthy or destructive: Nothing known as to previous peculiarities or intemperance in parents or rel.
No Sense disease or head injury. Patient has been confined in hospital at Brattleboro Vt. for 4 year + a half. Has received no other treatment. No further particulars noted on personal examination.
On admission put upon B.W. (C.H.N. Rpt. Complexion fair: hair brown partly gray: Eyes blue: Condition of skin normal: No marks scars or bruises noticed: Is very dirty; behavior quiet: does not speak English.)

1897 Feb. 4 Condensed Fountain Day Record:- Admitted Jan. 22.-97. Temperature during first week practically normal: Record shows that she ate regularly: In behavior she was a quiet case, apparently chronic in character & fitting in very well with the rest of the chronic patients on the ward: undoubtedly has been as she is now for a long time. Original Record Preserved

Feb. 25 Summary Nurse's Notes by Dr. D.L. Phelps: Has been receiving Gym. treatment every other day: troubled with incontinence at times: Helps with work occasionally: mental condition rather imbecile: Apr 97 Gen. Health good: does not work in laundry: very quiet & agreeable: neat: Speaks only when spoken to: appetite good: bowels regular: sleeps well: memory good: takes out door exercise: Transf. to annex.

May 7 Complained of head ache & pain bowels & fever several times during afternoon: T. 102. P. 114. R 28: Complained of pain in abdomen: face very flushed: put upon liquid diet: medicine given: May 9: T. 100 in a.m. 101 in p.m. Has diarhoea: Streaked with blood: Complains of pain: May 10 Slight hemorrhage from bowels: complained of pain in bowels: May 12 Seems much better: Slept better during night:

May 15. Has improved steadily since last note: Temp. normal: appetite improving: July 30 Appetite good: Habits clean: Gen. Health fair: Sleeps well: takes out door exercise.
Continued by Dr. D.M. Phelps. Oct 11. 97 Patient at annex: Is quiet & rather dull: Examination showed heart & lung signs to be fairly good. Feb 9. 98 Wt. 190 #.

Feb 15 99 General health good: Is drifting along in a quiet, dull demented way.

Mch 1- Aug 31. 99 Cont. by Dr. Bebb. General health & appetite good: Sleeps well. Takes out door exercise part of time: Is neat in habits & appearance & quiet in behavior: Never speaks except when spoken to Aug. 18. 196 # Sept 1- Feb 28. 1900 (Dr. Hyperdale) Neat: Quiet. Converses but little: Eats & sleeps well: Takes out door exercise. Mch 1- Aug 31. 1900 General health good. quiet & agreeable on ward: Does no work: July 30 Vaccinated: Takes out door exercise. Sept 1- Nov. 30 1900 Appetite good: Bowels regular:

Personal and Medical History of

Sleeps well: General health good: Does no work: Tidy in appearance: Does not speak English. Nov 24 Wt. 188 # Dec 1- Feb 28 1901 Appetite good: Bowels regular: Sleeps well: Attends no amusements: Takes no interest in work: Quite obstinate: At times does not converse: Habits clean: Mch 4 Wt. 185 # Mar 1- June 1- 1901 Does no work. No change in mental or physical condition. May 30 Wt. 173 #. June to Sept. Does no work, takes out door exercise. Sept. 3. Wt 180 #.

up to Feb. 1, 1903. General health good: appetite good: sleeps well: bowels regular: does no work: seldom takes exercise: habits and appearance neat: does not converse: is usually very quiet but is cross and disagreeable when disturbed by the other patients. Dec. 1st. Wt. 177 #.

Personal and Medical History of Johanna Tookey

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4659
Residence, Winona, Minn.
Date Admission, January 28' 1897.
Admitted by Dr. R.M. Phipps Hour, 6th P.M.
How Sent, H.L. Buck J.of P. Winona Co.
Sex, Female.
Age, - 32 -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, Housekeeper. (Father laborer)
Degree Education, Can read & write.
Profession Religion, Evangelical.
Habits, Not intemperate.
Nativity, Canada.
Physicians Committing, L.A. Kelly & Thos. A. Price.
Correspondents, August Tookey (Father) 516 E. 6th St. Winona, Minn.

No. for Year, 192.
Insane Relatives, None.
Cause Exciting, Not known
Cause Predisposing,
Form, Insel. Chron.
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Threatened - Propensity active.
Date of this Attack, Years ago
Duration, For years.
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. Phipps.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: 1/29/97.
Clear or Confused,
Quick or Sluggish, Very sluggish.
MEMORY:
Past Events, Impaired -
Recent Events, "
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Very dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Impaired -
Own Mental State,
Special Subjects, Impaired
GENERAL DESCRIPTIVE REMARKS: Patient was feeble-minded or as relatives say. since 14 has always been quiet & queer. Lately prominent delusions have appeared. Acts very reserved & queer - Rather unwilling to speak or do; at least is sluggish about talking or doing.

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

Personal and Medical History of Johanna Tookey

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. WEIGHT, 115 lbs. NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, None noted.
TONGUE, Tremors, Extreme tremor Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, Rather small.
Response Light, Normal Accommodation, Normal.
SIGHT, Normal
HEARING,
COORDINATION, Arms, Normal
Legs,
TREMORS, Hands, None. Tongue, None
Facial Muscles, General,
REFLEXES, Patellar, Normal
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Normal.
LUNGS, Stoop-shouldered - C. expansion poor
GYNÆCOLOGICAL EXAM., External genitals normal, hymen intact - Very close & firm - Uterus normal position & size
MENSTRUATION, Reg. Regular & free from pain - Estab at 15 yrs.
OPHTHALMOSCOPIC EXAM.,

TAKEN.

EXAM. URINE, Feb. 1' 97.
Color Yellow.
Character Cloudy with heavy ropy deposit.
Reaction Acid.
Sp. Gr. 1017
Albumen Trace by Tsuretts.
Sugar None.
Amt. 24 hrs. XLV ℥
Microscop. Amor. urates. Lge. amt. Bladder & Vaginal cells - a few fat globules & pus corpuscles.

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, ✓ She claims. Medium, Poor,
SLEEP, Good, ✓ Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Long - probably life long - ONSET GRADUAL OR SUDDEN, Gradual - inherited probably.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Dead "was healthy"
Father or Pat. Relations, - Came with her - pallid - appears -
Brothers or Sisters,

Personal and Medical History of Johanna Dockey.

This patient was brought here by Sheriff A.W. Fuhrmann attended by Emma Van Wald, in fair physical condition with the following history. No history of consanguinity. Patient never has been quite right, but has been worse since July last. Has acted queer wanting to be alone, to run away, of late has been vicious & threatened her life: Disease appears increasing: Not variable: No rational intervals. Derangement manifested by illusions & imagines children are troubling her; thinks she hears voices; cries quite a good deal. Is not disposed to injure others: Is filthy & destructive in habits: Previous peculiarities strong religious impressions: No history of intemperance in parents or self. No severe diseases or head injury; was a feeble child, easily frightened: Has been confined at home: has received no treatment. On personal examination is very nervous, staring eyes, twitching of muscles of eyes & face.

1897 Feb. 10. On admission was put on B' W(I.H. & Rpt. Complexion — hair & eyes brown, skin normal condition; no marks, scars or bruises, is clean; behavior quiet;) Condensed Fourteen Day Record:- Admitted Jan. 28-97: Temperature taken during first two weeks is normal throughout: Record shows her to have eaten regularly: no physical ailment of note is recorded: Patient a quiet chronic case, placed on B': Transferred the third day to C^2: Is rather Stupid & quite demented: Patient at times dirty in habits. Original Record Preserved

Mar. 4 Summary Nurse's Notes by Dr. S.S. Phelps:- Genl Health fairly good: very stupid: untidy in habit: answers some questions but otherwise does not talk: does no work:

Apr. 17 Fainted this morning, striking chin on door & cutting it badly: put to bed: Apr. 25 Has been steadily in bed since last note: Seems to be troubled with weak heart:

May 18 In bed: pulse very weak: heart stimulant given: May 22 Transf to Inf. May 30 Appetite good: pulse stronger: habits untidy: June: Seldom talks: quiet in behavior: Pulse rather weak: Is in bed: June 20 Visited by sister: July 30 menstr. regular: Aug 30: Sitting up part of each day: Very untidy: At times talks quite sensibly: seems brighter of late. Continued by Dr. S.S. Phelps. Nov. 29 97 Answers questions at times in a rational way, is rather feeble-minded Remains & quiet: Is slightly dull & melancholy.

Feb. 98 Wt. 178# June 4 Visited by relatives. Oct 3 Noted as being rather more stupid.

Febr '99. No essential change.

Mch 1- Aug 31 '99 Cont by Dr Bibb. Genral health fair: appetite usually poor: Bowels regular: Sleeps well: Takes outdoor exercise: usually clean in habits: Assists a little with work: Is usually quite agreeable: Occasionally inclined to be violent: Seldom speaks except in answer to questions, but talks quite sensibly.

Sept 1- Feb 28 1900 (Dr Heyerdale) Noisy & at times inclined to be violent: Appetite good: Menstruates regularly: Takes outdoor exercise: Depresses- Has many delusions about nurses & patients: Jan 18 Wt. 171# Feb 28 Commenced to assist with work.

Mch 1- Aug 31 1900 Neat in habits: Occasionally scolds sometimes sings to herself: Has

Personal and Medical History of

delusions: Is usually agreeable: Appetite good: Bowels regular: Sleeps well: Takes outdoor exercise: Menstruates regularly: Assists with ward work: Attends amusements & chapel: July 26. Vaccinated: Aug 29. Visited by friends Sept 1- Nov 30 1900 Appetite good: Bowels regular: Sleeps well: Menstruates regularly: Assists with ward work: Neat & clean: Usually quiet ~~but~~ seldom talks tho she does so very pleasantly at times: Nov 16 Wt. 121# Dec 1- Feb 28 no change General health good. Mch 1 Wt. 118#. Mar. 1 June 1-1901 Menstruates: Assists with work on ward. No change in mental or physical condition. May 29 Wt. 117 1/2#. June to Sept. Assists with ward work, takes out door exercise, attends amusements, menstruates, Sept. 2 Wt. 116#.

Sept. to Dec. Nov. 27 Wt. 120#. no change.

Sept to Feb 1, 1903. General health good: sleeps well: bowels regular: takes exercise: assists with the work: menstruates regularly: neat in habits and appearance: attends Chapel: exercises: As a rule does not converse but at times will answer questions intelligently Nov. 25 th. Wt. 114#.

Personal and Medical History of Edith Youngs.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. H661
Residence, Winona Co. Minn.
Date Admission, February 3rd 1897.
Admitted by S. B. Eby MD. Hour, 4.05 P.M.
How Sent, H. L. Buck. Jailer. Winona Co. Minn.
Sex, Female.
Age, 30.
Civil Condition, Married
Children, four.
Age Youngest Child, 4 mo.
Occupation, Housewife
Degree Education, District School.
Profession Religion, Methodist.
Habits, Not Intemperate.
Nativity, Minnesota (Parents Newyork.)
Physicians Committing, Chas. Robbins & D. A. Stewart.
Correspondents, Edw. Youngs Saratoga Winona Co. Minn.

No. for Year, 194.
Insane Relatives, None.
Cause Exciting, Puerperal Condition
Cause Predisposing, Not known.
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, About 5 mo. ago.
Duration, About 5 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 30
Time of Leaving, Aug 6. 1898
Time in Hospital, 1 yr. 6 m. 3d
Result, Discharged Feb. 8. 1899 Improved

EXAMINATION ON ADMISSION.

Exam by A. L. Phelps. 2/4/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Quite confused.
Quick or Sluggish,
MEMORY:
Past Events, Uncertain.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Quite illusive.
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State, "
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Worries a good deal. Talks in an incoherent manner. Very much confused. Many delusions.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Somewhat.
DELUSIONS: Many & varied.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Edith Youngs.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3½ in. WEIGHT, 135 lbs. NUTRITION, Impaired
WOUNDS OR ABNORMALITIES, Left clavicle has been broken so that left shoulder is higher than right.
TONGUE, Tremors, — Coatings, Quite heavy Yellow Promptness Movement, Quite heavy.
PUPILS, Equality, Equal. Size, dilated.
Response Light, Accommodation,
SIGHT, Impaired
HEARING, Good.
COORDINATION, Arms, Normal
Legs,
TREMORS, Hands, None Tongue,
Facial Muscles, General, None.
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Sounds are transmitted to right side
Irregular action.
LUNGS, Expansion poor. Sounds impaired
Rales in upper ½ of lung posteriorly.
GYNÆCOLOGICAL EXAM., Fig 8 gy Uterus normal position. Laceration of cervix large erosion of os. retrocele slight cystocele. Laceration of perineum.
MENSTRUATION, Usually regular. Last labor my back.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Feb. 5' 97.
Color. Yellow.
Character Cloudy.
Reaction Acid.
Sp. gr. 1020.
Albumen Trace by Heat & HNO³
Large quantity by Esbachs.
Sugar. Trace by Haines.
Amt. 24 hrs. XXX z.
Microscop. Amor. urates. Large amt. bladder & vaginal cells. Few fibrocysts & mucous bands.

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

CRANIAL MEASUREMENTS,
HISTORICAL, Fell down stairs before birth of last child & hurt head & back. Was troubled with head immediately afterward
LENGTH OF INVASION, Several months. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, One cousin nervous & had to go to hospital.
Father or Pat. Relations, Has always had asthma.
Brothers or Sisters, 4 brothers & 2 sisters. 1 brother insane & in hospital at one time.

Personal and Medical History of *Edith Youngs.*

This patient was brought here by Sheriff's deputy A.W. Fuhrmann accompanied by her husband Edward Youngs, in fair physical condition, with the following history: No history of consanguinity = 1st attack: first symptoms manifested about 5 months ago by delusions: Disease appears increasing: not variable with no rational intervals. Derangement manifested by fear of personal harm: sees objects that do not exist: Not disposed to injure others: Not suicidal: no filthy habits but destroys clothing: No previous peculiarities shown: No history of intemperance in parents or self: No severe disease but six years ago was struck upon head: Has not been confined or restraintd except by being watched at home: Has been treated at home by Drs Scott & Clark; no effect. On personal examination despondent, incoherent, restless & full of delusions. ——— ———
On admission put on Br (G.H.N. Rpt. Complexion dark; hair brown; eyes gray: Condition of skin normal: No marks, scars, or bruises noted: Is clean, rather excited; has delusions.)

16-97
Feb. 16. Condensed Daytica Day Record:- Admitted Dec 3-'97. Temperature taken during first week normal: Has eaten every meal & in general is in fairly good physical condition: Patient very noisy and incoherent in talk: Nervous in manner during the first day: Had been nursing child & breasts needed attention: Was rather noisy during the night & slept but an hour or two: Quite noisy & excited during the day: Her restlessness is of an agitated type, rather melancholy in character: Has very many delusions: During the remainder of the two weeks patient continued in about this state: Out of bed a good deal during the night & restless, noisy & talkative & occasionally quite excited: Talks to herself as well as to others. Original Record Preserved

Feb 22 Summary Nurse's Notes by Dr. S.D. Phelps:- Gyn. treatments given every other day: Very nervous & walks the floor most of the time: worries a good deal: Has many delusions: talks incoherently: takes tonic: Appetite fair: Mar. 30 Gyn. treatments continued: Does no work: careless about personal appearance: June Very disagreeable: makes disturbance when taken out of doors: fights every night when put to bed: menstr. regular: refuses medicine: July 17-18-26 Violent: fought nurses: quite noisy: requires undressing when put to bed: usually fights at this time: Aug 25 Still fights at bed time: usually more quiet during day: Gen'l health seems good. Continued by Dr. R.M. Phelps. Nov 16 '97 Rather restless & troublesome & resistive, especially when being put to bed. Talks in a rambling incoherent manner. Feb 9-'98 Wt. 129# Aug 6 '98 Is about the same altho has improved somewhat during the past year. Was taken home on trial today

Discharged.

Personal and Medical History of

Personal and Medical History of Francis Rauenhorst. (or Rounshorst)

EGBERT, FISCAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4662
Residence, Barber Township, Minn.
Date Admission, February 4th 1897.
Admitted by R. M. Phelps, M.D. Hour, 6th P.M.
How Sent, J. F. Minship, J. of P. Faribault Co.
Sex, Female -
Age, - 21 yrs -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, House work (Father farmer)
Degree Education, Common branches -
Profession Religion, Catholic -
Habits, Not intemperate
Nativity, Minnesota (Parents Germany)
Physicians Committing, A. J. Franklin & D. N. Hunt.
Correspondents, Theodore Rounshat. Easton Minn

No. for Year, 195
Insane Relatives, Aunt on mother's side.
Cause Exciting, Not Known.
Cause Predisposing, Heredity ?
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Talks about it: Has attempted
Date of this Attack, Dec. 1st 1896.
Duration, 2 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 21
Time of Leaving, Sept. 23. 1897
Time in Hospital, 7 mo. 19 da.
Result, Discharged Feb. 9. 1898
Much improved

EXAMINATION ON ADMISSION.

Exam. by D. Linton Phelps 2/5/97 — MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Very much confused.
Quick or Sluggish,
MEMORY:
Past Events, Much impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Very dull.
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Much impaired
Own Mental State, "
Special Subjects, "
GENERAL DESCRIPTIVE REMARKS: Mind seems void - Very sluggish & dull - Does not seem to realize her condition. Talks in a very incoherent & senseless manner. At times resists the nurses a good deal. Answers questions at random. Can not depend upon her statements. Physical condition seems fair quite fleshy.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS: Many & varied
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,
no reasoning power.

Personal and Medical History of Francis Rauenhorst.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 in. WEIGHT, 130 lbs. NUTRITION, Good
WOUNDS OR ABNORMALITIES, None. Condition of skin Normal.
TONGUE, ~~Tremors~~, Lips dry & cracked Coatings, Promptness Movement, Normal
PUPILS, Equality, Equal Size, Normal.
Response Light, Normal Accommodation, Normal.
SIGHT, Good.
HEARING,
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None. Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, Both normal
Other
ARTICULATION,
Slurred, Very slow.
Hesitating, ✓
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds normal - Regular
LUNGS, C. Normal but stooped Expansion fair - Breath sounds fairly good
GYNÆCOLOGICAL EXAM., Feb 8 '97 - Uterus retroverted & bound down toward left side - External genitals normal
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Feb. 6 '97
Color Yellowish red.
Character Ropy deposit.
Reaction Acid.
Sp. gr. 1022
Albumen None
Sugar None.
Amt. 24 hrs. XL Z
Microscop. Amor. urates - a few pus corpuscles. mucous bands & a few bladder cells.

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

CRANIAL MEASUREMENTS,
HISTORICAL, Cannot depend upon her statements.
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,

This patient was brought here by Sandy McDonald, Sheriff, attend by her mother; in fair physical condition with the following history:- No history of consanguinity: First attack: First symptoms manifested Dec. 1st 1896 by incoherent talk, & sleeplessness; is hard to control: Disease appears stationery; is variable with irregular rational intervals: Derangement now manifested by talking about things that happened long ago & imaginary things: Talks most of the time. Not disposed to injure others except when angry: Talks of suicide but never attempted it: Is not filthy or destructive: Has always been dull, hard for her to learn; never talked much & seemed nervous. No history of intemperance in parents or self: No severe disease: Had a fall when one year old, was stunned but not otherwise injured: Has been watched to prevent her running away: Has been treated since this attack, without benefit. On personal examination wont answer questions: wont give her hand or show her tongue or allow a physical examination. On admission put on Br. ~~G.N. Rpt~~ Complexion dark: hair black: eyes brown: Condition of skin normal: No marks, scars or bruises noticed: Is clean: behavior quiet: has delusions.

1897. Feb. 18. Condensed Fourteen Day Record:- Admitted Feb. 4. '97. Temperature taken only once but is practically normal: Appetite Good: medicine refused: Behavior at times quiet but at times also very stubborn & is somewhat deluded. In this quite stubborn, dull & half demented way she continued during the two weeks. Original Records Preserved

Mar. 1 Summary Nurse's Notes by Dr. S.C. Reeps:- Refuses medicine: silly in behavior: Quiet: takes out door exercise: sleeps well: Mar 25 Very quiet & agreeable on ward: bowels regular: appetite fair: physical health good: June 5 Very disagreeable on ward at times: takes out door exercise: appetite good: works on ward a little:

Aug. Sept 23 Quiet & agreeable: works in employes dining room: no change otherwise. Sept. 23 Went Home: Very quiet & agreeable: talked sensibly: gen'l health was good.

Discharged

Personal and Medical History of Madge Eisner

Whole No. 4668	No. for Year, 201
Residence, West St. Paul, Minn.	Insane Relatives, None known of.
Date Admission, February 9' 1897.	Cause Exciting, Do not Know.
Admitted by Dr. R.M. Phelps Hour, 7 PM.	Cause Predisposing, Previous attack.
How Sent, Thomas P. Moran J. of P. Dakota Co.	Form, Manic Dep.
Sex, Female.	Accompanying Bodily Disorder, None mentioned
Age, 28.	Suicidal or Not, yes. tried to hang herself. Talked of it last week.
Civil Condition, married.	Date of this Attack, —
Children, Two	Duration, 1st attack in June 1895
Age Youngest Child, one year old.	No. of Attack, 2nd
Occupation, Housewife. (Husband Laborer)	No. of Admissions, 1st
Degree Education, none.	Age First Attack, 26.
Profession Religion, yes catholic	Time of Leaving,
Habits, Not intemperate	Time in Hospital,
Nativity, Germany.	Result,
Physicians Committing, A.M. Adsit + A Van Beeck.	
Correspondents, Jos. Eisner, #653 Smyser Ave., West St. Paul, Minn.	

EXAMINATION ON ADMISSION.

Exam. by R.M. + D.L. Phelps 2/9/97 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:	EMOTIONAL STATE:
Clear or Confused, Confused	Normal, Calm,
Quick or Sluggish, Sluggish	Indifferent,
MEMORY:	Exalted,
Past Events, Impaired	Depressed,
Recent Events, "	DELUSIONS: Has many
Special Subjects,	Systematized or Not,
PERCEPTIVITY:	Special Subjects,
Alert or Dull, Quite bright appearing but has many	Transitory or Not,
Correct or Illusive, delusive ideas.	HALLUCINATIONS:
REASONING POWER:	ILLUSIONS:
Ordinary Subjects,	CONVERSATION:
Own Mental State,	Coherent or Incoherent,
Special Subjects, Impaired	Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Talks very willingly in a rather confused way about her condition: Seems to realize that she is not right. Says she has had a peculiar feeling in her head for 6 yrs. General physical condition is fairly good.

Personal and Medical History of Madge Eisner

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, — WEIGHT, — NUTRITION, Somewhat Impaired.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, White coat Promptness Movement, Sluggish.

PUPILS, Equality, Equal. Size, Normal.

Response Light, Sluggish Accommodation, Sluggish

SIGHT, Normal.

HEARING, Normal.

COORDINATION, Arms, Normal

Legs,

TREMORS, Hands, None. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal.

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries normal.

HEART, No murmurs. Regular

Chest type. normal. expansion normal

LUNGS, Breath sounds normal

TAKEN,

EXAM. URINE, Feb. 12' 97.

Color. Brownish red.

Character Flaky deposit.

Reaction Acid

Sp. gr. 1035

Albumen Trace by Tanrets

Sugar Trace by Haines + Bismuth

Amt. 24 hrs. —

Microscop. Amor. urates - a few bladder cells + mucin bands

GYNÆCOLOGICAL EXAM., Feb 12/97. Uterus normal position - Some endometritis - laceration perineum

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has been sick a good deal the past 6 years. Thinks not quite right in Germany before she came here.

LENGTH OF INVASION, Long. 6 yrs. ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, dead.

Father or Pat. Relations, dead - died dropsy

Brothers or Sisters,

Personal and Medical History of Madge Eisner

This patient was brought here by Sheriff Hoyland, attended by her husband, in fair physical condition, with the following history:- No history of consanguinity: First attack in June 1895 (Fasted 4 months) She thought she heard voices: Disease appears increasing: is variable with irregular rational intervals: Derangement now manifested by uncertain identity of persons & by hearing voices: Patient has attempted to injure her husband: Has attempted suicide by hanging: Is filthy & destructive: No previous peculiarities, severe disease or injury to head: No history of intemperance in parents or self obtainable: Patient has not been confined or restrained: Has received no treatment: On personal examination Ideas vague, is excitable; imagines she hears voices & answers them: Suffers from insomnia & poor appetite. ——— On Admission put upon B.T.W. (Ht. & Wt.) Complexion dark: hair brown: Eyes blue: Condition of skin normal: No marks, scars but bruises noted on arms: Is rather dirty: very excited & incoherent: fought when being taken to ward

1897 Feb. 22 Condensed Fourteen Day Record: Admitted Feb. 9. '97. Temperature taken first two days normal: Appetite is shown & is very good but patient is rather irregular in behavior and has refused medicine: At times somewhat excited: Had been nursing child at the time of Admission and medicine was prescribed: Has told is somewhat incoherent: very little in English: At times Quite excited: Slept rather better during the second week but otherwise is about the same.

Original Records Preserved.

Mar. 30 Summary Nurses Notes by Dr. S. E. Sheps: Gym. treatments given steadily every other day since admission: extremely noisy the greater part of the time: quite violent at times: fights a good deal: Does no work: Has many delusions: Apr. '97 Gym. treatments continued: May Still very noisy: Has delusions: works some in dining-room: appetite good: June 97 Noisy & quarrelsome: fought nurses: works occasionally: usually quite excited & scolds a good deal: July: No change: Aug 31: Has become quiet & is more agreable: sleeps well: works in dining-room. Continued by Dr. B. M. Sheps

Nov 1898 At times very noisy: Has delusions & is occasionally inclined to be violent:
Feb 1899 Wt. 124#. Aug 17 Assists with work on ward. Goes out walking: Behaves fairly well. Feb 1899 Still rather incoherent: At times violent but on the whole fairly quiet & good. Mch 1 - Aug 31 '99 Cont. by Dr. Bebb. Physical condition quite good: Appetite good: usually sleeps Well: Takes out door exercise: Assists some with work on ward: Is very noisy at times & inclined to be violent. Sept 1 - Feb 28 1900. (Dr. Heyerdale) Noisy at times & inclined to be violent: Appetite good: Menstruates regularly: Takes out door exercise: Refuses medicines Wt. 110#. Mch 1 - Aug 31 1900. (Dr. Linton) Very noisy at times: Talks incoherently

Personal and Medical History of

Has many delusions: usually sleeps well. Appetite good: Bowels regular: Menstruates regularly: Sometimes refuses meals: Goes walking & riding: Assists in dining room: July 16 Vaccinated.

Sept 1 - Nov. 30 1900. Has delusions & at times refuses to eat: Usually sleeps well: Bowels usually regular: menstruates regularly: Goes riding & walking: Somewhat noisy most of time: Talks a great deal to herself: Is at times violent: Nov 17. Wt. 125#. Dec 1 - Feb 28 1901 General health good: violent & resistive at times & has to be held about ½ hour. Expresses delusions freely, one being that children are here: Wt 129#

Mar. 1 June 1 - 1901. Assists with work on ward no change. During April patient was broken out with a rash which at first had some appearance of chicken pox was kept in seclusion until rash disappeared. May 29 Wt. 121#

June to Sept. Menstruates, does a little work, Sept. 22 Wt. 124#.

Sept. to Dec. mental condition unchanged. Nov. 23 Wt. 130#.

Up to Feb 1, 1903 General health good: sleeps well as a rule: appetite good: bowels regular: menstruates regularly: takes exercise: is very noisy most of the time: sometimes violent: attacks the nurses and patients: is destructive at times of furniture. Nov. 28th. Wt. 120#.

Personal and Medical History of Mary Holst.

LUDDEN, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4694

Residence, Plainview Minn.

Date Admission, February 10th 1897.

Admitted by Dr. R. M. Phelps, Hour, 3 P.M.

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

Sex, Female.

Age, 33.

Civil Condition, Married

Children, - 5 -

Age Youngest Child, one year.

Occupation, Housewife.

Degree Education, Common school.

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Germany.

Physicians Committing, W. S. Tufft + J. P. Waste M.D.

Correspondents,

No. for Year, 205

Insane Relatives, None.

Cause Exciting, Over taxation of vitality.

Cause Predisposing, Previous attack.

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, Feb. 8th 1897.

Duration, 2 days.

No. of Attack, 2nd

No. of Admissions, 2nd

Age First Attack, 28 yrs.

Time of Leaving, March 23. 1897

Time in Hospital, 1 mo 13 da

Result, Discharged Aug. 11. 1897. Improved.

EXAMINATION ON ADMISSION.

Exam. by Dr. R. L. Phelps 2/11/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Quite clear.

Quick or Sluggish, Quick

MEMORY:

Past Events, Fairly good.

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Fairly correct.

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State, "

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient very quiet + pleasant - Talks sensibly + willingly Complains of a good deal of headache + realizes she was brought here because she was sick - No delusions manifested in her conversation.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS: None determined

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Mary Holst.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5½ in. WEIGHT, 133½ lbs. NUTRITION, Fairly good.

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Coatings, Promptness Movement, Somewhat sluggish

PUPILS, Equality, Equal. Size, Normal.

Response Light, Normal. Accommodation, Normal.

SIGHT, Good

HEARING, "

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None. Tongue, None

Facial Muscles, " General, "

REFLEXES, Patellar, 4 to 5

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries - normal.

HEART, No murmurs - Sounds normal Apex beat normal position Regular.

Chest sym. normal. Expansion impaired

LUNGS, Sounds rather shallow.

Shoulders somewhat stooped.

TAKEN,

EXAM. URINE, Feb. 26' 97.

Color. Yellow Red.

Character. Cloudy with heavy flaky deposit

Reaction Acid.

Sp. gr. 1026

Albumen Trace by Tanrets

Sugar None.

Amt. in hrs. L. Z.

Microscop. Amon urates large quantity a few vaginal + bladder cells.

GYNÆCOLOGICAL EXAM., Feb 15' 97 Uterus normal position - Extensive laceration of cervix - erosion of os. Endometritis + Hypertrophy of cavity. Length of cavity 3½ in. - Laceration of perineum.

MENSTRUATION, Somewhat irregular but no pain.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Headaches a good deal of time. Vertigo at times; Almost always when she stoops

LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN, Gradual

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

Mother or Mat. Relations, living - has trouble with legs + feet.

Father or Pat. Relations, dead - Sick 7 yrs.

Brothers or Sisters, Both Ill. 1 sister dead.

Personal and Medical History of Mary Holst.

This patient was brought here by Sheriffs deputy L. Underwood attended by husband & G. Drews, in fair physical condition, with the following history:- No history of consanguinity, heredity or intemperance in parents or self. First attack occurred about 5 yrs. ago when she had violent paroxysms every 2 or 3 weeks: was confined in this (Rochester)[x] hospital from Dec 9. '92 to Jan. 6 '93. First symptoms of present attack manifested Feb. 8th 97 by violent blow on schoolteacher's face. Disease appears stationary: is variable with quite regular rational intervals of two or three weeks: Derangement manifested by an ungovernable temper: is disposed to injure others: has tried to destroy clothing by fire: Previous peculiarity an excitable temper: No severe disease or injury to head: Has been confined as stated above: has received no other treatment. On personal examination pulse intermittant. Five years ago, four days after confinement ran four miles in the snow. Note[x] for further particulars see Volume 21, Folio 189, No. 3201.

On admission put upon B[r] W.Q.H.N. Rpt. Complexion dark: hair light: eyes gray: condition of skin normal: No marks, scars or bruises noted: Is dirty: behavior quiet: talks sensibly.

1897 Feb. 18. Condensed Fourteen Day Record:- Admitted Feb. 10 '97: Patient was here once before and is about the same as at that time: Temperature is normal & bodily condition is very good: Was quiet & listless upon admission: A few days later, however, talked & lessly somewhat & was rather nervous & scolding: For the most part, however, she answers questions well & makes a fairly good appearance of intelligence both in behavior and talk: Is a chronic case & conditions do not change. Original Record Preserved

Feb. 23 Summary Nurse's Notes by Dr. L. L. Phelps:- Transf to Inf. Operation done: curettment: trachelorrhaphy, perineorrhaphy: took ether well: reaction good: May 13 Has been steadily in bed: made a good recovery: Improved much mentally: May 20. up & around the ward: takes out door exercise: works in dining-room. Has been very anxious to go home & husband came to-day & she Went Home much improved.

Discharged.

Personal and Medical History of

Personal and Medical History of Myrtle Z. Cole

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4682

Residence, Lyle, Minn.

Date Admission, Feb. 16' 1897.

Admitted by Dr. C. B. Eby Hour, 7.35 P.M.

How Sent, A. L. Washburn Jr. of P. Moore Co.

Sex, Female.

Age, 30.

Civil Condition, Divorced

Children, 1

Age Youngest Child, 5 yrs old.

Occupation, None. (Father farmer)

Degree Education, Common school.

Profession Religion, Methodist

Habits, Good.

Nativity, Iowa (Parents New-York)

Physicians Committing, A. W. Allen & L. H. Johnson

Correspondents, Father

No. for Year, 315

Insane Relatives, None. Father intemperate.

Cause Exciting, Not known.

Cause Predisposing, Previous attack

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, — —

Duration, — —

No. of Attack, 2nd

No. of Admissions, 2nd

Age First Attack, 28

Time of Leaving, May 29. 1897.

Time in Hospital, 3 mos. 15 da.

Result, Improved

EXAMINATION ON ADMISSION.

Exam. Feb. 16'97 by D. L. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Seems clear.

Quick or Sluggish,

MEMORY:

Past Events, Good

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Seems correct.

REASONING POWER:

Ordinary Subjects, Somewhat impaired

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, ✓ Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS: None.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS: None

ILLUSIONS: "

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Rather weak minded & childish in talk. Very talkative Does not think she is insane but says she cannot get along with her folks & will not stay at home. Is in very good physical condition.

April '98 In Probate Court.

Mrs. McConnell of Lyle, filed information of insanity against her daughter, Mrs. J. J. Harrison, formerly Mrs. Cole, in probate court yesterday. An examination was held and Mrs. Harrison discharged. A. W. Wright acted for Mrs. Harrison. Mrs. Harrison recently married J. J. Harrison, who was formerly married to Mrs. Topliff.

Medical History of Myrtle Z. Cole.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HABITUS, Spare in WEIGHT, 119 lbs. NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None Condition of skin Normal.

TONGUE, Tremors, Coatings, heavily coated Promptness Movement,

PUPILS, Equality, Equal Size, Normal

Response Light, Accommodation,

SIGHT, Somewhat impaired

HEARING, Good

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None. Tongue, None.

Facial Muscles, General,

REFLEXES, Patellar, Normal

Other

ARTICULATION, Normal

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Normal

HEART, No murmurs - sounds normal Regular

LUNGS, Normal

TAKEN,

EXAM. URINE, Feb. 18' 97.

Color Light yellow.

Character Cloudy, flaky deposit.

Reaction Acid.

Sp. gr. 1008

Albumen Trace by Esbachs.

Sugar None.

Amt. 24 hrs. —

Microsop. Amor. urates - a few bladder & vaginal cells & mucus bands.

GYNÆCOLOGICAL EXAM., 3/10/97 Uterus normal position, some laceration perineum, slight rectocele.

MENSTRUATION, regular.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Spinal meningitis when 6 yrs old. Was rather maniacal when here before.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual

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

Mother or Mat. Relations, Not well. Very Nervous

Father or Pat. Relations, Drinks Constantly

Brothers or Sisters,

Personal and Medical History of Myrtle Z. Cole

HERBERT, PUCKAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4682

Residence, Lyle, Minn.

Date Admission, Feb. 16' 1897.

Admitted by Dr. C. B. Eby Hour, 7 35 P.m.

How Sent, A. L. Washburn Jof. P. Mower Co.

Sex, Female.

Age, 30.

Civil Condition, Divorced

Children, 1

Age Youngest Child, 5 yrs old.

Occupation, None. (Father farmer)

Degree Education, Common school.

Profession Religion, Methodist

Habits, Good.

Nativity, Iowa (Parents New York)

Physicians Committing, A. W. Allen & C. H. Johnson

Correspondents, Father

No. for Year, 315

Insane Relatives, None. Father intemperate.

Cause Exciting, Not known.

Cause Predisposing, Previous attack

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, — —

Duration, — —

No. of Attack, 2nd

No. of Admissions, 2nd

Age First Attack, 28

Time of Leaving, May 29. 1897.

Time in Hospital, 3 mo. 13 da.

Result, Improved

EXAMINATION ON ADMISSION.

Exam. Feb. 16'97 by D. L. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Seems clear.

Quick or Sluggish,

MEMORY:

Past Events, Good

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Seems correct.

REASONING POWER:

Ordinary Subjects, Somewhat impaired

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, None.

Special Subjects,

Transitory or Not,

HALLUCINATIONS: None

ILLUSIONS: "

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Rather weak minded & childish in talk. Very talkative. Does not think she is insane but says she cannot get along with her folks & will not stay at home. Is in very good physical condition.

Chas. ... sor of ... mary. ... e pres- ... body. ... nce to ... ch, of ... con on ... ere as ... duraed

Sioux City, Iowa, ... $2.75@3.80; cows, $2.50; heifers ... $3.65@4.05; stockers, ... $4.75@4.95. Sheep, 3.50

ENGLAND GETS WE...

Arrangements Made ... London, proval of Jap... cially announced that G... has made arrangements

Personal and Medical History of Myrtle Z. Cole.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 4 in WEIGHT, 119 lbs. NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None Condition of skin Normal.

TONGUE, Tremors, Coatings, Heavily coated Promptness Movement,

PUPILS, Equality, Equal Size, Normal

Response Light, Accommodation,

SIGHT, Somewhat impaired

HEARING, Good

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None. Tongue, None.

Facial Muscles, General,

REFLEXES, Patellar, Normal

Other

ARTICULATION, Normal

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Normal

HEART, No murmurs - sounds normal

Regular

LUNGS, Normal

TAKEN,

EXAM. URINE, Feb. 18' 97.

Color Light yellow.

Character Cloudy, flaky deposit.

Reaction Acid.

Sp. gr. 1008

Albumen Trace by Tanrets.

Sugar None.

Amt. 24 hrs. —

Microscop. Amor. urates - a few bladder & vaginal cells & mucus bands.

GYNÆCOLOGICAL EXAM., 3/10/97 Uterus normal position, some laceration perineum, slight rectocele.

MENSTRUATION, regular.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Spinal meningitis when 6 yrs old. Was rather maniacal when here before.

LENGTH OF INVASION, 0 ONSET GRADUAL OR SUDDEN, Gradual

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

Mother or Mat. Relations, Not well - very nervous

Father or Pat. Relations, drinks constantly

Brothers or Sisters,

Personal and Medical History of Myrtle Z. Cole.

This patient was brought here by Sheriff's deputy J. W. Galt attended by Mrs Galt in fair physical condition, with the following history:- No history of consanguinity: First attack in Aug. 1895 Patient was confined in this (Rochester) hospital from Aug 17 '95 to Dcember 25 '95. (Vol. 28 - Fol. 337) & was discharged in May '96 improved First symptoms of present attack manifested by wandering away from home half clad: Disease appears stationary: Variable with rational intervals Has illusions - speculative fits - lack of good judgment etc: Thinks parents are persecuting her: Is not disposed to injure others: Is not filthy or destructive: No previous peculiarities noted: Father intemperate: No severe disease or injury to head: Confined as above stated, at Rochester Hospital:

On personal examination has delusion ideas on many subjects. ——— ———

On admission put upon D' W. (Gilt Rpt Complexion fair: hair light: eyes blue: Skin normal: No marks or scars noticed: Is clean: behavior quiet.)

1897 Mar. 2. Condensed Fourteen Day Record:- Admitted here Feb. 16,-'97 for the second time: Physical condition good in every way: During the first time she had an attack of mild mania from which she slowly recovered, settling down into a condition which, although not a good recovery, was right of fair appearance with a mild feebleminedness or demented: In that condition she seems to have been ever since, but lately has manifested some tendencies toward irregularities in behavior, which have sent her here again: She remained the same in every way during the two weeks: Seemed to be fairly sane in appearance, but did some silly things & shows a tendency toward great feebleness of judgment & of general mental state. Original Record Returned

Mar. 3 Summary Nurse's Notes by Dr. S. L. Phelps: Fell & hurt her back: put to bed: ointment applied: Has a good appetite & sleeps well: May 19. Remained in bed a few days after last note: Found to be no serious injury: At times seems quite simple in appearance & behavior: usually talks quite sensibly: works some on ward & also for herself. May 29 Went Home with father.

Discharged.

Personal and Medical History of

Personal and Medical History of Elizabeth A. Barker.

FOSTER, FICLAS & GRAMMER, DAVENPORT, IOWA

Whole No. 4684	No. for Year, 217.
Residence, St. Paul, Minn.	Insane Relatives, Unknown.
Date Admission, February 18th 1897.	Cause Exciting, Can't know - ascribes it to a nervous attack
Admitted by Dr. H. H. Herzog Hour, 6th P.M.	Cause Predisposing, Unknown.
How Sent, J. Willrich J.P. Ramsey Co.	Form,
Sex, - Female -	Accompanying Bodily Disorder, None mentioned.
Age, - 38 -	Suicidal or Not, Has threatened suicide
Civil Condition, - married -	Date of this Attack, Some weeks ago.
Children, - None -	Duration, -
Age Youngest Child, -	No. of Attack, 1st
Occupation, Housewife (Husband works on Dispatch)	No. of Admissions, 1st time was at St. Luke's H. St Paul.
Degree Education, Fair.	Age First Attack, 38
Profession Religion, Yes Episcopal.	Time of Leaving, Apr. 25th, 1897.
Habits, Not intemperate.	Time in Hospital, 2 mos. 7 da.
Nativity, Illinois.	Result, Discharged Aug. 11. 1897 Improved
Physicians Committing, Arthur Swasey + C.E. Riggs	
Correspondents, J. W. Barker (Husband) % St. Paul Dispatch. St. Paul, Minn.	

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by A.M. + H. Phelps 2/18/97.

MENTAL ACTIVITY:	EMOTIONAL STATE:
Clear or Confused, Seems clear.	Normal, Calm, Normal -
Quick or Sluggish, Quick.	Indifferent,
MEMORY:	Exalted,
Past Events, Seems normal.	Depressed, at times.
Recent Events, "	DELUSIONS: None determined upon
Special Subjects,	Systematized or Not, Examination but is said
PERCEPTIVITY:	Special Subjects, to have delusions of persecution
Alert or Dull, Alert	Transitory or Not,
Correct or Illusive, Seems correct	HALLUCINATIONS:
REASONING POWER:	ILLUSIONS:
Ordinary Subjects, Impaired.	CONVERSATION:
Own Mental State, Seems "	Coherent or Incoherent,
Special Subjects,	Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient intelligent + quiet. Ladylike + rational in appearance. Not seen especially nervous about things. Laughs about the various incidents but does not worry much. Dates the trouble back to a "shock". This is private + she dont like to talk about it. She + her husband differed about it + she could not make him see things in her way. Worried some but dont think was melancholy.
Has chronic stomach trouble, not such as to affect her general health.

St. Paul Dispatch.
BUSINESS MANAGER'S ROOM.

St Paul. Minn Febs. 20. 97

Robt M. Phelps M.D
Rochester. Minn

Rec'd

Attack & Twitching

My dear Sir:

In the confusion and excitement of the moment, I neglected to tell you anything about Mrs Barker and I do not know that I will be able to convey my observations any better today than I could have that evening. These disturbing spells that my wife has, come many where from 7 to 10 days apart and the early indication of trouble makes its appearance by pains behind the ears, particularly the right and back of head and in the front - the scalp has a prickling sensation - there is a thickening of speech and the loss of a word to round of the sentance, & in her head moments if she has any she is conscious of this, poor child would probably tell you of it - if you can gain her confidence - There always seems to be under a current of that when she seems brightest and happiest - If she is withholding anything

Pain good.

NE, Mar. 20 '97.

urates. a few
ge and bladder
mm.

SLEEP, Good, until recently Poor, last night, disturbed by vomit Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Scarlatina - Has recently had mild headaches beginning at back of neck.

LENGTH OF INVASION, 1 to 2 months ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, Healthy

Father or Pat. Relations, D. abt age

Brothers or Sisters, Healthy

Degr… was at St. Luke's H. St Paul.

Profession

Habits,

Nativity,

Physicians Committing,

Correspondents, J. W.

Dispatch, St. Paul

Apr. 25th. 1877.

2 mo. 7 da.

Discharged Aug. 11. 1877

Improved

…N ON ADMISSION.

Exam. by Drs + St. Phelps 7/18/77.

…CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Seems clear.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Seems normal.

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Seems correct

REASONING POWER:

Ordinary Subjects, Unpaired.

Own Mental State, Seems "

Special Subjects,

EMOTIONAL STATE:

Normal, Calm, Normal -

Indifferent,

Exalted,

Depressed, at times.

DELUSIONS: None determined upon

Systematized or Not, examination but is said

Special Subjects, to have delusions of persecution

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient intelligent + quiet. Ladylike + rational in appearance. Not very especially nervous about things. Laughs about the various incidents but does not worry much. Dates the trouble back to a "shock". This is private + she dont like to tell about it. She + her husband differed about it + she could not make him see things in her way. married some but dont think was melancholy.

Has chronic stomach trouble, not such as to affect her general health.

Paul Dispatch.

BUSINESS MANAGER'S ROOM.

She will probably carry it to her grave as she seems to have wonderful faculty of control. She has often said to me there was a something that compelled her not to talk, that completely tied up her tongue.

These pains, I have spoken of, come on about 5 days before that, & are cerebral that pass over the brain and that keeps her in a most disturbed condition until by some means she is soothed into a good humor and which leaves her thoroughly ashamed like one who has suffered from a violent attack of bad temper. When in this [illegible] condition she is determined, resentful and does not seem to care what occurs, threatens all manner of things. She will refuse food thinking it is adulterated with some drug to control her mind (it generally appears in the Coffee or tea) so as to bring her under subjection to others influence and her very best friends become the agents of those who wish her harm; she will form dislikes for people on very trivial things, for instance, for instance, and if reference to her health or if any one refers to their own, that is sufficient to make her think, that this party is an agent of the enemy

SLEEP, Good, until recently Poor, last night, disturbed by voices Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Cachexia - Has recently had mild headaches beginning at back of neck.

LENGTH OF INVASION, 1½ 2 months ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, Healthy

Father or Pat. Relations, D. old age

Brothers or Sisters, Healthy

…NE, Mar. 20 '97.

…Pain good.

…urates. a few …ge and bladder …mm.

Dispatch. MANAGER'S ROOM.

reference to one of our City Hospitals, dress, and mail service will or dressing
return her - super sensitiveness is one
her greatest troubles - If you wish to
write me a list of questions, I will gladly
answer them, anything I can do to assist
her to regain her health I will -

I should like to hear regularly of
in accord with the rules of the Hospital
regarding her health -

Do you wish me,
to come over or would it be better for me
not to see her until you request it? I can &
write and place her name on mail
list of the paper (the latter she is liable
to object to) - have you listed her
clothing, if so, is there any thing I
can do to make her comfortable -

I know what the struggle is going
to be, the first time she shows any
indication of disturbance, she has
had always her own way, — but
I am in hope your methods and treatment
will bring her back soon to good health,
I feel you cannot give me any impression
of her mental health before at least 10 days
or two weeks - I left [your] a gold watch, hunting
Carl, at the Cook House Thursday evening, has
she received it - Sincerely - James W Barkin

Pain good.

NE, Mar. 20 '97.

urates. a few
ge and bladder
mm.

at St. Luke's H. St Paul.

Pr.
Habits,
Nativity,
Physicians Comm.
Correspondents, J. R.
Dispatch, St. Pa.

r. 25th. 1897.
ms. 7 da.
ssigned Aug. 11. 1897
mproved

ADMISSION.

Exam. by Rev + M. Phelps 7/8/97

ACTERISTICS.

MENTAL ACTIVITY:	EMOTIONAL STATE:
Clear or Confused, Seems clear.	Normal, Normal -
Quick or Sluggish, Quick.	Indifferent,
MEMORY:	Exalted,
Past Events, Seems normal.	Depressed, at times.
Recent Events, "	DELUSIONS: None determined upon
Special Subjects,	Systematized or Not, examination but is said
PERCEPTIVITY:	Special Subjects, to have delusions of persecution
Alert or Dull, Alert	Transitory or Not,
Correct or Illusive, Seems correct.	HALLUCINATIONS:
REASONING POWER:	ILLUSIONS:
Ordinary Subjects, Impaired.	CONVERSATION:
Own Mental State, Seems.	Coherent or Incoherent,
Special Subjects,	Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient intelligent & quiet. Ladylike & rational in appearance. Not
seem especially nervous about things. Laughs about the various incidents but does not worry much.
Dates the trouble back to a "shock". This is private &
differed about it & she could not make him
dont think was melancholy.
Has chronic stomach trouble, not such as to affect her general health.
see things in her way - worried some but

SLEEP, Good, until recently Poor, last night, disturbed by vomit Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Scarlatina - Has recently had mild headaches beginning at back of neck.

LENGTH OF INVASION, 1 to 2 months ONSET GRADUAL OR SUDDEN, Gradual.

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies severe nervousness
Mother or Mat. Relations, Healthy
Father or Pat. Relations, D. abt age
Brothers or Sisters, Healthy

ersonal and Medical History of Elizabeth C. Barker.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, —— WEIGHT, —— NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, None excepting perforation of drum of right ear. Pupils good.

TONGUE, Tremors, Pale Coatings, no especial coating Promptness Movement,

PUPILS, Equality, Equal. Size, Slightly dilated

Response Light, — Accommodation, —

SIGHT, Good - no glasses.

HEARING, Slight impairment in right ear.

COORDINATION, Arms, Good

Legs,

TREMORS, Hands, Steady Tongue, —

Facial Muscles, — General, —

REFLEXES, Patellar, Normal.

Other

ARTICULATION,

Slurred, Normal

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal

LUNGS, Normal.

EXAM. URINE, Mar. 20 '97.

Color Pale Yellow.
Character Clear
Reaction Acid.
Sp. Gr. 1020
Albumen None.
Sugar None
Microscop. Amor. urates. a few pus corpuscles. Large ant. bladder + vaginal epithelium.

TAKEN,

GYNÆCOLOGICAL EXAM., Normal condition.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, until recently	Poor, last night, disturbed by noise	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Scarlatina. Has recently had mild headaches beginning at back of neck.

LENGTH OF INVASION, 1½ or 2 months ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, Healthy

Father or Pat. Relations, D. old age

Brothers or Sisters, Healthy

+ St. Luke's H. St. Paul.

Pr

Habits,

Nativity,

Physicians Comm.

Correspondents, J. r

Dispatch, St. Pa

. 25th, 1897.

ns. 7 da.

ceipt Aug. 11. 1897

pproved

ADMISSION.

Exam. by Rtn + Al Phelps 7/18/97

STERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Seems clear.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Seems normal.

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Seems correct

REASONING POWER:

Ordinary Subjects, Impaired.

Own Mental State, Seems "

Special Subjects,

EMOTIONAL STATE:

Normal, Calm, Normal -

Indifferent,

Exalted,

Depressed, at times.

DELUSIONS: None determined upon examination but is said to have delusions of persecution

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient intelligent + quiet. Ladylike + rational in appearance. Not from especially nervous about things. Laughs about the various incidents but does not worry much. Dates the trouble back to a "shock". This is private + she dont like to talk about it. She + her husband differed about it + she could not make him see things in her way. worried some but dont think was melancholy.

Has chronic stomach trouble, not such as to affect her general health.

Personal and Medical History of Elizabeth C. Barker.

This patient was brought here by Sheriffs Deputy P. J. Nissen attended by Miss M. McGuinne, in fair physical condition, with the following history:- Nothing known as to consanguinity: First symptoms of attack manifested some weeks ago by delusions of persecution: Has been at St Lukes Hospital, St. Paul: no apparent benefit received: Disease seems increasing: Is variable: she is at times apparently rational: Derangement manifested by delusions of persecution: Has threatened to injure others: Is not filthy or destructive: No previous peculiarities shown. Nothing known as to intemperance in parents or self: No severe disease or injury to head: Has received treatment, nerve sedatins, etc.

On personal examination no further facts learned. On admission put upon A' W (Gen'l Rpt. Complexion dark: Hair partly gray & brown: Eyes brown: Condition of skin normal: No marks or scars noticed: is clean: behavior quiet, has delusions.)

1897
Mar. 3. Condensed Inactive Day Record: Admitted Feb. 18-'97. In appearance a healthy intelligent woman, quite sensible & indeed sane. During first two weeks nurses were unable to find any delusions as she has been quiet & well behaved: She is however, somewhat cautious in a sentence which indicates the presence of delusions, testified as yet, however, only by relatives & friends who have known her if before coming here. Original Record Reserved

Mar. 10 Summary Nurse's Notes by Dr. F. L. Phelps:- Has delusions: became quite excited & disagreable with room mate: Mar. 12 Unsettled. Mar. 14 At times quite nervous: Has delusions; although usually talks quite sensibly: appetite fair: usually sleeps well: bowels at times constipated: takes cathartics: goes riding & walking: Apr. 10 Very quiet: takes cathartics: Apr. 18 Quite cheerful: talks sensibly: anxious to go home: takes medicine for stomach: Apr. 25 Husband came & took her Home. Was very anxious to go. In physical condition was much improved: Mentally very agreeable & pleasant: Seemed to have dropped her delusions at that time.

Discharged.

Personal and Medical History of

Personal and Medical History of May Brooks

FORBES, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4685

Residence, St. Paul, Minn.

Date Admission, February 18 1897.

Admitted by Dr. R. M. Phelps. Hour, 6th P.M.

How Sent, G. Willrich, J. of P. Ramsey Co.

Sex, -Female-

Age, -20-

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, Factory girl -

Degree Education, Fair

Profession Religion, Catholic

Habits, Not intemperate.

Nativity, Minnesota.

Physicians Committing, J. Chase - J. A. Finnegg

Correspondents,

No. for Year, 218

Insane Relatives, None.

Cause Exciting, -

Cause Predisposing, Not known.

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, October 96

Duration, Since october -

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 20

Time of Leaving, Apl. 6th, 1897.

Time in Hospital, 1 mo. 16 ds.

Result, Discharged May 5. 1897 Not Insane.

EXAMINATION ON ADMISSION.

Exam. by Drs. Phelps. 2/19/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, Somewhat sluggish

MEMORY:

Past Events, Good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dull but

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Somewhat impaired.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects, } None.

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Mental state defective - somewhat feeble-minded. Ran away from home at Thanksgiving - Roomed with a young girl down-town - Lived a fast life - Was accused of extreme degree of sexual intercourse, falsely, by people she never met before. Admits the life but nothing worse than the other girls she was with. Denies any special sexual inclinations. Says she thinks her brother wanted to send her down here to avoid workhouse. Bites off finger nails & picks her face as that has sores in different places.

Personal and Medical History of May Brooks.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. 7 ins. WEIGHT, 100 NUTRITION, Fair - but pale - Skin - always pallid.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, no special coating Promptness Movement, fairly prompt

PUPILS, Equality, Equal. Size, Normal.

Response Light, yes. Accommodation,

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms, Normal

Legs,

TREMORS, Hands, Not special Tongue, -

Facial Muscles, - General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Good.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal.

LUNGS, Chest sym. good. slightly stooped - Expansion fair - Sounds normal

TAKEN.

EXAM. URINE, Feb 20 '97

Color. Yellow.

Character. Cloudy. ropy deposit.

Reaction Alkaline.

Sp. gr. 1016.

Albumen None.

Sugar None.

Amt. 24 hrs. L XIV ℥

Microscop. Amor. urates - Large quantity pus. + a few fat globules.

Bladder + vaginal cells

GYNÆCOLOGICAL EXAM., 2/19/97 Leg eruption around external genitals. Uterus retroverted + bound down on left side by a mass of adhesions. Pain in left ovarian region.

MENSTRUATION, Regular, usually - Last time flowed 1½ weeks.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Measles most severe disease - had it when 3 yrs old. Pain in side last 3 or 4 wks - Seemingly in left ovary.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Living - healthy

Father or Pat. Relations, Living - was insane 17 yrs ago in St. Peter. stay short. Fathers sister + brother insane in Iowa. Still alive but out of

Brothers or Sisters, Healthy.

This patient was brought here by P. J. Meisen, Sheriff's deputy, attended by Mrs. Sylvester, in fair physical condition, with the following history:- No history of consanguinity: heredity or intemperance in parents or self: This is first attack: First Symptoms manifested in October by an uncontrollable desire for coitus: Disease appears stationary: Nothing known concerning rational intervals: Derangement manifested by Nymphomania: Not disposed to injure others: Not filthy or destructive: No previous peculiarities: No severe disease or injury to head: Has not been confined or restrained: Has received no treatment. On personal examination no further information obtained: On admission put upon B'M. (G.S.H.U.Rpt. Complexion fair: Hair light: Eyes blue: No marks or scars noticed: Is clean: Behavior quiet: Talks sensibly.)

1897
Mar. 4. Condensed Fourteen Day Record: Admitted Feb. 18th. '97. Patient shown to be a fairly healthy appearing young girl, although slightly anaemic, & has local trouble needing gynaecological treatment: Patient during first two weeks complained only of Headache No delusions or evidences of incoherence appeared. Original Records on file.

Mar. 30 Summary Nurse's Notes by D. S. L. Phelps:- Very quiet & agreeable on ward: takes tonic three times a day: talks sensibly: Has no delusions: bowels regular: Gyn treatments given steadily every other day since admission: Apr. 6 Went Home Discharged.

Personal and Medical History of Gunild (or Gunnel) Grasdalen

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4686

Residence, Manchester, Minn.

Date Admission, February 20th 1897.

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

How Sent, G.W. Bank Ct. Conv. Freeborn Co.

Sex, Female.

Age, 32.

Civil Condition, Single

Children,

Age Youngest Child,

Occupation, Farmers daughter. (Father Farmer)

Degree Education, Alright.

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Freeborn Co. (Parents Norway)

Physicians Committing, P.A. Blackmer & G.W. Bank.

Correspondents,

No. for Year, 219.

Insane Relatives, None.

Cause Exciting, Epilepsy.

Cause Predisposing, Unknown.

Form,

Accompanying Bodily Disorder, Hysterics & Epilepsy

Suicidal or Not, Not.

Date of this Attack, within 14 yrs of age.

Duration, 18 yrs.

No. of Attack, 1st Continuous

No. of Admissions, 1st

Age First Attack, 14 yrs.

Time of Leaving, Sept. 17. 1897.

Time in Hospital, 6 mos. 28 da

Result, Died in an Epileptic Convulsion

EXAMINATION ON ADMISSION.

Exam. by A.H. Phelps 2/21/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Very confused & dull.

Quick or Sluggish,

MEMORY:

Past Events, Much impaired

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull, Very dull

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, } Much impaired.

Own Mental State, }

Special Subjects, }

GENERAL DESCRIPTIVE REMARKS: Struggles violently. at times requires 4 or 5 to manage her. Mental condition very dull & demented. Will not talk.

EMOTIONAL STATE:

Normal, Calm, Very much excited.

Indifferent,

Exalted,

Depressed,

DELUSIONS: Seems to have many.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Gunild Grasdalen.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in. WEIGHT, 125 lbs. NUTRITION, Impaired.

WOUNDS OR ABNORMALITIES, Condition of skin fairly good.

TONGUE, Tremors, Will not show Coatings, Coated Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, – Accommodation,

SIGHT, Seems good.

HEARING,

COORDINATION, Arms, Hysterics - tossing about - throwing arms & legs around.

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General, Gneral irregular movements.

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating, Hesitating.

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

EXAM. URINE, Feb 26 '97.

Color. Reddish yellow.

Character. Cloudy - Flaky deposit.

Reaction Very acid

Sp. Gr. 1027

Albumen. Trace by Heat & Nitric Large quantity by Tanrets.

Sugar. Trace by Haines & Bismuth

Microscop. Large amt. amor. urates & uric acid crystals. A few pus corpuscles & bladder epithelium.

GYNÆCOLOGICAL EXAM., 2/27/97 Uterus retroverted & bound down by adhesions, discharge, large cystic tumor of right labia majora. Otherwise normal

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Headaches - Has had Epilepsy since 14 years of age. Continuous but growing worse last few years.

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 Gunild Grasdalen.

Personal and Medical History of

This patient was brought here by Sheriff's deputy E. N. Ellickson attended by Mrs. C.E. Richardson, in fair physical condition, with the following history: No history of consanguinity, heredity or intemperance in parents or self: Ever since 14 yrs of age patient has been more or less affected: Disease appears increasing: Is variable: Patient is irrational in talk & actions Derangement manifested on no particular subject: Is at times disposed to injure others: Is filthy in habits: No previous peculiarities shown: Subject to epilepsy & to hysterics: Has been restrained by holding for a short time: Has not been confined, except at home: Has received treatment, with out benefit to her. On personal examination: "Looks insane." On admission put upon Ward (G.S.H. Pt) Complexion dark: hair & eyes brown: Condition of skin normal: No marks or scars noticed: Both legs arms bruised: Is very dirty: behavior very violent: Talks a little & is incoherent)

Mar. 6. Summary Nurse's 14 Day Record:- Patient was quite violent on admission: Had an apparent fainting spell while being bathed: Temperature taken during first week was normal: Was able to eat well three times a day during the two weeks which the record covers. Was, however, quite uniformly stupid and violent in the way of resisting while being dressed, undressed, or taken care of in other manner: Became rather more violent at the end of the first week and the last five days was kept in restraint. Original Record Preserved.

Apr. 1 Summary Nurse's Notes by Dr. L. L. Phelps:- Appetite good: bowels regular: Quite violent: In seclusion all of time: Apr. 9 Had a hard fit this morning: Apr. 11 & 12 Had hard fits. Apr. 15 Has had fit: fell & bruised head: June 17 Habits dirty: resists a good but not often violent of late: Quite emaciated: Has fits often: Often falls & bruises face: mental condition very poor: July 13 Was struck by another patient on forehead: slightly bruised. July 16 Had a number of very hard fits:

Sept. 6 Dirty in habits: untidy in appearance: usually quiet: at times resists but seldom fights: Has fits quite often: Sept. 17 Ate breakfast & dinner as usual: Had a fit about two P.M. Then had another very hard one & died in a short time

Died-

Personal and Medical History of Mary Kuethe

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4687

Residence, Pickerel Lake, Minn.

Date Admission, Feb. 20 1897

Admitted by Dr. R. W. Phelps Hour, 7 P.M.

How Sent, Herman Blackmer Jop. Emmet Co.

Sex, Female.

Age, 43

Civil Condition, Married

Children, 7

Age Youngest Child, 2 yrs. old.

Occupation, (Husband Farmer)

Degree Education, Common School.

Profession Religion, Lutheran

Habits, Not intemperate.

Nativity, United States (Parents Germany)

Physicians Committing, Jr. Reg. Henri R. Lisson

Correspondents,

No. for Year, 320.

Insane Relatives, Grandfather, aunt & uncle,

Cause Exciting, Unknown,

Cause Predisposing, Heredity & previous attack.

Form, Mania chr.

Accompanying Bodily Disorder, Very deaf.

Suicidal or Not, Not.

Date of this Attack, Feb. 13 1897.

Duration, 1 wk.

No. of Attack, 2nd

No. of Admissions, 1st

Age First Attack, 23 yrs

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Examined by Dr. R. W. Phelps. 2/21/97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Impaired

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, Very much impaired.

Own Mental State, "

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS: Many & varied.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION: Very slow of speech

Coherent or Incoherent, Talks but little

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: 20 yrs. ago had an attack of insanity for 2 or 3 weeks after birth of child. 2 yrs ago had milk leg after birth of child. Has not been well since. Last fall complained unreasonably about some medicine & has been growing worse. Very noisy & excited. Mild & incoherent. Maniacal behavior.

Personal and Medical History of Mary Kuethe.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 6 in. WEIGHT, 198 lbs. NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None. Skin dry.

TONGUE, Tremors, Mouth parched. Coatings, dry & cracked. Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Seems good.

HEARING, Very deaf - hears but little in right ear.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None. Tongue, None.

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating, Slow & thick.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries normal.

HEART, Is murmurs.

LUNGS, Normal

TAKEN,

EXAM. URINE, Mar. 17 '97.

Color Pale yellow.

Character Clear.

Reaction Acid

Sp. Gr. 1008

Albumen None.

Sugar None.

Amt in hrs. L 3.

Microscop. Amor. urates - a few pus corpuscles Large ant. bladder - Vaginal cells.

GYNÆCOLOGICAL EXAM., 3/10/97 Laceration of perineum, rectocele, uterus normal position, erosion of os. discharge.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Milk leg 2 yrs. ago. Running sore on leg for 1½ yrs.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Mary Kuethe

This patient was brought here by Sheriff Deputy Ed. Honey attended by Henry Kuethe in fair physical condition with the following history:- No history of consanguinity: First attack occurred twenty years ago lasting about 2 weeks (Puerperal mania) The first symptoms of this attack manifested February 15'97 by irrational talk on religious subjects. Disease appears increasing: Derangement manifested on subject of religion = wants to talk about it all the time; sings cries & laughs. Is disposed to injure others: Is not filthy or destructive. A couple of weeks before the attack disgused religious subjects in a different way than usual: Was sleepless: No history of intemperance in parents or self: No severe disease or injury to head: Has been confined & watched in her room: opium & chloral given in evening, without producing sleep: On personal examination,- Very deaf ever since childhood: Is since morning, more quiet than ever before since commencement of attack; sits still & wont talk except when asked questions: Looks downhearted & tired. Pulse 108 - On admission put upon Bd (C.H.U. Pap. Complexion dark: hair black: eyes brown. Condition of skin normal: Scar on left leg: Is dirty: Fought while being bathed. Incoherent)

Mar. 5. Summary Nurse's 14 Day Record:- On admission patient resisted a good deal, tried to hit her head against the wall: Was put in restraint: During the next day (24 pt) was kept in room all day: was very noisy: was visited by her husband Is a large, very strong woman, quite deaf, talking but very little English: Mch 22nd was in her room and was extremely noisy all day: During the next four days was very noisy, and resisted a great deal; would frequently eat nothing and with difficulty was kept out upon the ward: During the second week- ending Feb. 5th - patient was taken stubborn and restless and occasionally noisy: was fed with tube once but toward the end of the time ate much better. Original Record Pursued

Mar. 15 Summary Nurse's Notes by Dr. L. L. Phelps:- At times quiet & sensible in talk: assisting with work: appetite good: bowels usually constipated: Mar. 20 Visited by husband & sister: very noisy & excited: Apr. 20 Has many delusions: restless & noisy most of time: Appetite good: general health good: May 20 Very noisy day & night: bowels constipated: Gen'l health good: June Still very noisy: clean but violent & destructive at times: goes out riding & walking: Aug Extremely noisy & a great deal of the time violent. Continued by Dr. W. M. Phelps.

Nov 1 '97 Patient incoherent & very noisy in talk; of fairly good disposition, however. Goes out walking: Jan 5 '98 Visited by husband: Feb 27 Wt. 175# Mch 31 '98 Visited by husband: July 20 By Husband & sister Feb 18 '99 Had to be fed with tube Now at times somewhat melancholy & depressed.

Personal and Medical History of Mary Kuethe.

1899

Mch - Aug 31 '99 Cont. by Dr. Bibb. General health & appetite good: Sleeps well: Takes outdoor exercise: Neat in habits & appearance: Has many delusions: Talks to herself in German a great deal. Is very noisy at times Assists some with work on halls & part of time in laundry Mch 28 Visited by husband & brother Mch 30 Went home on trial. Apr 3. Retd. July 29-30 Visited by husband - Aug 18 21st

Sept 1 - Feb 28 1900 (Dr. Heyerdale) Nov 29. Visited by friends: Neat: Has many delusions: Talks to herself a great deal: Assists in dining room: Takes out door exercise: General health good: Eats & sleeps well: Dec 31 & Jan 1st. Visited by husband: Jan 12 Wt. 222 lbs. Feb 29 No change Works in laundry part of time. Mch 1 - Aug 31 1900 Neat: Stubborn: Answers questions sensibly: reads a great deal: At times talks to herself Has delusions: Sometimes noisy: General health & appetite good: Sleeps well: Bowels regular: Assists in laundry: May 29-31 Visited by husband: & July 10 by friend July 23 Vaccinated.

Sept 1 - Nov 30 1900 - Oct 21 Visited by husband: 24 by lady friend: Appetite good: Bowels regular: Sleeps well: Habits clean: Talks quite rationally at times: reads a great deal: Quite deaf: Assists in laundry. Nov 28 Wt 214

Dec 1 - Feb 28 1901. Jan 7. Visited by husband: Taken out riding No change in condition: Generally quiet & agreeable on ward. Health good. Talks quite sensibly also reads.

Mar 1 - June 1 - 1901 No change in mental or physical condition. Assists in laundry. May 31 - Wt. 209 #. June to Sept. June 25 & 26 July 16 and Aug. 23 visited by friends, assists with the ward work, attends chapel and amusements, Sept. 3. Wt. 209 #.

Sept. to Dec. Oct. 3 visited by friends, oct. 10 & 11 by husband and daughter, Nov. 30 Wt. 207 #

Up to Feb. 1, 1903. General health good: appetite good: bowels regular: menstruates regularly: sleeps well - takes exercise and works in the laundry: is quite deaf: as a rule does not converse but reads a great deal: is sometimes noisy and very stubborn and disagreable occasionally is aroused to violence. Died 1st. Wt. 198 3/4 #.

Personal and Medical History of Katie Mulhall.

EGGERT, FOLAN & CHAMBERS, DAVENPORT, IOWA

Whole No. 4690

Residence, St. Paul, Minn.

Date Admission, February 24th 1897.

Admitted by Dr. H. H. Herzog. Hour, 6th P.M.

How Sent, G. Willrich J. of P. Ramsey Co.

Sex, Female.

Age, 32.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Has none

Degree Education, Common School.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Wheatland, Minn. (Parents Ireland)

Physicians Committing, Park Ritchie & Alex Donald.

Correspondents,

No. for Year, 223.

Insane Relatives, No information given in papers.

Cause Exciting, Epilepsy

Cause Predisposing, Previous attacks.

Form,

Accompanying Bodily Disorder, Epilepsy.

Suicidal or Not, Not.

Date of this Attack, Feb. 23'97.

Duration, 1 day.

No. of Attack, 4th? 1

No. of Admissions, 1st

Age First Attack, —

Time of Leaving, Apr. 17. 1899

Time in Hospital, 2yr. 1 m. 24 d.

Result, Died. Exhaustion in Post Epileptic Mania.

EXAMINATION ON ADMISSION.

Exam by L. L. Phelps Feb. 25/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Very excited & confused.

Quick or Sluggish,

MEMORY:

Past Events, Impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Impaired.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Very.

Depressed,

DELUSIONS: Many & varied.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Very wild & maniacal - Fights & struggles very violently. Very noisy - Talks in wild, incoherent manner - Continually - Requires constant holding & attention.

Medical History of Katie Mulhall.

FIGHTS THE OFFICERS.

Kitty Mulhall Is Insane and She Is Locked-Up.

Kitty Mulhall was taken to the county jail last night, violently insane. She came to the city about five weeks ago from Northfield to live with her sister at 226 Carroll street. Officers Beattie and Gerber, of the Rondo street station, had a desperate struggle with her and at the county jail she gave several of the deputies a hard fight before they got her into the cell. Religion seems to be the cause of her mental trouble. She is thirty years old and is unmarried.

Feb. 24'97

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, ——— NUTRITION, Fair.

...ALITIES, None. Skin - normal.

TONGUE, Tremors, Cracked - parched - Coatings, Heavily coated Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, — Accommodation, —

SIGHT, Seems good -

HEARING, Seems good.

COORDINATION, Arms, So restless cannot test.

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General, Some from exhaustion.

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Not examined. Regular but mat & rapid.

LUNGS, Not examined

GYNÆCOLOGICAL EXAM. May 7/97 Uterus normal position - external genitals normal

MENSTRUATION, Regular & Normal

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Mar. 16'97.

Color Pale yellow.

Character Clear with flaky deposit

Reaction Acid.

Sp. gr. 1020.

Albumen Trace by Heat & Tannic

Sugar None.

Amt. 24 hrs. XV ℥

Microscop. Amor. urates - Large quantity Mucus casts. few bladder & vaginal cells. & uric acid crystals

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

CRANIAL MEASUREMENTS,

HISTORICAL, Fits very often for 12 yrs. Had headache.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Epileptic fit for years.

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Katie Mulhall.

EGGERT, FISCAH & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4690

Residence, St. Paul, Minn.

Date Admission, February 24th 1897.

Admitted by Dr. H. H. Herzog. Hour, 6th P.M.

How Sent, Warwick J. of P. Ramsey Co.

Sex, Female.

Age, 32.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Has none

Degree Education, Common School.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Wheatland, Minn. (Parents Ireland)

Physicians Committing, Park Ritchie & Alex Donald.

Correspondents,

No. for Year, 223.

Insane Relatives, No information given.

Cause Exciting, Epilepsy

Cause Predisposing, Previous attacks.

Form,

Accompanying Bodily Disorder, Epilepsy

Suicidal or Not, Not.

Date of this Attack, Feb. 23. 97.

Duration, 1 day.

No. of Attack, ~~4th~~ 1

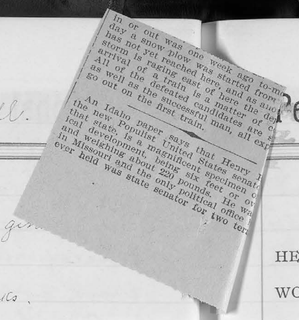
No. of Admissions, 1st

Age First Attack, —

Time of Leaving, Apr. 17. 1899

Time in Hospital, 2yr. 1 m. 24 d.

Result, Died. Exhaustion in Post Epileptic Mania.



In or out was one week ago to-day a snow plow was started from the north. It has not yet reached here, and the storm is farther east and the storm is farther east of here. The arrival of the belated soldiers of the arrival of the belated soldiers of the as was the case on the first train.

An Idaho paper says that Henry the new Populist United States senator from that state, is an excellent specimen of the statesman, being about five feet nine inches and weighing about 225 pounds. In Missouri and the only political office he ever held was state senator for two terms.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam by L. L. Phelps Feb. 25/97.

MENTAL ACTIVITY:

Clear or Confused, Very excited & confused.

Quick or Sluggish,

MEMORY:

Past Events, Impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Impaired.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Very mild & maniacal - Fights & struggles very violently Very noisy. Talks in mild, incoherent manner continually. Requires constant holding & attention.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Very.

Depressed,

DELUSIONS: Many & varied.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Katie Mulhall.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, —— WEIGHT, —— NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, None. Skin - normal.

TONGUE, Tremors, Cracked - parched - Coatings, heavily coated Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, — Accommodation, —

SIGHT, Seems good -

HEARING, Seems good.

COORDINATION, Arms, Restless cannot test.

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General, Some from exhaustion.

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Not examined. Regular but weak & rapid.

LUNGS, Not examined

EXAM. URINE, Mar. 16'97.

Color Pale yellow.

Character Clear with flaky deposit

Reaction Acid.

Sp. gr. 1020.

Albumen Trace by Heat & Tannic

Sugar None.

Amt. in hrs. XV ℥.

Microscop. Amor. urates - Large quantity Mucin tands. few bladder & vaginal cells. & uric acid crystals

TAKEN,

GYNÆCOLOGICAL EXAM. May 7'97 Uterus normal position - external genitals normal

MENSTRUATION, Regular & Normal

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Fits very often for 12 yrs. Had headaches.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Epileptic fit for 9 years.

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Katie Mulhall.

This patient was brought here in my office by Sheriffs Deputy P.J. Minnis attended by James Brogan + Mrs. Sylvester, in poor physical condition, with the following history:- No history of consanguinity, lunacy or intemperance in parents or selfs. Had 3 attacks before 1896, of short duration: First symptoms of present attack manifested Feb. 22d '99 by violent mania: disease appears stationary: not variable, no rational intervals: Patient is maniacal: not disposed to injure others: not suicidal filthy or destructive: Has had epilepsy 12 years: Has not been confined or restrained except during acute attacks: Nothing known concerning treatment. On personal examination, patient shows acute mania from epilepsy + no other known cause. On admission put upon No 4 W. (Gt. N. Rpt. Complexion dark, hair brown; eyes blue; Condition of skin normal: No marks or scars noticed: a few bruises on arms + legs: Is dirty: Behavior maniacal, fought when being bathed + used a great deal of profane + obscene language)

Mar. 8. Summary Nurse's 14 Day Record:- Patient admitted as an epileptic= During the first three days was kept in bed: took chiefly milk, but from that time on ate quite well: patient had been very suddenly violent before coming here and this violence continued during the first day of her stay here: was put in restraint and hypodermic given: During the second day she was somewhat more quiet and during third day she was not only out of restraint but was able to answer some questions: was in restraint some of the time on the 27th and 28th: March 1st was quite rational; Slept well and seemed to be rapidly becoming normal: During second week patient became quite rational and sane in manner: The attack was evidently due to an Epileptic condition: Patient says she had one or two attacks before, but never one so severe. Original Record Preserved.

Mar. 15 Summary Nurse's Notes by Dr. S.B. Phelps- Very quiet + agreeable on ward: appetite good: takes out door exercise: takes tonics + cathartics; Jan 24 Has fits very often: May Bowels irregular: appetite fair: has fits very often: June 20 Has fits very often: menstr. regular: appetite fair: bowels usually constipated: Aug Quiet on ward takes tonic + cathartics: Takes outdoor exercise: works a little on the ward. Continued by Dr. W.M. Phelps. Nov 30 97. Has occasional convulsions, does not hormone behave very violently after them. Has had an attack like she had at the time of coming. Nov 26 Wt. 133# Patient quite feebleminded has a good many delusive ideas July 1 had a fit + bruised her forehead badly. Oct 25 Patient has been slightly maniacal of late. Is quite disagreeable + full of delusions. Feb 25 99 Wt. 127# Since last year has been for the most part fairly well behaved although full of vague delusions.

Personal and Medical History of Katie Mulhall.

1899
Apr. 13 (Cont. by Dr. R.S. Bell): Frequent convulsions: extremely noisy day and night: refuses food: so excited that she is rapidly becoming exhausted: Apr 14 Transferred to Infirmary: but in restraint: pulse weak: temp. 103: Sponge bath given: slept well: Apr. 15 Temp. 102 2/5 P. 140 R. 30: continues very noisy: struggles considerably: Sponge baths given: cold applications to head: Apr. 16 T. 104 4/5 P. 152: enemata + stimulants given: visited by Priest: Apr. 17 Temp. rose from 104 2/5 to 106 2/5: P. 158: R. 35: Visited by Priest + sister: became quieter in p.m. pulse very rapid + weak: became comatose: Died 9:50 a.m.

Died

Personal and Medical History of Anna Smith

ROBERT, PIZLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4699
Residence, Lakeville Township, Dakota Co, Minn.
Date Admission, March 4th 1897.
Admitted by Dr. Rm. Phelps Hour, -
How Sent, Thos. A. Moran, J. of P. Dakota Co.
Sex, Female.
Age, -38-
Civil Condition, -married-
Children, -2-
Age Youngest Child, 10 yrs.
Occupation, -Housewife-
Degree Education, Common school.
Profession Religion, Lutheran -
Habits, Not Intemperate
Nativity, Norway.
Physicians Committing, W.H. Dodge + H.M. Rogers.
Correspondents, W.S. Smith (husband)
Farmington. Dakota Co. Minn.

No. for Year, 232
Insane Relatives, One uncle. insane.
Cause Exciting, Epilepsy
Cause Predisposing, Heredity?
Form,
Accompanying Bodily Disorder, Epilepsy + chorea.
Suicidal or Not, Not.
Date of this Attack, Feb. 28 1897.
Duration, 4 days.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 38
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by Rm. + Al. Phelps 3/5/97 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Not specially sluggish.

MEMORY:
Past Events, } Poor now.
Recent Events, }
Special Subjects, }

PERCEPTIVITY:
Alert or Dull, Dulled
Correct or Illusive, Incorrect.

REASONING POWER:
Ordinary Subjects, } Very poor now.
Own Mental State, }
Special Subjects, }

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

DELUSIONS: Delusive ideas.
Systematized or Not,
Special Subjects,
Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Had series of fits commencing last Wednesday. By Saturday night had become delirious. Since Monday has been kept quiet by Hyocine. This morning answers many questions with fair accuracy. Mental state unstable + vacillating however. Exhausted in appearance. Activity is a sort of aimless struggling. Was in restraint last night. Quieter this morning. Excitable + restless - Irritable - Health seems fair.

Personal and Medical History of Anna Smith.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, not taken NUTRITION, Not much impaired.
WOUNDS OR ABNORMALITIES, Slight scalp wounds + bruises. bruises on body.
TONGUE, Tremors, Slightly pale. Coatings, Promptness Movement, Some sordes + exhaustion
PUPILS, Equality, Equal Size, Dilated.
Response Light, - Accommodation, -
SIGHT, Says is good
HEARING, Good.
COORDINATION, Arms, Now in restraint - can't test - would- Probably good.
Legs,
TREMORS, Hands, Nervous movements of whole Tongue,
Facial Muscles, body. General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Good.
Hesitating, no.
FACIAL EXPRESSION,
SENSIBILITY,
Arteries Normal.
HEART, No murmurs noted. Sounds fair- At times palpitates.
LUNGS, Chest sym. normal. Expansion Normal. Breath sounds normal.
GYNÆCOLOGICAL EXAM., 3/10/97 Uterus normal position, some laceration-perineum, some rectocele. otherwise normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, June 1897
Color Yellow
Character White flaky deposit.
Reaction Acid
Sp. Gr. 1030
Albumen Trace by Tannic
Amt. 24 hrs. 24 oz.
Sugar No Sugar.
Microscop. Large quantity bladder + vaginal Epithelial cells
Triple Phosphates.

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, } until past week. Constipated, Irregular,
APPETITE, Good, } Medium, Poor,
SLEEP, Good, } Poor, Now. Irregular,
PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, I.
LENGTH OF INVASION, 3 fits for 10 yrs. decided delirium since Saturday last. ONSET GRADUAL OR SUDDEN, Sudden (as to delirium)
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denied but her statements are unreliable.
Mother or Mat. Relations, Died -64- heart disease
Father or Pat. Relations, Died Consumption
Brothers or Sisters,

Personal and Medical History of Anna Smith

This patient was brought here by Wm. Smith in an exhausted physical condition with the following history: No knowledge concerning consanguinity: First symptoms of attack occurred on Feb. 28 '99 after Epileptic convulsions: Disease is not variable, no rational intervals: Derangement manifested concerning present condition & concerning being sent away from home: Not disposed to injure others; not filthy or destructive: No previous peculiarities except in connection with Epilepsy: Has not been confined or restrained: has received treatment for epilepsy.

On personal examination: Has had spells of walking: Bending her joints: pulling fingers: picking at clothing: looking around her.

On admission put upon B'd W. Qtl. Rpt. Complexion dark: eyes blue: hair dark brown: Condition of skin normal: Large cut on right side of head: Bruises on forehead, both knees & on right hand. So dirty: very maniacal & violent: Some remarks were sensible)

Mar 17. Summary Nurse's 14 Day Record: Patient was admitted March 4th, at that time appearing rather restless, noisy, & incoherent: Struggled some during her bath & was put in restraint at night. Was, however, somewhat more quiet the next day (Mar. 5): During the next two days was quite incoherent and rambling in her talk, but gradually quieted down: For the rest of the time has been becoming more quiet and rational, although there is much of the impatience and irritability of the epileptic condition: Patient has history of long continued epilepsy: Appetite had been good and physical condition approximately normal: Original Record Preserved

Apr. " Summary Nurse's Notes by Dr. L.L. Phelps:- Menstr. regular: Has some uterine trouble for which she takes treatment: Has convulsions occasionally: May 21 Menstr. Gen'l health good: June 6 Appetite good: bowels regular: takes out door exercise: May quiet & agreeable on ward: talks quite sensibly: June 17 Had a convulsion:

Aug. 9 Menstr. Gen'l health good: no mental change. Continued by Dr. R.M. Phelps.

Nov 1/99 Has had a fairly good appetite & is in good health. Has received gynaecological treatment a good deal of the time. Is rather disagreable in manner.

March 99 Visited by husband & taken home. June 29 '98 Brought on ward rather noisy & excitable. Bruised herself in bed kicking against bed. Has a bruised eye also. Is violent. July 2 Patient quieted down a good deal. Dec 25 '98 Was transferred to Infirmary & operated upon for repair of cervix & perineum. Feb 25 '99 Wt. 146½ Had no especial sickness or trouble after operation. Seems in good general health. (Cont by Dr. R.A. Bell.) Mar. '99: Makes frequent complaints: accuses nurses of not giving her proper attention: Scolds a great deal: uses violent language: Apr. 30 Some what more agreeable: assists with work in

Personal and Medical History of Anna Smith

dining room: bowels & menstr. regular: takes out door exercise: May 6 '99 Trans. to B 3: May 7 Transferred back to B 2 because she scolded & was so disagreeable & noisy: May 10 Transferred to B 3: has frequent convulsions: gradually becoming more agreeable: May 28 Fell out of bed in night during convulsion: bruised left side of face badly: May 30: Complained of fever & pain in chest: slight trace of blood in sputum: June 15: Again fell out of bed during convulsion & bruised right of face. Stitches taken: June 19: Stitches removed: for several days was very disagreeable to both nurses & patients: June 27-8 Remained in bed, complaining of pain: Sept. 1 '99 Menstr. flows quite profusely: Sept 10 Again bruised face by falling out of bed during convulsion. Sept. 28 1900 (to Weyerdale) Neat: General health good: has occasional convulsions when she becomes very disagreeable & irritable & expresses many delusions: Is very nervous: Takes out door exercise. Oct 18 Fought nurses: Had convulsions Oct. 20, 26, 27, 28, 29. Jan 13 Wt. 161½. Feb 27. Scolds a great deal: menstruation regular - flow profuse. March 1 - Nov 30 1900. Quite disturbed at times: Has many delusions: thinks that chairs & bed move about & that mattress moves under her: Is incoherent frequently: Is irritable. March 27 Trans. to B 3. Apr 4, 6, 16 had convulsions Apr 19 Fought nurses; Trans. to C 3. June 27 had a severe convulsion bruised face. July 21 Vaccinated. Menstruation regular: Assists with ward work. Aug 28 Very irritable of late: Expresses many delusions Oct 30 Had severe convulsion; much excited afterward: Burned side of face Nov 13 Wt 153 lbs. Dec 1 - Feb 28 1900 Still has frequent convulsions & occasionally injures herself. Feb 27 Wt. 152½ lbs. General health good: Is occasionally disturbed. Mar to June 1901 No change in either mental or physical condition. May 29 Wt. 150#.

June to Sept. July 15 visited by brother, general health good, menstruates regularly sleeps well, when not disturbed will converse intelligently and is quite agreeable, takes regular out door exercise, has epileptic seizures frequently after which she expresses delusions and is extremely irritable. July 16 taken home. Sept. to Dec. Oct. 7- patient returned to the hospital, received on Infirmary bathed and put to bed, menstruating, is somewhat disturbed, says she is very badly treated and that people are trying to put her out of the way. Oct 13. transferred to C. 3, Nov. 25 Wt. 150#.

Up to Feb 1, 1903. Gen'l health fairly good: has good appetite: occasionally requires cathartics: sleeps well: takes exercise & has numerous convulsions immediately following which she is disagreeable and noisy: sometimes requires seclusion: makes her excited and disturbed: these occur sometimes daily at times at intervals of an hour. Dec 20 had an abscessed finger requiring lancing and bandaging for some days. Jan. Fell in convulsion & bruised & cut large cut on right

Personal and Medical History of Sarah L. Barthalamew

GIBERT, FIDLAR & GRAMBERS, DAVENPORT, IOWA

Whole No. 4703

Residence, Janesville Minn.

Date Admission, March 10th 1897.

Admitted by Dr. C.B. Eby Hour, 7.45 P.M.

How Sent, Gro. A. Wilson, J. of P. Waseca Co.

Sex, Female.

Age, (53 she says)

Civil Condition, married

Children, 4.

Age Youngest Child, 19.

Occupation, Housewife (Husband Painter)

Degree Education, Common School.

Profession Religion, Baptist.

Habits, not intemperate.

Nativity, Pennsylvania (Father Ky. mother Penn.)

Physicians Committing, Dr. J. McMahon + Mr. J. Taylor M.D.

Correspondents, none given in papers.

No. for Year, 236.

Insane Relatives, Mother - one sister - two aunts.

Cause Exciting, unknown.

Cause Predisposing, Heredity + previous attack.

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Has been attempted. propensity not active

Date of this Attack, 4 weeks ago.

Duration, about 4 weeks.

No. of Attack, 2nd

No. of Admissions, 1st

Age First Attack, - -

Time of Leaving, May 17th. 1897.

Time in Hospital, 2 mo. 7 da.

Result, Discharged Nov. 3. 1897.
Improved

EXAMINATION ON ADMISSION.

Exam. by R.M. + A.L. Phelps 3/11/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Fairly clear.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Says it has failed

Recent Events, considerably.

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, } Only fair.
Own Mental State, }
Special Subjects, }

EMOTIONAL STATE:

Normal, ✓ Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS: None appeared in this examination

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient talks quite clearly but in a weak-minded way. Gives quite full history. Says memory is poor. Mental trouble is a quite symmetrical dementia + physical trouble is chorea progressive, with probable circulatory failure at base of both. Hereditary tendency is extremely strong. Mother had this chorea, also Mother's Mother + 2 sisters. Mothers 7 brothers both died of cancer at 60 + 70 yrs. of age. Says Mother's name was Copley + that she was once here in this Hospital. Chorea commenced in Rt. side - especially in Rt. hand - Now is quite general. even speech shows it.

Personal and Medical History of Sarah L. Barthalamew

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. WEIGHT, 91 lbs. (usually 95) NUTRITION, As fair as usual.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Some whitish coating Promptness Movement, Prompt.

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Poor with age.

HEARING, Somewhat poor in right ear. Cannot hear at all in left ear.

COORDINATION, Arms, } Incoordination of a choreic character.
Legs, }

TREMORS, Hands, } Choreic movements Tongue,
Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Slightly jerky

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs noted. No very notable sign at present.

LUNGS, Flat chested Sounds fairly good

EXAM. URINE, 3/17/97.

Color. Yellow.
Character. Cloudy White flaky deposit
Reaction Acid.
Sp. Gr. 1016.
Albumen Trace by Tests.
Sugar. None.
Amt. 24 hrs. XV Z.
Microscop. Amor. urates - a few pus corpuscles + bladder epithelium
Large amt. Oxalate of lime.

TAKEN,

GYNÆCOLOGICAL EXAM., 3/15/97 Uterus normal position, endometritis, slight laceration of perineum.

MENSTRUATION, Menopause passed 2 yrs.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor, very
SLEEP, Good,	Poor, Never good.	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Lung fever - Bilious Fever 15 yrs ago. Scarlet fever. Shaking for 6 yrs. Dizzy spells commenced in Dora 6 yrs ago. Says had Consultations at birth of 3rd Child

LENGTH OF INVASION, 2 years ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, Died in Dora 15 yrs ago - Paralysis - Died in Hospital at Mt. Pleasant. Mothers Father died of consumption Mothers " " paralysis 2 Mothers " died of cancer

Father or Pat. Relations, Died of heart trouble 6 years ago.

Brothers or Sisters, 5 Brothers 1 sister. Children + all living + miscarriage - married at age of 20 - Children fairly healthy now has large head - Born with water on brain - Has considerable trouble yet. Is Professor in High school

Personal and Medical History of Sarah L. Bartholomew.

This patient was brought here by sheriff's deputy George Goodspeed attended by husband of patient, in fair physical condition, with the following history:- No history of consanguinity or intemperance in parents or self: First attack occurred 3 years ago & lasted 2 weeks: First symptoms of present attack manifested 4 weeks ago: Disease appears increasing; is variable with irregular, rational intervals. Derangement manifested by imagining that people are going to injure her & trying to get away, screaming with fear: Is not disposed to injure others: Not filthy or destructive: No previous peculiarities shown: Patients mother, sister & 2 aunts were all confined in insane asylums: No severe disease or injury to head: Has had nurse constantly with her & has been given hypnotics with no beneficial result. On personal examination has a vacant, staring expression, expressive of fear.
On admission put upon B & W (U.S.N. Rpt. Complexion dark: hair brown partly gray: eyes gray: Condition of skin normal: No marks, scars or bruises noted, Tongue clean: Quiet but very nervous: Talks sensibly)

Mar. 10 Summary Nurse's 14 Day Record:- Patient admitted Mar. 10. Is apparently a marked case of mild feeble-mindedness accompanying chorea: During the two weeks this is all that has been apparent: She answers quite accurately and sensibly and is troubled chiefly by the chorea with a mild irritability and feebleness of mind: Appetite uniformly good and physical condition good otherwise than is affected by the chorea. Original Record Preserved.

May 18 Summary Nurse's Notes by Dr. S.L. Phelps:- Takes Gym. treatment: talks quite sensibly: takes tonic: May 17 Went Home - Had improved a good deal mentally, but was still very nervous & feebleminded: physical condition impaired was frail & able to do very little: Very anxious to go home and as she was quiet & easily managed it was thought best to allow her to go out on trial -

Discharged.

Personal and Medical History of Anna D. Smith.

side of head which bled very freely requiring stitches: This was dressed for some days: healed without any complications,
Dec. 1st. Wt. 154#. Has frequent convulsions.

Personal and Medical History of Caroline Lawston.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4704
Residence, Amherst, Minn.
Date Admission, March 11' 1897.
Admitted by Dr C B Eby Hour, 2 P.M.
How Sent, C.V. Farmington J. of P. Fillmore Co.
Sex, - Female -
Age, - 30 -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, Housework.
Degree Education, Common School.
Profession Religion, Not a church member.
Habits, - Not intemperate -
Nativity, Minnesota (Parents Norway)
Physicians Committing, J.H. Phillips & G.A. Low.
Correspondents, None Charles Lawston
Highland, Fillmore Co.

No. for Year, 237
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, Unknown.
Form, Mania. Chronic.
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Has attempted to poison herself. Previously taken.
Date of this Attack, 3 years ago.
Duration, About 3 years.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 27.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. 3/11/97 by Rau & Dr. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Not apparently confused.
Quick or Sluggish, Active.

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

PERCEPTIVITY:
Alert or Dull, Alert but in ways deluded.
Correct or Illusive,

REASONING POWER:
Ordinary Subjects, -
Own Mental State, Impaired
Special Subjects,

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

DELUSIONS: Has many.
Systematized or Not, Thinks she has had
Special Subjects, several children & that she
Transitory or Not, is pregnant now.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient a ready-talking young woman, with slightly defective appearance. At times talks & answers questions quite sensibly then her mind wanders off & she talks in a very deluded manner & seem confused.

Personal and Medical History of Caroline Lawston.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, —— WEIGHT, 165 — usually 176 NUTRITION, Fair
WOUNDS OR ABNORMALITIES, Skin good condition.
TONGUE, Tremors, Coatings, Coated. Promptness Movement,
PUPILS, Equality, Equal. Size,
Response Light, Accommodation,
SIGHT, Normal
HEARING, Good.
COORDINATION, Arms, Probably good.
Legs,
TREMORS, Hands, Some tremors Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Good.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries Seem normal.
HEART,
Normal.
LUNGS, Normal.

TAKEN,

EXAM. URINE, Apr. 16'97.
Color Pale Yellow.
Character Cloudy.
Reaction Alkaline.
Sp. gr. 1020.
Albumen Trace by Tests.
Sugar None.
Amt 24 hrs. XXXV ℥.
Microscop. Large amount amor. urates
Bladder + ~~vaginal~~ cells.

GYNÆCOLOGICAL EXAM., 3/17/97 Uterus retroverted - Long conical cervix - Labia majora greatly hypertrophied External genitals excoriated
MENSTRUATION, Regular
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Typhoid fever when 6 yrs. old - Diphtheria - Scarlet fever. Dizziness & headache for 3 yrs.
LENGTH OF INVASION, 3 yrs ago ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Living - not very healthy - no special disease.
Father or Pat. Relations, Living. Not very healthy.
Brothers or Sisters, 2 sisters poor health. —

Personal and Medical History of Caroline Lawston.

This patient was brought here by sheriffs deputy Charles Lawston; in fair physical condition, with the following history: No history of consanguinity, heredity or intemperance in parents or self: First symptoms manifested 3 years ago by Acute mania, has delusions: Disease appears increasing: Not variable: no rational intervals: Derangement manifested by delusions in regard to having had four children: Not disposed to injure others: Not filthy or destructive: No previous peculiarities: No severe disease or injury to head: Has not been confined or restrained: Has been to several physicians but has obtained no relief.
On personal examination has fixed delusion that she has had four children which have been stolen from her.
On admission put upon S & W (On N. K. Ward) Complexion dark: hair & eyes brown: Condition of skin normal: No marks scars or bruises noted: Is rather dirty: behavior quiet: has delusions.)

Mar. 24 Summary Nurse's 14 Day Record:- Admitted March 11th: Quiet in behavior and with no notable symptoms: talks not talk much: seems dull and a trifle obstinate: During next week delusions became more apparent and after the first two or three days patient became more restless and noisy and irregular in behavior: Her appetite and general condition have been good throughout: During 2nd week her condition has changed little: Does not talk very much, but talk is incoherent - Original Record Preserved.

Apr. 6 Summary Nurse's Notes by Dr. L. L. Phelps:- Quite noisy at times: talks incoherently: Has delusions: appetite good: bowels regular: sleeps well: May 30 Patient dirty: Quite careless in personal appearance: Sleeps well: bowels regular: genl health good:
June 17 Noisy quite often appetite good: takes outdoor exercise: untidy in appearance:
Aug 21 Lungs & heart examined: Genl health good: Chest expansion fair: Resp. 18: Breath sounds normal: Heart sounds normal: pulse 82: Genl health good: mentally rather dull. Continued by Dr. W. M. Phelps. Nov 30 '99 Visited by father for 1st time: Seems somewhat more disturbed since: Is restless & silly. Dec 99 Visited by sister. Feb 99. Wt. 140#. May 16 Visited by Cousin. Nov 20 Patient's general condition unchanged up to date. Mch 1 - Aug 31 '99 Cont by Dr Bibb. General health & appetite good: Sleeps well: Takes outdoor exercise: Neat in habits & careless in appearance: Has many delusions: Talks to herself & uses profane & obscene language: Is troublesome often picking at other patients & striking them without provocation. Answers questions quite sensibly at times Aug 18 Wt. 160#
Sept 1 - Feb 1901 (Dr Reynolds) neat in habits but careless in appearance: Very restless & at times profane: Eats & sleeps well: Takes outdoor exercise Dec 8 Visited by father: would not talk to him. Profane & abusive Jan 12 Wt. 161#

Personal and Medical History of

Mch 1 - Aug 31 1900 (Dr. Linton) untidy in appearance & habits & at times noisy talks incoherently: has delusions: uses profane language: is at times very silly: & rather obstinate. General health good: appetite good bowels regular: sleeps well: Menstruates regularly: Takes out door exercise: Apr 17 Visited by a niece. May 27th by a friend & 29th by brother. July 17 vaccinated Sept 1 - Feb 28 1901 No change during period. At times disagreeable & quarrelsome & profane. Menstruates regularly. Mch 1 Wt. 160#
General health good. Mar. 1 - June 1 - 1901 No change in mental or physical condition. Does no work. May 30. Wt 156#
June to Sept. June 19 July 10 menstruating, does no work. attends school for patients and does fairly good work, answers questions addressed to her, Sept. 3. Wt. 154#. Sept. to Dec. Nov. 29 visited by brother-in-law and friend, the past few months has begun to work, assists every day with work on the ward, apparently the effect of her attending school, is still quite vulgar and profane when disturbed and at times is very disagreeable, sometimes striking other patients, Nov. 30 Wt. 146#.
Dec to Feb. 1st. 1903. Sept. 4th visited by friends: general health very good: bowels regular: sleeps well: menstruates regularly: assists with the work: takes exercise: attends amusements: is noisy most of the time: cross and disagreeable to the other patients: at times attacks them. Nov. 29th. Wt 132#.

Personal and Medical History of Christina Billings

EGBERT, FIELAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4706
Residence, Brownsville, Minn.
Date Admission, March 12' 1897.
Admitted by Dr. P.M. Phelps Hour, 4 P.M.
How Sent, Thomas Ryan J.P. Houston Co.
Sex, Female.
Age, 34.
Civil Condition, Married.
Children, Two.
Age Youngest Child, 3 yrs.
Occupation, - (Husband laborer)
Degree Education, Can read & write.
Profession Religion, Lutheran.
Habits, Not intemperate.
Nativity, Minnesota (Parents Germany)
Physicians Committing, W.W. Freeman & R.J. Ferguson
Correspondents, Mr. Wm Billings. Brownsville, Minn.
Carrie Swartz, Lacrosse, Wis.

No. for Year, 239.
Insane Relatives, None.
Cause Exciting, Depressing surroundings.
Cause Predisposing,
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, February 23'97
Duration, 17 days.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 34
Time of Leaving, June 11. 1898
Time in Hospital, 1 yr. 3 mo. 30 d.
Result, Discharged Dec. 17. 1898
Unimproved

EXAMINATION ON ADMISSION.

Exam. by P.M. & D.L. Phelps 3/13/97

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient is a quiet, melancholy but chiefly confused & dulled mental state. Health seems fairly good.

Personal and Medical History of Christina Billings.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, 130 usually 145 NUTRITION, Fair
WOUNDS OR ABNORMALITIES, Scar on neck. Skin - Eruption quite general.
TONGUE, Tremors, Coatings, Blackish coating Promptness Movement,
PUPILS, Equality, Equal. Size, Dilated some.
Response Light, Accommodation,
SIGHT, Normal.
HEARING, Normal.
COORDINATION, Arms, Normal.
Legs,
TREMORS, Hands, None of note. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, ? Equal.
Other
ARTICULATION, Good but has to
Slurred, think a long time to find
Hesitating, answer to questions
FACIAL EXPRESSION,

TAKEN,

EXAM. URINE, Mar. 17'97.
Color. Yellow red.
Character Cloudy - pink, ropy deposit
Reaction Acid.
Sp. gr. 1016
Albumen Trace by Tanrets.
Sugar Trace by Bismuth - Large quantity by Haines.
Amt 24 hrs. —
Microscop. Amor. & Sodium urates
Pus. Corpuscles. Bladder epithelium fat
Globules & uric acid crystals & Mucus Casts

SENSIBILITY,
Arteries - Normal.
HEART, No murmurs noted. Sounds fair. Size normal. Apex beat normal.
LUNGS, Expansion fair Breath Sounds fairly good
Stoop shouldered - Kyphosis existed.
GYNÆCOLOGICAL EXAM., 3/15/97 Uterus retroverted Endometritis of tenderness - some haemorrhoids. Left ovary prolapsed - a good deal
MENSTRUATION, Regular
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium, ✓	Poor,
SLEEP, Good, Restless at night	Poor, for a month past.	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, Has trouble in remembering. Always had headaches at times.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Died of heart disease.
Father or Pat. Relations, Dead
Brothers or Sisters, 2 children 4 & 6 yrs.

Personal and Medical History of Christine Billings.

This patient was brought here by Sheriffs Deputy J Johnson, in fair physical condition with the following history: No information Concerning Consanguinity: First symptoms of attack manifested Feb. 23'97 by wild gesticulations: disease appears increasing: variable with irregular rational intervals: Derangment manifested on no particular subject: Is not disposed to injure others: Not suicidal: Father committed suicide: Not filthy or destructive: No previous peculiarities shown: Father & brother both used alcohol: No severe disease or head injury but has been severly frightened: Has not been restrained or confined: Has received no treatment: On personal examination:- gave appearance of extreme depression & despair on her condition in life, as having worked all her life for nothing: said she thought herself insane & was willing to go to any place for treatment: Talked rationally but for the prevading element of despair. At first acted as if she did not want to submit but afterward sat in a moody condition, quiet & exhibiting extreme dejection. On admission put upon B & W. (O.H.C. Rit. Complexion dark: Hair brown: Eyes blue: Condition of skin normal: No marks or scars noted: Eruption on back & abdomen: Is rather dirty: behavior quiet: Talks very little & has delusions)

Mar. 25 Summary Nurse's 14 Day Record: Patient admitted March 12th: Put to bed: Behavior quiet: Sleep during first night rather restless: March 13 Appetite good: was kept in bed: Quite melancholy, crying a great deal: During first week Temperature was taken and appeared normal: Ate meals regularly, although appetite was not very Good. Talks little, rather stupid & melancholy: During 2nd week - 19th to 25th Patient mentally rather worse than better: rather more depressed & dull in behavior: Sleeps poorly, and although eats regularly yet not at all well: has to be fed with Spoon at times. receives medicine regularly. Original Record Preserved

Mar. 27 Summary Nurse's Notes by Dr. S.E. Phelps:- Gyn. treatment given every other day: Quiet- rather stupid at times: Has some delusions: does no work: Apr. 30 Has had Gyn. treatments regularly every other day: resists a good deal: Has a great many delusions: talks quite incoherently: destructive at times: Appetite poor: May 27 Appetite fair: does no work: refuses medicine: Many delusions: Gyn. treatment continued: June 25: Noisy: Struck one of the nurses: very disagreeable: uses very bad language: refuses medicine: July 5 Visited by sister & children: seemed to enjoy visit: July 16: Fought nurses: Aug 9 In bed: complains of pain in stomach: proved to be nothing serious: Aug 24 Continues erratic in behavior: rather noisy in talk: uses bad language: Quit health good. Continued by Dr. P.M. Phelps.

Nov 2 '98 Has occasional headaches: at times gets quite noisy & excited & is also silly & incoherent. General health is fairly good. Jan 28 '98 Temp. to 6.3 Tries to get out of clothes. Is noisy & restless. June 11 '98 Has been working in the laundry some. Was today

Personal and Medical History of

allowed to go home on trial at the request of her relatives: Behavor fairly well: Has improved somewhat mentally altho is still somewhat incoherent.

Discharged.

Personal and Medical History of Freda Katchel

BERGEY, PUCKAN & SAUNDERS, DAVENPORT, IOWA.

Whole No. 4710

Residence, St Paul. Minnesota.

Date Admission, March 17 1897

Admitted by Dr. R.M. Phelps - Hour, 7 PM.

How Sent, G. Willrich J. of P. Ramsey Co.

Sex, Male.

Age, 17.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, None - school girl - (Father none)

Degree Education, Very good

Profession Religion, Not a church member.

Habits, not intemperate.

Nativity, Germany.

Physicians Committing, Daniel Paul. W.D. Kelly.

Correspondents,

No. for Year, 243.

Insane Relatives, Sisters died insane - Father insane

Cause Exciting, Possibly masturbation.

Cause Predisposing, —

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Has been attempted - Propensity not active

Date of this Attack, Apr. 1896. (first attack)

Duration, Present attack 2 mths.

No. of Attack, 1st not first. circular written only

No. of Admissions, None.

Age First Attack, 16.

Time of Leaving, July 20. 1898

Time in Hospital, 1 yr. 4 m. 3 d.

Result, Discharged Feb. 8. 1899 Unimproved

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by P.M. & A. Phelps 3/17/97

MENTAL ACTIVITY:

Clear or Confused, Much confused.

Quick or Sluggish,

MEMORY:

Past Events, Good.

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Much impaired

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Very emotional. Cries one minute & laughs the next. Very careless about her personal appearance. Very incoherent in talk - Mind wanders from one thing to another.

EMOTIONAL STATE:

Normal, Calm, Very hysterical & excitable

Indifferent, Laughs & cries.

Exalted,

Depressed,

DELUSIONS: Many & varied.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Freda Katchel.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 7 in WEIGHT, 106½, usually 114 NUTRITION, Good.

WOUNDS OR ABNORMALITIES, Goitre beginning. Skin normal condition.

TONGUE, Tremors, Coatings, Very heavily coated Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Normal.

HEARING, Normal.

COORDINATION, Arms, Normal.

Legs, "

TREMORS, Hands, Fine tremor Tongue,

Facial Muscles, General, None.

REFLEXES, Patellar,

Other

ARTICULATION, Prompt.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs noted Sounds Normal. Brat Regular

LUNGS,

TAKEN,

EXAM. URINE, Apr. 14 '97.

Color, Brownish red.

Character, Cloudy. Ropy sed.

Reaction, Acid.

Sp. Gr. 1033

Albumen None.

Sugar None.

Microscop. Amor. urates. bladder & vaginal cells. Oxalate of lime & a few blood corpuscles.

GYNÆCOLOGICAL EXAM., 4/18/97 Uterus normal position - external genitals normal.

MENSTRUATION, regular

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, About 2 years ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, Dead - Catarrh of Stomach

Father or Pat. Relations, Living rather demented -

Brothers or Sisters, Sister insane for 2 yrs - died.

Personal and Medical History of Freda Katchel.

This patient was brought here by sheriffs deputy J. P. Flaudrake attended by Anton Katchel in fair physical condition: No history of consanguinity: First attack manifested by melancholia in April 1896. has had several attacks since lasting from one to 2 mths: (First occurred after Sister was sent away insane) Disease appears increasing: Variable with rational intervals: Trouble increases during menstruation: Derangement manifested by musical eccentricities: Not disposed to injure others: Has attempted suicide by poisoning & drowning: Propensity not active now. Is filthy & destructive: Sister, Anna Kachel, was confined in this hospital in 1896. (died at home in June '96) Father is insane now. No previous peculiarities known: No history of intemperance in parents or self. No severe disease or head injury: Has not been confined or restrained. Has received a general treatment.

On personal examination, no further particulars noted.

On admission put upon B^r W. (Gth H. Rpt. Complexion Dark: Eyes gray: hair brown: Condition of skin normal. No marks or scars noticed: Is rather dirty Goitre on right side of neck: Behavior hysterical: has delusions & is rather incoherent)

1897 Mar 28 Summary Nurse's 14 Day Record:- ~~March 30~~ Patient put to bed: rather noisy, restless and in a state of mild acute mania: During the first week patient uniformly in a state of mild mania, hysterical, noisy in talk & more or less incoherent most of the time: Appetite good, temperature normal: During second week patient grew rather more quiet: Mar. 25, 26, 27, was able to be in sewing room: Mar. 28th, although not at all well was taken out on trial by special request of her brother & father. Original record preserved.

Apr. 3 Summary Nurse's Notes by Dr. St Phelps. Returned: Very noisy & excited: hysterical in behavior: quite violent: fought most of day: Apr. 7 In seclusion 3 hours: fought most of day: Apr. 9: In restraint 21 hours: Apr. 10-11-12 In restraint most of day: May 8 Very quiet & agreeable on ward: Improved a good deal: appetite fair: bowels regular: menst. regular: May 22 Extremely noisy: at times quite violent: June 30: Violent & destructive: July 1. In seclusion: July 2- Very cross & irritable: In seclusion: put in restraint during night: July 21 Quiet & agreeable: takes out door exercise: Aug 1 Very noisy & disagreeable: Aug 7 Menst. Has been rather dull for past 3 days. Aug 31 Quiet & rather dull: appetite fair: usually sleeps well. Continued by Dr. W.M. Phelps. Nov 29 '97 Patient rather melancholy at times, at others quite violent & very incoherent in behavior. Dec 1 Has been quite violent today

Jan 6 '98 Visited by father: Feb 27 Wt. 121 lbs. Has been rather melancholy during last month

May 26 Has been visited a good many times by her brother who is staying in town. Is quite disturbed. July 28 '98 Patient taken out by brother & sister who wished to give her a trial. She is quite melancholy & quiet at present.

Discharged.

Personal and Medical History of

Personal and Medical History of Mattie Quam

EBERT, FULLER & EKLUNDH, DAVENPORT, IOWA.

Whole No. 4713

Residence, Freedom Co, Minn.

Date Admission, March 18' 1897.

Admitted by Dr. R.M. Phelps Hour, 7 P.M.

How Sent, Herman Blackmer Dep? Freedom Co.

Sex, Female.

Age, 19

Civil Condition, - Single -

Children,

Age Youngest Child,

Occupation, School Teacher

Degree Education, - Good.

Profession Religion, yes Lutheran.

Habits, not intemperate.

Nativity, Minn. (Parents Norway)

Physicians Committing, A.L. Wedge & F.A. Blackmer.

Correspondents, Mrs O.J Quam Box 87. Glenville Minn.

No. for Year, 246.

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing,

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Aug. 1896

Duration, 6 to 7 months.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 19.

Time of Leaving, Aug. 11. 1900

Time in Hospital, 3 yr. 8 m. 24 d.

Result, Died Tuberculosis Pul.

EXAMINATION ON ADMISSION.

Exam. 3/18/97 by Dr. R.M. & A.L. Phelps

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused -

Quick or Sluggish, Sluggish -

MEMORY:

Past Events, Somewhat impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Is quiet & pleasant but is rather confused in mind. Says she has bad feelings around heart at times. Pupils widely dilated.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Is sure that she is Vice

Special Subjects, President's daughter.

Transitory or Not, Dresses her relation & known family.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Mattie Quam.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in. WEIGHT, 171 lbs. when NUTRITION, Fair, fleshy & good color.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Slight coat Promptness Movement,

PUPILS, Equality, Equal. Size, Widely dilated.

Response Light, Accommodation,

SIGHT, Impaired.

HEARING, Normal.

COORDINATION, Arms, Normal.

Legs,

TREMORS, Hands, None. Tongue,

Facial Muscles, General, None.

REFLEXES, Patellar, Both about 7

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Seem normal.

HEART, Distinct murmur. Irregular at times.

LUNGS, Normal.

EXAM. URINE, Mar. 20'97.

Color Yellow.

Character Clear.

Reaction Acid.

Sp. gr. 1010

Albumen none.

Sugar None.

Quit 24 hrs. XXV Z.

Microscop. Amor. urates. Triple phosphates, a few pus corpuscles & bladder cells.

TAKEN,

GYNÆCOLOGICAL EXAM., Uterus Normal position. Some erosion of os: external genitals excoriated

MENSTRUATION, Some trouble for past year with menstruation - Took cold & ceased for some time.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Has peculiar fullness of forehead.

HISTORICAL, Has had measles - no other diseases.

LENGTH OF INVASION, 1 year. ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, Aunt insane.

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Mollie Quaw.

This patient was brought here by Sheriff's deputy W.C. Mitchell, attended by Anna Quaw. in fair physical condition with the following history:- No information concerning consanguinity: First symptoms manifested August 1896: Disease appears increasing: variable but with no rational intervals Derangement manifested by delusions: thinks she is daughter of the Vice President of United States, And Alice Means of Madison Wisconsin: Is disposed to injure others: Not filthy or destructive: Previous peculiarities was not disposed to work but was quietly thoughtful: No history of intemperance in parents or self: Had a severe convulsion at age of 4½ years. Patient has been held for a short time to prevent throwing things about the house: No treatment pursued.

On personal examination:- Said in Conversation that she has delusions as stated above: She is persistent in statement that her family are not her relations & that she was brought to them when a child, she is determined to go to her mother- On admission put upon B'k'd/Gen'l Rpt Complexion fair, hair brown: Eyes gray: No marks, scars or eruptions noted: Is clean: Behavior quiet: Has delusions.)

Mar. 31 Summary Nurses 14 Day Record:- A young looking girl, quite healthy in appearance: Temperature during first week normal, appetite good: Is delusive & silly in her talk, growing more so the latter part of the week: First day or two answered questions much better than on 7th day: During the second week the same condition continued: was once or twice quite excited: Often very silly: At times very stubborn. Original records preserved.

Apr. 8 Summary Nurse's Notes by Dr. E.E. Phelps. Threw dishes in dining-room: Apr. 28: Tried to choke by tying string around throat: quite noisy at times: very stubborn has many delusion: careless in personal appearance: does no work:

June 20 Fought nurses: June 27: untidy in appearance: appetite good: quite quarrelsome:

July 4 Attempted suicide by tying string around neck: Fought desperately: tried to stab herself with knife in dining-room: tried to strike her head against wall:

Aug. 29. Becoming quite stupid: refuses to talk: Attempts suicide in various ways very often Continued by Dr. E.E. Phelps Nov. 14'99 Inclined to be suicidal: Cut her arm with a knife in the dining room. Jan. 1'99 Fought nurses. Is, however, quite stupid & silly of late

Mch. 1 '99 Trans to 6th. Has been rather more troublesome & violent. Feb 2 '99 Has continued quite stupid & silly, at times inclined to be somewhat violent.

Mch 1- Aug 31 '99 Cont. by Dr. Bess. Appetite good: sleeps well: bowels regular: habits filthy: Takes outdoor exercise: Is extremely noisy. Aug 30 Visited by relatives, refused to talk to them.

Sept 1- Feb 28 1900 (Dr. Heyndale) Appetite good: Dirty & careless: Takes outdoor exercise: Violent at times: Bowels regular: Menstruates regularly. Mch 1- Nov 30 1900 In bed feet swollen: Very stupid: Fed by nurses: Temp. 99°: Pulse 76 R 20.

Personal and Medical History of

Apr 17. 1900 Up on ward. Seemed weak: Put back to bed. May 5 Trans. to Infirmary May 30. Very untidy; quiet in behavior, does not converse. Requires laxatives. May 30. In bed. Fed mechanically. Occasionally answers when spoken to: very untidy - coughs some. July 30 Given liquid diet. Gradually growing weaker: Aug 10. Very weak. Somewhat restless during night. Seemed to be in pain shortly before 12 M. & Died at 12:45. Cause of death - Tuberculosis of Lungs-

Died.

Personal and Medical History of Mary Moraw

BURGERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. H 715
Residence, St. Paul, Minn.
Date Admission, March 20th 1897.
Admitted by Dr. Asa. Phelps. Hour, 7 P.M.
How Sent, G. Willrich & Co. & P. Ramsey Co.
Sex, - Female.
Age, - 37 -
Civil Condition, married.
Children, Two.
Age Youngest Child, 3 years -
Occupation, - Housework.
Degree Education, - Common school -
Profession Religion, Ups - Catholic -
Habits, Not Intemperate
Nativity, Wisconsin. (Mother Germany)
Physicians Committing, E. C. Eshelby & Gustav A. Renz.
Correspondents,

No. for Year, 248.
Insane Relatives, Unknown.
Cause Exciting, Worry & uterine disease
Cause Predisposing, Previous attack.
Form,
Accompanying Bodily Disorder, Uterine trouble.
Suicidal or Not, Ups. attempted hanging - propensity active.
Date of this Attack, —
Duration, —
No. of Attack, Has had several.
No. of Admissions, 1st
Age First Attack, About 30 yrs -
Time of Leaving, Apr. 19. 1897
Time in Hospital, 30 da.
Result, Discharged Sept 28. 1897. Recovered.

EXAMINATION ON ADMISSION.

Exam. 3/22/97 by Drs R. M. & A. L. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Seems fairly clear on most subjects
Quick or Sluggish,
MEMORY:
Past Events, Good.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Quite correct.
REASONING POWER:
Ordinary Subjects, Somewhat Impaired.
Own Mental State, Dau. says she has been out of mind twice before.
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Talks a great deal - Memory seems good. Quiet & well behaved - Thinks this trouble with her head came on from overwork. General physical condition good.

EMOTIONAL STATE:
Normal, Calm, A little excitable.
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Thinks she is pregnant.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,
Seems quite correct in her statements - Pleasant in manner. Says she

Personal and Medical History of Mary Moraw.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 2 in. WEIGHT, 94½ lbs. NUTRITION, Good.
WOUNDS OR ABNORMALITIES, None Skin Normal condition.
TONGUE, Tremors, Coatings, Slight white - Promptness Movement, Deviates toward left.
PUPILS, Equality, Unequal. Size, Left larger.
Response Light, Normal. Accommodation, Normal.
SIGHT, Says usually good.
HEARING, Normal.
COORDINATION, Arms, Normal.
Legs, Normal.
TREMORS, Hands, None. Tongue, None.
Facial Muscles, General, None.
REFLEXES, Patellar, Both ↑.
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries Normal.
HEART, No murmurs.
Sounds normal - Regular.
LUNGS, Normal.
TAKEN,

EXAM. URINE, Mar. 27'97
Color Yellowish red.
Character Cloudy. Flaky deposit. ↑
Reaction Acid.
Sp. gr 1024
Amt 24 hrs. XV ½.
Albumen Trace by Esbachs
Sugar None
Microscop. Large amt. Amor. urates a few bladder & vaginal epithelium Large amt. Oxalate of lime

GYNÆCOLOGICAL EXAM., 3/24/97 Uterus enlarged. Finds her to be pregnant about 5½ mos. Os is lacerated. Menstruation continues.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Fretful at times - No disease
LENGTH OF INVASION, Since last Fall - ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Died years ago.
Father or Pat. Relations, Strong & healthy 76 When died - Inflammation of bowels.
Brothers or Sisters,

This patient was brought here by sheriff deputy P.J. Mines attended by Mrs. Sylvester, in fair physical condition:- No history of consanguinity: First attack 7 yrs. ago, another 5 yrs. ago - several since. duration 9 weeks. First symptoms of present attack manifested by melancholia & refusal to speak: thoughts of persecution: disease appears increasing: variable with irregular rational intervals. Derangement manifested by melancholia, delusions of prosecution, attempts at suicide, refusal to speak: Not disposed to injure others: No destruction of furniture etc. No previous peculiarities: Nothing known as to intemperance in parents or self: No severe disease or head injury: Not restrained or confined: No treatment pursued: On personal examination is depressed, pale, paresis of right eyelid, refuses to speak.
On admission put upon Br W (Gtn. Apt. Complexion fair: hair light brown: Eyes gray: Condition of skin normal No marks or scars noted. Red rash on chest & back. No bruises or ulcers. Is very dirty: Right side of face scarred & left eye crossed: Behavior quiet. Talks sensibly.)

1897
Apr. 3. Summary Nurses' 14 Day Record:- A sensible, quiet intelligent appearing patient: Temperature during first week normal & appetite fair: Talked quietly & answered questions with fair accuracy: agreeable in manner: Same condition continued during second week, in which she did some work: She herself admits some spells of mild mental trouble, but thinks at present she is somewhat better. Original Record Preserved.

Apr. 18 Summary Nurses' Notes by Dr. L.L. Phelps:- Quiet & agreeable on ward: bowels regular: appetite fair: takes tonic: takes outdoor exercise: works most of time in employe's dining-room- Apr. 19 Went Home-

Discharged.

Personal and Medical History of Edith Huntress

EBERT, FISCAL & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4719
Residence, St. Paul, Minn.
Date Admission, March. 22' 1897.
Admitted by Dr Rlw. Phelps. Hour, 6 P.M.
How Sent, G. Willrich J. of P. Ramsey Co.
Sex, Female.
Age, -
Civil Condition, -
Children, -
Age Youngest Child, -
Occupation, -
Degree Education, -
Profession Religion, -
Habits, Used morphine & Liquor alcoholics.
Nativity, -
Physicians Committing, C.E. Riggs & A. MacDonald MD.
Correspondents,

No. for Year, 257.
Insane Relatives,
Cause Exciting,
Cause Predisposing,
Form, Insanity again
Accompanying Bodily Disorder,
Suicidal or Not,
Date of this Attack,
Duration,
No. of Attack,
No. of Admissions, 2 Legs unsane Sane as inebriate -
Age First Attack,
Time of Leaving, Apl. 22. 1897
Time in Hospital, One month
Result, Died. Sub-acute Meningitis

EXAMINATION ON ADMISSION.

Exam. by Rlw. & Sh. Phelps 3/23/97

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 refused to say a word while in Hospital at St. Paul. Refuses now. Lies in apparently fair comfort. dazed or confused. No signs of any reaction from stopping of morphine & no assurance that she has been taking any lately.
Previous history gives more of detail. No information obtained this time.
No friend came with her.

Personal and Medical History of Edith Huntress.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Whitish coat slight Promptness Movement,
PUPILS, Equality, Equal Size, dilated
Response Light, Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms, Previous Examination
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Sounds quick - No special murmur
LUNGS, Normal
GYNÆCOLOGICAL EXAM., Normal condition
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Mar. 29. 97.
Color Reddish brown.
Character Cloudy with thick ropy deposit
Reaction Acid.
Sp. gr. 1025
Amt. 24 hrs. XX 3.
Albumen Trace by Tanrets.
Sugar None.
Microscop. Amor. urates - a few bladder & vaginal epithelium. Some fat globules, pus & a few blood corpuscles.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE, 104	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, Has taken morphine & liquors - Said to have had a similar attack 3 yrs. ago. Was in Mendota.
LENGTH OF INVASION, Probably short ONSET GRADUAL OR SUDDEN, Sudden (of this attack
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Edith Hurtuss

This patient was brought here by sheriffs deputy P. J. Mosier attended by miss Jules in fair physical condition. No information concerning patient given in papers. Note says she refused to answer questions & no information obtainable. Patient was confined in this institution as an inebriate warrant from Sept. 1' 1896 to October 6th 1896. Used both morphine & alcoholics. For further information see Vol. 3r. Page 191. No. 4511. On admission put upon B.W. (G.H.U. Rpt. Complexion dark: hair brown: eyes gray: condition of skin normal. no marks noticed: small scar on left arm & upper lip: a few small bruises on arms: Is clean: behavior quiet: Will not talk.)

1897. Apr. 5. Summary Nurse's 1st Day Record: Admitted upon warrant as insane: Found to be very stupid, refusing to talk, although apparently knowing what was done, with a half delirious manner, however: Temperature varied from 99.2 to 101.2 during first week. Was rather stupid, dirty in habits, obstinate and nervous. Her manner was best described as dazed & bewildered, suggesting somewhat the tremulous indecision accompanying meningetis: During second week grew worse rather than better: Grew restless & destructive, resisting a great deal: Appetite became poored & general condition worse. Original Record Preserved.

Died April 22' 97.

Personal and Medical History of

Personal and Medical History of Rose A. Major.

Whole No. 4725
Residence, Wasseca, Minn.
Date Admission, Mar. 28, 1897.
Admitted by Dr. R. M. Phelps. Hour, 7:30 P.M.
How Sent, Gw. A. Wilson, Q. of P. Wasseca Co.
Sex, - Female -
Age, - 25.
Civil Condition, - Married -
Children, - 2 -
Age Youngest Child, - 3 yrs.
Occupation, Housewife (Husband Railroad Clerk)
Degree Education, Common school.
Profession Religion, Catholic.
Habits, Not intemperate.
Nativity, Minn. (Father Ireland Mother Rhode Island)
Physicians Committing, J.B. Lewis & D.J. McMahon.
Correspondents,

No. for Year, 258.
Insane Relatives, None.
Cause Exciting, Unknown
Cause Predisposing, Unknown.
Form,
Accompanying Bodily Disorder, None Mentioned.
Suicidal or Not, Not.
Date of this Attack, Jan. 1' 97.
Duration, Nearly 3 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 25
Time of Leaving, July 26. 1897
Time in Hospital, 3 mos. 28 d.
Result, Discharged Nov. 3. 1897 Unimproved

EXAMINATION ON ADMISSION.

Exam. by Rill & Al. Phelps 3/29/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Not so much confused as deluded.
Quick or Sluggish, Fairly quick.

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

PERCEPTIVITY:
Alert or Dull, Fairly alert.
Correct or Illusive, Incorrect.

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

GENERAL DESCRIPTIVE REMARKS: Patient states that in looking out window came to think neighbors were watching her. Was afraid they were going to harm her. One time yesterday thought a man made her to be a dog. Today these seem largely "imaginings" Still she is not quite free. Thinks people do watch her.

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

DELUSIONS:
Systematized or Not, Fairly systematized.
Special Subjects, Thinks she is a dog at times

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Rose A. Major

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in. WEIGHT, 97½ lbs. NUTRITION, Impaired.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Yellow coat. Promptness Movement, Prompt.
PUPILS, Equality, Equal Size, dilated.
Response Light, Yes Accommodation, yes.
SIGHT, Normal.
HEARING,
COORDINATION, Arms, Fair - full tests not made
Legs, "
TREMORS, Hands, at times Tongue, –
Facial Muscles, – General, –
REFLEXES, Patellar, 8 Equal.
Other
ARTICULATION,
Slurred, } Normal.
Hesitating,
FACIAL EXPRESSION,

EXAM. URINE, Apr. 2' 97.
Color Reddish yellow.
Character Cloudy - flaky deposit.
Reaction Acid.
Sp. Gr. 1012
Albumen Trace by Esbachs
Sugar None.

SENSIBILITY,
Arteries Normal.
HEART, No murmurs. Sounds fair Size-possible, weak & somewhat enlarged after beat under nipple nearly. Regular
LUNGS, Narrow chested. Stoop shouldered & rather Breath sounds good.
TAKEN,
GYNÆCOLOGICAL EXAM., 3/31/97 Uterus normal position Laceration cervix & perineum Erosion of os.
MENSTRUATION, Regular
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Had Pneumonia. - Headaches & dizzy spells
LENGTH OF INVASION, "Since June" ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") No Heredity.
Mother or Mat. Relations, Dead - Rheumatism & heart disease
Father or Pat. Relations, Living Healthy.
Brothers or Sisters, 5 brothers living 2 dead - 4 sisters living 1 dead.

Personal and Medical History of Jose A. Major.

1897

This patient was brought here by Sheriff's deputy George Goodspeed, attended by her husband & sister, in fair physical condition, with the following history: No history of consanguinity, heredity or intemperance in parents or self: First symptoms of attack manifested Jan. 1, 1897 by imagining she had offended her neighbors: Disease appears increasing: Is variable with irregular rational intervals: Derangment manifested by imagining that every one is against her, is afraid of bodily harm & wants to get away from town. Not disposed to injure others: not suicidal, filthy or destructive: No severe disease or injury to head: Has received tonic & bromide treatment.
No further particulars noted on personal examination.
On admission put upon B' W. Ward Rpt. Complexion dark: hair brown: eyes gray: Condition of skin normal: Small scar on forehead above left eye: Eruption on face, arms & back. No clews or bruises noted. Is clean; behavior quiet (has delusions)

1897
Apr. 10. Summary Nurse's 14 Day Record:- Temperature taken during first week shown to be normal: Patient ate quite regularly, although refusing once or twice and not eating very well: Second day talked somewhat rationally, but afterward always full of delusions of a depressing character: Quiet & melancholy during second week also: So depressed as to be unable to talk much or answer questions: Was getting out of doors some but at end of fourteen days shows little or no improvement. Original Record Burned.

Apr. 26 Summary Nurses Notes by Dr. Phelps Has been upon Gynaecological treatments every other day: Is quiet & agreeable on ward: Very melancholy: Has many delusions. May 28 Salt baths & massage given three times a week: Patient talks a good deal about killing herself: Appetite quite good: bowels regular: Does no work: June 27 Patient takes salt baths & electrical treatments three times a week: Is quiet: has delusions: June 28 Visited by husband: July 26 Visited by husband & taken home against advice of physicians.

Discharged.

Personal and Medical History of

Personal and Medical History of Sarah McKay

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4726

Residence, St. Paul, Minn.

Date Admission, March 29. 1897.

Admitted by Dr. R.M. Phelps Hour, 7 P.M.

How Sent, G. Willrich J. of P. Ramsey Co.

Sex, Female.

Age, 23

Civil Condition, Single

Children, none

Age Youngest Child, -

Occupation, none.

Degree Education, Common school.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, United States.

Physicians Committing, H.J. O'Brien & Arthur Downey.

Correspondents, none given in papers.

No. for Year, 259.

Insane Relatives, None.

Cause Exciting, Malnutrition + Typhoid.

Cause Predisposing, —

Form,

Accompanying Bodily Disorder, Malnutrition.

Suicidal or Not, ? never attempted.

Date of this Attack, July 1896.

Duration, 8 months.

No. of Attack, 1st.

No. of Admissions, 1st.

Age First Attack, 23.

Time of Leaving, May - 13, 1898

Time in Hospital, 1 yr. 2 m. 15 d.

Result, Discharged Nov. 9 '98 Unimproved

EXAMINATION ON ADMISSION.

Exam. by R.M. + A.L. Phelps. 3/29/97 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Impaired.

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects, Impaired

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, + Excitable

DELUSIONS:

Systematized or Not, Seems to have many.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient refuses to talk or answer questions excepting to shake her head. At times repeats things over + over to herself in an excited manner. Picks her face + scalp in places until it bleeds. Quite exhausted in general appearance. Put upon daily salt baths - Eggnog twice per day - Malting + Cod liver oil.

Personal and Medical History of Sarah Mc Kay

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, —— WEIGHT, —— NUTRITION, Impaired.

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Coatings, White Coat - red + irritated in places. Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Accommodation,

SIGHT, Says good.

HEARING, Seems normal.

COORDINATION, Arms, Normal.

Legs, "

TREMORS, Hands, None Tongue, None

Facial Muscles, " General, "

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Will not talk.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Sounds Normal - Quite at Normal condition.

LUNGS, Chest symmetry normal. Expansion + normal - Breath sounds "

EXAM. URINE, Apr. 3 '97.

Color, Reddish Yellow.

Character, Cloudy.

Reaction, Acid.

Sp. Gr. 1030.

Amt. 24 hrs. XV ℥.

Albumen, Trace by Tannets.

Sugar, None.

Microscop. Bladder cells - a few pus corpuscles - Amor urates + a few uric acid crystals.

TAKEN,

GYNÆCOLOGICAL EXAM., 4/23/97 Uterus retroverted + bound down - Otherwise normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has had Typhoid fever.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Sarah McKay

1897

This patient was brought here by sheriffs deputy P.J. Meiss attended by her mother & S. Marks. in a somewhat exhausted condition, with the following history:- No history of consanguinity: First symptoms manifested after an attack of Typhoid fever in July 1896 has been melancholic ever since. Was in St. Josephs Hospital St. Paul: Disease appears increasing; is variable: on one or two occasions has been semi-rational for a day or two. Derangement manifested by General agitated melancholia of a religious type: Is disposed to injure others: Has never attempted suicide but think there is danger of it: Occasionally destroys clothing: No previous peculiarities shown: No history of intemperance in parents or self. No injury to head. Has been restrained both by manual & mechanical restraint at St. Josephs Hospital. Has received no treatment except at hospital.
On personal examination Is noisy, incoherent & violent with religious delusions: On admission put upon B.W. Cot Complexion dark: hair brown: eyes gray: No marks or scars noted: Several sores on head: bruises on body: Is dirty: Very excited: Has delusions)

1897
Apl. 1 1897 Summary Nurse's 14 Day Record: Patient was put to bed, several bruises being found on her body: Resisted quite actively: was restless the first night: Mar. 30 Patient found to be very dirty in habits & so restless as to have to be put in restraint: also refused to eat: picks her face: was fed with tube: Mar. 31. Patient still in restraint: Slept only one hour: Struggling whenever awake:
Apl. 1. In restraint 10 hours: very nervous, picking her face & hands: was fed with spoon: Apr. 2.- Ate breakfast but no dinner & supper: In restraint:
Apr. 3. Restless, nervous worrying: Eating some at each meal: Record during Second week shows this same condition to continue, with some slight improvement: Became more quiet but was very uncertain in behavior: Several times trying to run away: Occasionally had to be put in restraint & was quite dirty in habits. Original Record Removed.
Apr. 30 Summary Nurses Notes by Dr. Phelps. Behavior quiet: Very seldom talks: answers a few questions: Is dirty in habits & has many delusions: Does no work. Continued by Dr. Rm. Phelps.
Nov. 1897 General health apparently good: Is taking gynaecological & has also been given massage: Is rather anaemic, quiet & dull: May 1898 Taken home on trial. Has improved some walks still coughs some & is in rather poor health & is very dull.

Discharged.

Personal and Medical History of

Personal and Medical History of Ellen Murphy.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4731
Residence, Hastings Minn.
Date Admission, April 2nd 1897
Admitted by Dr R.M. Phelps Hour, 7 PM.
How Sent, Thos. P. Moran J. Spt Dakota Co.
Sex, Female -
Age, - 40.
Civil Condition, Single
Children, -
Age Youngest Child, -
Occupation, - Servant - (Father Farmer)
Degree Education, none -
Profession Religion, Catholic -
Habits, Not intemperate.
Nativity, Illinois (Parents Ireland)
Physicians Committing, A.M. Adsit & J.C. Fitch M.D.
Correspondents, brother Thomas Murphy
Rich Valley Dak. Co. Minn.

No. for Year, 264
Insane Relatives, None.
Cause Exciting, Not Known
Cause Predisposing, Not Known.
Form, Melancholia Acuta -
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Never attempted - Propensity active.
Date of this Attack, —
Duration, —
No. of Attack, ~~First~~ Only "never recovered" ~~(4th time)~~
No. of Admissions, 1st
Age First Attack, 38
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps. 4/3/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Quick
Quick or Sluggish, Confused.
MEMORY:
Past Events, Somewhat 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:

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Somewhat Systematized.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Ellen Murphy.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 7 in WEIGHT, 101 lbs NUTRITION, Somewhat poor
WOUNDS OR ABNORMALITIES, None
TONGUE, Tremors, Coatings, Slight coat. Promptness Movement,
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,
GYNÆCOLOGICAL EXAM. 4/3/97 Uterus 2nd degree prolapsus - some haemorrhoids
MENSTRUATION, menopause passed
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Apr. 7/97-
Color. Pale yellow.
Characte Cloudy flaky deposit.
Reaction Acid.
Sp. gr. 1018
Amt. 24 hrs. XXX ℥
Albumen Trace by Tanrets.
Sugar. None.
Microsop. Large amt. amor. urates,
bladder & vaginal cells & oxalate of lime.

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

CRANIAL MEASUREMENTS,
HISTORICAL, Don't know age gave 35 yrs. Headaches - but very seldom. Attack been practically continuous since 90.
LENGTH OF INVASION, 2 or more years. ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any
Mother or Mat. Relations, Healthy
Father or Pat. Relations, Died suddenly 3 yrs. ago.
Brothers or Sisters, ~~No~~ 9

Personal and Medical History of Ellen Murphy

1897

This patient was brought here by Sheriffs deputy John Wasser attended by Mrs. M. Wasser & Thomas Murphy, in fair physical condition with the following history: No history concerning Consanguinity, heredity or intemperance in parents or self. First attack in 1895: were recovered first symptoms manifested by delusions of persecution: Disease appears increasing: Is variable; with ½ rational - Believes herself persecuted & certain friends ill. Is disposed to injure others: No filthy or destructive habits: Previous peculiarities shown, depressed at times & at others greatly excited. No severe disease or head injury: Not confined or restrained: Jonies & bromides etc given to produce sleep: On personal examination

Apr 2 appears excited & very abusive - Threatens to kill people whom she thinks have persecuted her. On Admission put upon Br W. (Gth Apt.

Complexion dark: hair & eyes brown: condition of skin normal: No marks: scars or bruises noted: Is rather dirty: Behavior excited: Has delusions)

1897 Apl. 16 Summary Nurse's 14 Day Record:- Patient put to bed, ate supper and slept six hours the first night: Apr 3:- Patient's condition fairly good: behavior quiet:- Is in a state of seemingly chronic mania: Scolds some & resisted some in going to bed: Temperature normal during the first week: Appetite fairly good: Patient evidently has been as she is now for some time, there being only a Gradual mental invasion. During second week continued about the same: Usually quiet, although occasionally scolding & talking about herself as not insane, & wishing to go home. Original Record Transmd

Apr 17 Appetite good: Talks quite sensibly: Takes a good deal of exercise: May 10 Very easily excited: very quarrelsome & destructive: June 1 Appetite good: Works on ward: Is excitable & rather destructive.

Continued by Dr. W.M. Phelps. Nov 21 '97 Rather melancholy at times: Talks some at present. Trans today to A2. Feb 22 Patient becoming somewhat noisy. Trans. to B3. Feb 24 Quite melancholy: bruised her head & pulled out her hair during night. Feb 26 Trans. to B2. Apr 26 Patient has been quite noisy, agitated & melancholy. Aug 26 Wt. 104#. Has quieted down somewhat. Feb 25 '99 Wt. 107½# Has improved somewhat in behavior: Is quieter, but is still quite depressed & easily excited. Mch 1 - Aug 31 '99 Cont. by Dr Bebb General health somewhat impaired: Appetite very: Sometimes refuses to eat: Several times necessary to feed her mechanically: Very nervous & restless, also melancholy & cries a great deal resists being bathed & being taken to dining room, is noisy & nurses are often obliged to feed her. Is very untidy in habits & careless in appearance: Seldom takes out door exercise: works but little. Aug 26 Visited by sister. Aug 29 Wt. 99#. Always has a distressed expression.

Personal and Medical History of Ellen Murphy.

1899-1900.

Sept 1 - Feb 28 1900 (Dr Heyerdale) Very restless & nervous: noisy at times: Appetite poor: Eats & sleeps well. Takes occasional outdoor exercise. Fed by nurses at times Jan 18 00. Wt 97#. Mch 1 - Nov 30 1900 (Dr Linton) Clean but rather careless: Very restless & nervous & walks up & down a great deal: begging to be sent home: Sometimes cries. Appetite poor. Often has to be compelled to go to dining room Menstruation regular: Sleeps quite well: Takes outdoor exercise Assists a little with work: July 16 Vaccinated Nov 16 Wt. 100#. Does not menstruate: Takes out-door exercise: Is inclined to be melancholy & resistive: Is incoherent & comprehension dull: Op wanders unhappily about ward most of time unless requested to sit in bay. Sometimes asks if she is to be left all alone. Dec 1 - Feb 28 1900 Appetite good: bowels regular: Physical condition good: Does not attend amusements: Nervous & discontented: Does not read nor converse but will answer questions quite intelligently: Much disturbed if patients are fed or treated in anyway thinks they are being killed Mch 1 - Mr. 99# Mar. 1 - 1901 June 1 - 1901

No change in mental or physical condition. Does no work

May 29 Wt. 99# June to Sept. Does no work, attends no amusements, menstruates regularly Sept. 2 Wt. 95#.

Sept to Dec. No change during quarter, Nov. 22 Wt. 100#.

Up to Feb. 1, 1903 appetite rather poor: bowels regular: sleeps well: menstruates regularly: takes exercise: attends no amusements as a rule does no work: occasionally assists with the hall work: is at times quite noisy: scolds and gesticulates: does not converse intelligently. Nov. 30th. Wt 100#.

Personal and Medical History of Maria Garlick

Whole No. 4732

Residence, Wells, Minn.

Date Admission, April 2nd 1897.

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

How Sent, J. F. Winship Dep. P. Faribault Co.

Sex, Female.

Age, 35

Civil Condition, Single

Children, one

Age Youngest Child, Three years.

Occupation, None. (Father day laborer)

Degree Education, — None.

Profession Religion, Catholic.

Habits, not good.

Nativity, Germany (Parents Germany.

Physicians Committing, F.W. Lindlock & M. McKelson.

Correspondents, G. M. Graham. (Friend) Wells Minn.

No. for Year, 265.

Insane Relatives, Don't know, none ascertained.

Cause Exciting, —

Cause Predisposing, Probably heredity.

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, —

Duration, —

No. of Attack, 1st

No. of Admissions, 1st (First time at poorhouse)

Age First Attack, —

Time of Leaving, Feb. 14. 1899

Time in Hospital, 1 yr. 10 m. 12d.

Result, Transferred to Fergus Falls

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by P.M. Phelps 4/2/97

MENTAL ACTIVITY:

Clear or Confused, Weak minded

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events, Seems somewhat poor

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Weak.

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 says she was without father, mother brothers or sisters in Germany & a man brought her on here. Kept house for a man - until she had a child. (illegitimate) when he turned her out & called her crazy. She don't know her age, can give little information. Seems defective. Spinal curvature antero-posterior. Chest projecting. Size very small.

Personal and Medical History of Maria Garlick.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 6 in WEIGHT, 98 lbs. NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, Skin fairly good condition

TONGUE, Tremors, Good - Coatings, — Promptness Movement, —

PUPILS, Equality, Equal Size, Dilated Some.

Response Light, Yes - Accommodation,

SIGHT, Probably good.

HEARING, Fair.

COORDINATION, Arms, Probably good; now in bed.

Legs, "

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, 7-8 equal.

Other

ARTICULATION, Normal in

Slurred, German - Nasal

Hesitating, Quality to speech.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries somewhat prominent - sclerotic

HEART, Normal.

LUNGS, Normal.

TAKEN,

EXAM. URINE, May 6/97

Color	Yellow
Character	Cloudy flaky dep.
Reaction	Acid.
Sp. gr.	1025
Amt. 24 hrs	XXXIII ℥
Sugar,	None
Albumen	None
Microscop.	Amor. urates + triple phosphate crystals.

GYNÆCOLOGICAL EXAM., 4/23/97 Uterus retroverted - os lacerated - Cystic degeneration cervix - some discharge

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Drinks some

LENGTH OF INVASION, Many years. ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters, Denies remembering any father, mother brothers or sisters - Has one child

Personal and Medical History of Maria Garliet.

1897

This patient was brought here by Sheriffs deputy LC. Taylor accompanied by mrs LC. Taylor, in fair physical health with the following history: Nothing can be ascertained as to consanguinity, heredity or intemperance in parents or self: This is 1st attack, continuous - Has been so as long as known (15 months) Roving & restless; disease is stationary & variable, without obvious cause becomes uncontrollable. Will escape from place of abode or friend on any opportunity to do so & rove about the country: Is disposed to injure others: No filthy or destructive habits: Nothing known of her condition previous to coming to poor house 15 months ago. No severe disease or head injury. Confined at poor house as above stated: no treatment pursued: On personal examination. her mind is incoherent, does not understand her condition: She is in such a state mentally & physically that she cannot care for herself. On admission put upon infirmary list. Complexion dark: hair brown partly gray; eyes gray: Condition of skin normal: no marks, scars or bruises noted: Is clean; behavior quiet: Does not speak English)

1897
Apr. 15 Summary Nurse's 14 Day Record:- Received on Infirmary Ward in a rather untidy condition but seemingly healthy. Apr 3:- Ate well & helped in dining room the first day: Rather noisy in talk during the afternoon: During first week patient fitted at once in to the work upon the ward: Seemed inclined to do something continually: Is evidently in a chronic state of mild dementia & is possibly somewhat of an imbecile: During second week same behavior continues: At times patient cries and is melancholy: occasionally somewhat stubborn: usually, however, gets along quite well. Original record Removed.

May- General health good: No Mental change: Menstruation regular; July- Mental condition is that of imbecile: Physical health remains good: August Appetite good: At times resists & cries: General health good.
Continued by Dr. R.M. Phelps. Oct 7'97 Has been of late rather inclined to be violent & troublesome & scolds a good deal. Chest examination made today. Shows no very marked impairment has found, there is some deformity. Feb 9' 98 Wt. 95#
Feb 14'99. Transferred to Fergus Falls today. Has been at times somewhat restless & excited but is usually quiet, feebleminded & demented.

Personal and Medical History of

Personal and Medical History of Jurina Malo

ROBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4735
Residence, Black Hammer Minn.
Date Admission, April 6' 1897.
Admitted by Dr. A.L. Phelps Hour, 4 P.M.
How Sent, Thomas Ryan J. af P. Houston Co.
Sex, Female.
Age, 27.
Civil Condition, Married.
Children, 6
Age Youngest Child, 10 mo.
Occupation, Housewife.
Degree Education, Can read & write.
Profession Religion, Lutheran.
Habits, Not intemperate.
Nativity, Minnesota (Parents Norway)
Physicians Committing, Wm Freeman & Ry. Ferguson (Hot)
Correspondents, None given in papers. F.A. Allen (Father) Spring Grove, Minn.
Dr Jensen, Spring Grove, Minn. (Physician)

No. for Year, 268
Insane Relatives, One Aunt.
Cause Exciting, Religious excitement.
Cause Predisposing, Heredity?
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, Mar. 7 '97
Duration, 1 mo.
No. of Attack, 2nd.
No. of Admissions, 1st
Age First Attack, 27.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by A.L. Phelps 4/7/97

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: When asked questions tries to answer but is very incoherent. Talks to self. Does not realize anything. Very restless most of the time. Very dirty & combed with mitts. Habits dirty.

Personal and Medical History of Jurina Malo.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ WEIGHT, 176½ NUTRITION, Good.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Accommodation,
SIGHT, Seems good.
HEARING, "
COORDINATION, Arms, Seems normal.
Legs,
TREMORS, Hands, None. Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Slurred.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs.
Strength. Sounds normal.
LUNGS, Chest sym. normal Expans. good. Breath sounds normal
GYNÆCOLOGICAL EXAM., 4/16/97 Uterus retroverted & bound down by adhesions. Os lacerated. Long tear in posterior vaginal wall. which bleeds freely. Perineum lacerated.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,
TAKEN,

EXAM. URINE, Apr. 7 '97.
Color Yellowish red.
Character Cloudy ropy deposit
Reaction Acid.
Sp. gr. 1025
Albumen Trace by Heat & HNO_3
Sugar None.
Microscop. Amor. urates Large quantity pus & vaginal epithelium & some blood.

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

CRANIAL MEASUREMENTS,
HISTORICAL, Had an attack 10 yrs ago
LENGTH OF INVASION, 0 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 Gurina Malo

1897

This patient was brought here by Sheriffs deputy Geo. N. Brenard attended by her husband Peter Malo, in fair physical health with the following history.
No history of consanguinity. First symptoms manifested Mar. 7 '97: Disease appears increasing, not variable, no rational intervals: Derangement manifested on religious subjects & by crying & singing & emotional symptoms generally: Not disposed to injure others: Is filthy & distructive in habits: An aunt sent to asylum about 10 yrs. ago.: No previous peculiarities shown: No history of intemperance in parents or self: No severe disease or injury to head: Has not been confined or restrained: No treatment pursued:
On personal examination patient sat quietly but on questioning became talkative & said she saw snakes all the time, also gave other evidences of hallu-
Apr. 6 cinations & delusions: Commitment recommended because patient is incapable of caring for herself. On admission put upon B W (Gitt. Rpt. Complexion fair - hair black: partly gray: eyes gray: Condition of skin normal: No marks or scars noticed: eruption on legs & body. Vermin on body: Very dirty: behavior quiet. Is incoherent)
Apr. 8 Summary 14 day record On admission patient was stupid for first 24 hrs then became quite violent & was put in restraint sheet: struggled a great deal: Appetite rather poor: Very restless & violent unless in restraint: Was kept in restraint most of time during first 14 days. She injured herself sometime during first few days in external genitals so that there was considerable Haemorrhage: Temp 100°. A vaginal douche given each day: Became quite weak from loss of blood: After 10 days wound healed: Apr. 30 untidy in dress & habits: Appetite poor has to be fed with spoon: Sleeps very poorly: May 25 Visited by sister:
May 31 During past month patient has improved a good deal: Appetite is fair: Does not attempt to fight. July 10 Patient fought nurses: put in restraint. July 13 Out on ward - very violent. Aug 1 Patient very quiet at present but at times quite violent: Appetite is good: Menstruation regular. Continued by Dr. Wm. Phelps.
Sept 26 Trans. to B 2. Oct 5 Visited by friends: Trans. to B 4. Has been quite Troublesome & violent Feb. 9 '98 Wt. 152#. Has been comparatively quiet altho behavior is uncertain. Nov 10 '98 Visited by mother. Feb 28 '99 General health good: Habits, however, are rather dirty & she is rather more dull & demented.
Mch 1 - Aug 31 '99 Cont. by Dr. Bebb Appetite good: Sleeps well: Takes outdoor exercise: Neat in habits: assists some with work: Bowels usually constipated. June 7 Visited by relatives, became very violent requiring several nurses to take her back to ward & afterward refused to eat several meals & was irritable, but gradually quieted down. Sept 1 - Feb 28 '900 (Dr. Reynolds) Patient usually quiet in manner: occasionally very violent. Never speaks. Appetite good: works some on ward: habits clean: Takes out door exercise: Bowels usually constipated.

Personal and Medical History of Gurina Malo.

Jan 17 1900. Wt. 177#. Mch 1 - Aug 31 1900 (Dr Linton) Habits clean most of time: Is at times violent. Appetite good: Sleeps well: Bowels usually regular. Takes outdoor exercise. Refuses to work. July 17 Vaccinated. July 23 Became very violent & pulled mothers hair - Threw to floor & kicked her in face. In restraint 4 days. Sept 1 - Nov 30 - Appetite quite good: works some on ward. Takes outdoor exercise. Bowels regular. Violent & destructive at times but usually very quiet & tidy. Does not converse. Oct. 20 - 23 In bed - menstruated frequently goes to bed at this time. Quite neat in habits. Dec 1 - Feb 28 '01 No change: General health good: assists with work. Wt. 142½#. Mar. to June 1901 May 18 Visited by husband, no change in mental or physical condition. May 29 Wt. 175#.
June to Sept. Patient's general condition remains unchanged, Aug. 31 Wt. 179#.
Sept. to Dec. Ds. physically well,, eats and sleeps well, bowels regular, appetite good, takes out of door exercise, attends chapel and amusements, assists with ward work, never talks, neat in habits and appearance, sometimes violent. Nov. 24 Wt. 175#.
Dec. to Feb 1 - 03. No change in condition. Wt about 181#.

Personal and Medical History of Caroline Knutson.

EGBERT, FOLEY & CHAMBERS, DAVENPORT, IOWA

Whole No. 4747

Residence, Belvidere Goodhue Co. Minn.

Date Admission, April 10 1897.

Admitted by P.M. Phelps M.D. Hour, 1:30 P.M.

How Sent, Axel Haller J. of P. Goodhue Co.

Sex, Female.

Age, 33.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Teacher. (Father farmer)

Degree Education, Common School.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, Minn. (Parents Norway)

Physicians Committing, B Jaching + Geo. C. Wilmer M.D.

Correspondents, None given in papers.
Harold Knutson, Belvidere Mills, Minn.

No. for Year, 275.

Insane Relatives, None.

Cause Exciting, Mental overwork.

Cause Predisposing, Unknown

Form,

Accompanying Bodily Disorder, Insomnia. Nervousness.

Suicidal or Not, Not.

Date of this Attack, July 1894.

Duration, about 1 yr. 9 mo.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 33

Time of Leaving, Oct 23. 1899

Time in Hospital, 2 yr. 6 m. 13 d.

Result, Discharged May 2. 1900
Unimproved

EXAMINATION ON ADMISSION.

Exam by P.M. + Dr. Phelps 4/10/97 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events, Seems good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Only partially correct.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, + rather

DELUSIONS:

Systematized or Not, Says she has currents

Special Subjects, of Electricity passing thro

Transitory or Not, her when she is out among people.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Talks freely about her condition. Has ideas that she knows what other people are thinking about. + that they know her thoughts. Thinks this must be done by Electricity. Seems to partially realize that these ideas are false but can not get rid of them. answers thoughts that come to her by whispering to herself.

Personal and Medical History of Caroline Knutson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, usual 170 now 110½ NUTRITION, Impaired.

LITIES,

of skin normal.

Coatings, Slight coat. Promptness Movement,

gual Size, Normal.

Accommodation,

Slightly impaired uses glasses.

HEARING, Impaired.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands,

Facial Muscles, None.

REFLEXES, Patellar, Both ↑

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

Tongue, Considerable fine tremor.

General,

EXAM. URINE, May 13/97.

Color Yellow
Character Cloudy.
Reaction Acid.
Sp. gr. 1020
Albumen Trace by Tanrets
Sugar. 0 None.
Microsc. Triple Phosphates + uric acid crystals - a few pus cells

SENSIBILITY,

Arteries Normal.

HEART, No murmurs.

Sounds Normal. - Regular.

LUNGS, Stoop shouldered. Expansion fair.

TAKEN,

GYNÆCOLOGICAL EXAM., 5/97 Uterus ↓ retroverted + bound down by adhesions: External genitals normal

MENSTRUATION, regular but painful

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has vertigo in morning headache + bad feelings in head.

LENGTH OF INVASION, Nearly 3 years ONSET GRADUAL OR SUDDEN, Gradual

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

Mother or Mat. Relations, Living Nervous one uncle insane.

Father or Pat. Relations, Nervous age 76.

Brothers or Sisters, Brother nervous.

SCHOOL TEACHER INSANE.

Believes Every One Is Trying to Hypnotize Her—Sent to Asylum.

Fergus Falls, Minn., Sept. 10.—Miss Caroline A. Knutson was brought down from Moorhead yesterday and committed to the insane hospital here. The young lady has been teaching school in Goodhue county and arranged to attend the Moorhead normal, but on her arrival in Moorhead it was discovered that she was mentally unbalanced and Secretary Gates ordered her committed here. Her mania is hypnotism. She has been reading books on the subject and has finally come to believe that every one is trying to hypnotize her.

Personal and Medical History of Caroline Knutson

LOTTERS
JULIUS B.
10 South Broadway.
One Pair Tro

Whole No. 4742

Residence, Belvidere Goodhue Co. Minn.

Date Admission, April 10 1897.

Admitted by P.M. Phelps M.D. Hour, 1.30 P.M.

How Sent, Axel Haller J. of P. Goodhue Co.

Sex, Female.

Age, 33.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Teacher. (Father farmer)

Degree Education, Common School.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, Minn. (Parents Norway)

Physicians Committing, B Jaching + Geo. C. Wilson M.D.

Correspondents, None given in papers.

Harold Knutson, Belvidere Mills, Minn.

No. for Year, 275.

Insane Relatives, None.

Cause Exciting, Mental overwork.

Cause Predisposing, Unknown

Form,

Accompanying Bodily Disorder, Insomnia. Nervousness.

Suicidal or Not, Not.

Date of this Attack, July 1894.

Duration, about 1 yr. 9 mos.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 33

Time of Leaving, Oct 23. 1899

Time in Hospital, 2 yr. 6 m 13 d.

Result, Discharged May 2. 1900 Unimproved

EXAMINATION ON ADMISSION.

Exam by R.M + Pd. Phelps 4/10/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events, Seems good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Only partially correct.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, + rather

DELUSIONS:

Systematized or Not, Says she has currents

Special Subjects, of electricity passing thro

Transitory or Not, her when she is out among people.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Talks freely about her condition. Has ideas that she knows what other people are thinking about + that they know her thoughts. Thinks this must be done by electricity. Seems to partially realize that these ideas are false but can not get rid of them- answers thoughts that come to her by whispering to herself.

Personal and Medical History of Caroline Knutson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, usual 170 now 110½ NUTRITION, Impaired.

WOUNDS OR ABNORMALITIES, Condition of skin normal.

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

PUPILS, Equality, Equal Size, Normal.

Response Light, Accommodation,

SIGHT, Slightly impaired uses glasses.

HEARING, Impaired.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Tongue, Considerable fine tremor.

Facial Muscles, None. General,

REFLEXES, Patellar, Both ↑

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Normal.

HEART, No Murmurs.

Sounds Normal. - Regular.

LUNGS, Stoop shouldered. Expansion fair.

EXAM. URINE, May 13/97.

Color	Yellow
Character	Cloudy.
Reaction	Acid.
Sp. gr.	1020
Albumen	Trace by Tanrets
Sugar	None.
Microsc.	Triple Phosphates + uric acid crystals a few pus cells

TAKEN,

GYNÆCOLOGICAL EXAM., 5/97 Uterus retroverted + bound down by adhesions: External genitals normal

MENSTRUATION, Regular but painful

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has vertigo in morning, headache + bad feelings in head.

LENGTH OF INVASION, Nearly 3 years ONSET GRADUAL OR SUDDEN, Gradual

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

Mother or Mat. Relations, Living Nervous one uncle insane.

Father or Pat. Relations, Nervous age 76.

Brothers or Sisters, Brother nervous.

Personal and Medical History of Caroline Knutson.

1897

This patient was brought here by Sheriff's Deputy A. Gross, attended by father, in fair physical condition, with the following history:- This is first attack; first symptoms manifested July 1894. by lost of control over her thoughts. Says she thought she could read the thoughts of others in a crowd. Disease appears increasing: variable with irregular rational intervals. Derangement manifested on no particular subject. Thinks she is insane, has an irritable temper, is excitable, & incoherent in thoughts. Not disposed to injure others: No filthy or destructive habits. No previous peculiarities, injury to head, or intemperance in parents & self. Has not been confined or restrained but watch has been kept over her. Nothing known as to treatment pursued.

On Personal examination Suffers from insomnia, & nervousness. Talks to herself, has a haggard expression.

On Admission put upon B. W. (Gth. Dept. Complexion dark: hair light brown: eyes blue: Condition of skin normal: no marks, scars or bruises: Is clean: behavior quiet: Talks very little but sensibly)

April 3. Summary Nurse's 14 Day Record: Patient came of her own accord, although not very willingly & in hope of some benefit for the morbid state of mind which she herself recognized. During first week temperature showed itself to be normal: appetite good: was placed upon tonic medicine: Behavior at first was mostly quiet & agreeable, although later (3rd or 4th day) patient began to be restless & talked to herself: complained of headache nearly every day: During 2nd week same condition continued without change: Received massage & attempt was made toward thorough tonic treatment. Original Records Received.

Physician's Note - Patient on admission was thin & pale. Mentally was was rather suspicious of every one: Has delusions that every one knows what she is thinking about: Sits & talks to herself: Patient was put upon tonic. daily salt baths. Massage treatment 3 times per week: Is very quiet in behavior & usually talks fairly well when addressed.

Apr 26 Massage treatment given: Takes a salt bath every day. May 25 Massage treatment has been given every other day: Salt bath every day: Appetite fair: bowels regular.

June Patient very noisy & destructive on ward: Takes out door exercise: On salt baths & electrical treatments. Has many delusions: July 19 Visited by father: Is very anxious to go home: Very much disturbed most of time: Bought purses: massage & gynaecological treatments every other day: Salt baths each day:

Aug 28 No special change in any way, continued by Dr. R.M. Phelps. Nov 20 '97 Patient's behavior is rather troublesome: Has delusions: Thinks that Electricity & hypnotism are being used on her & is very obstinate at times. Jan 21 '98 Transf. to C 3 Wt 107 lbs. Jan 24 Became angry & broke dishes. Feb 27 '98 Patient still has the same delusions & is rather more persistent about them: Is inclined to get angry & fight

Personal and Medical History of

or beat things when excited. Mch 1 - Aug 31 '98 Cont. by Dr. Bess. General health good: Appetite poor: refuses meals at times: Keeps self. Takes out door exercise: Has delusions & is very disagreable on ward: sometimes disturbed during night: has a mania for breaking chairs. Apr 23 Visited by Lady friend May 8 by father

Sept 1 '98 - No change: Mingles regularly. Oct 24 '99 Neat in personal appearance. Was today taken home on trial by relatives

Personal and Medical History of Clara Olson

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4748
Residence, St. Paul, Minn.
Date Admission, April 16' 1897.
Admitted by Dr. R. M. Phelps Hour, 6.45 P.M.
How Sent, G. Willrich J. of P. Ramsey Co.
Sex, Female -
Age, - 29 -
Civil Condition, - Married -
Children, - 3 -
Age Youngest Child, 3 mo.
Occupation, - Housewife -
Degree Education, - Common school.
Profession Religion, - Lutheran -
Habits, Not Intemperate.
Nativity, - Norway -
Physicians Committing, Talbot Jones - A.B. Auker M.D.
Correspondents, husband - watchman Minnesota Transfer - Ole Olson -

No. for Year, 281
Insane Relatives, Mother & one brother.
Cause Exciting, —
Cause Predisposing, Heredity & previous attack.
Form,
Accompanying Bodily Disorder, Sleeplessness
Suicidal or Not, Not.
Date of this Attack, About 2 weeks ago.
Duration, 2 weeks.
No. of Attack, 2nd
No. of Admissions, 2nd time.
Age First Attack, 28.
Time of Leaving, May 25. 1899
Time in Hospital, 2 yr. 1 m. 9 d.
Result, Discharged Dec. 27. 1899
Improved.

EXAMINATION ON ADMISSION.

Exam by Drs. R. & H. Phelps 4/19/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish,
MEMORY:
Past Events, Seems good.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive.
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, very.
DELUSIONS: Many & varied.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient very much depressed. Cries & is restless & noisy. Worries constantly. Resists everything. Physical condition impaired. Nutrition poor.

Personal and Medical History of Clara Olson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1½ WEIGHT, 102 lbs. NUTRITION, Impaired
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, Condition of skin Normal. Coatings, Yellow coating Promptness Movement,
PUPILS, Equality, Equal. Size,
Response Light, Normal. Accommodation,
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms, Normal
Legs,
TREMORS, Hands, None. Tongue,
Facial Muscles, General, None.
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Normal.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs - Sounds feeble - Regular.
LUNGS, Expansion impaired R. lung resonance impaired. 4/24/97
GYNÆCOLOGICAL EXAM., Uterus normal position - Laceration cervix - Erosion of os - foul discharge - Laceration of perineum.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Apr 27'97.
Color. Reddish yellow.
Character Flaky deposit
Reaction Acid.
Sp. gr. 1018
Amt. 24 hrs. XXVz
Albumen Trace by heat, HNO3 & Cannets
Sugar None.
Microscop. Amor. urates - Large and. Bladder & vaginal cells - Fat globules & fungus.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓ very
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, 120. Regular	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, Has a young baby 3 months old.
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 Clara Olson.

1897

This patient was brought here by Sheriffs deputy P. J. Miesen attended by Mrs. Sylvester in fair physical condition, with the following history:-
No history of consanguinity. First attack occurred in July 95 when patient was admitted to this (Rochester)* hospital + remained until January 1896. left here recovered. First symptoms of present attack were manifested about 2 weeks ago by sleeplessness, crying, fear of injury, ideas as to having committed crimes etc; Disease appears increasing, not variable, no rational intervals: Believes she has been guilty of serious misdemeanors, + also manifests derangement on subject of religion + persecution.
Not disposed to injure others: No information concerning habits: It is claimed that patients mother was insane; one brother, John Christianson, died at this (Rochester) hospital. No previous peculiarities shown: No history of intemperance in parents or self: No severe disease or head injury:
Has been in City + Co. hospital since April 13' 1897.
No further information noted on personal examination.
On admission put upon Br W. (G.H.& Apt. Complexion fair: hair light: eyes blue: Condition of skin Normal: No marks, scars or bruises noted; is clean; very excited; has delusions)

*Note - For further particulars see Vol. 2 93 No. 4147

1897
Apr. 30 Summary Nurses 14 Day Record:- Admitted in the evening as quite noisy, crying and melancholy: Was put to bed and the breasts were found to need attention: Apr 17. Temperature normal, but the patient quite noisy, crying, full of depressive delusions + in a state of melancholia with some agitation: This behavior continued during the first + second weeks, getting rather worse toward the latter portion: Had to be fed with a tube the 4th day and quite a number of times since: Cries considerably and noisy in manner. Original Record Preserved.

May 3 Summary Nurses Notes by Dr. H. Phelps. Gynaecological treatments given every other day.
May 16 Tried to choke herself with apron: May 29 More quiet in behavior: Assists some with work: Refuses to eat - fed with tube: Has many delusions
May 31 Has been quite well last two days. June Massage treatments given:
July Takes salt baths *, gynaecological + electrical treatments + massage every other day. Aug 31 Patient cries a good deal: very much agitated + very resistive: Physical health failing; quite thin + pale. Continued by Dr. Phelps.
Patient rather violent at times + rather untidy. Feb 27 Patient usually sits about in a quiet way but will fight at times + gets very much excited + very incoherent:
Aug 25 Rather hard to manage at times on Ward. Sept 9 Trans. to Co. Feb 29 '98 Patient has been very troublesome in behavior: at times; has coughed some of late + has seemed to be failing, sits in a bent or curled up position most of time.
Mch 1 '98 Cont. by Dr Bass. Appetite poor: Sleeps quite well part of night: Is quite noisy greater part of

Personal and Medical History of

af time: Habits untidy: Mch 16 Visited by brother: became very excited + insisted upon being taken home by him. Apr 30 Has improved very much + is anxious to go home. Assists with work on ward: Is neat in habits + takes care of herself: Appetite has improved. Takes outdoor exercise. May 10 Trans. to B3. Is noisy at times + uses profane language. May 25 Visited by Mother, brother + friend: was rather noisy, excitable + nervous but was taken home by them.

Discharged

Personal and Medical History of Amelia Grady.

EGBERT, FOLEY & GRAMBERS, DAVENPORT, IOWA.

Whole No. 4751

Residence, 228 Grove St. St. Paul, Minn.

Date Admission, April 17' 1897.

Admitted by Dr C B Eby Hour, 6.45 P.M.

How Sent, G. Willich Jap. Ramsey Co.

Sex, Female.

Age, 27.

Civil Condition, widowed

Children, 2.

Age Youngest Child, 5 yrs.

Occupation, Seamstress in factory.

Degree Education, Common School.

Profession Religion, Common school.

Habits, Not intemperate.

Nativity, U. S. (Parents Germany)

Physicians Committing, A.W. Whitney & E. J. Schmidt.

Correspondents, Father - John Augustine 228 Grove St. St Paul, Minn.

No. for Year, 284

Insane Relatives, None.

Cause Exciting, Worry over loss of money.

Cause Predisposing, —

Form,

Accompanying Bodily Disorder, health impaired.

Suicidal or Not, Not.

Date of this Attack, April 9' 1897.

Duration, 1 week.

No. of Attack, 1st.

No. of Admissions, 27. 1st

Age First Attack, 27

Time of Leaving, Sept. 21. 1897.

Time in Hospital, 5 mos. 4 d.

Result, Discharged Mar. 21. 1898 Recovered

EXAMINATION ON ADMISSION.

Exam. by P.W. & E.S. Phelps 4/19/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Impaired

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, Much impaired.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS: Many & Varied.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: General physical health much impaired. Very restless, noisy & excited. Resists everything - Refuses to eat. Very incoherent in talk - Mind full of delusions. Physical condition much impaired - Very thin & pale.

Personal and Medical History of Amelia Grady.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in. WEIGHT, not taken NUTRITION, Impaired - pale.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Heavily coated Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Accommodation,

SIGHT, Says good

HEARING, " "

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Normal Tongue,

Facial Muscles, General, Normal.

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs.

Strength sounds normal. Regular.

LUNGS, Chest symmetry normal. Expansion impaired.

GYNÆCOLOGICAL EXAM., 5/3/97. Uterus retroverted & bound down - some endometritis - cystic degeneration of cervix to lacerated - external genitals normal.

MENSTRUATION, Irregular.

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Apr. 27'97.

Color Yellow red.

Character Cloudy.

Reaction Acid.

Sp. gr. 1018

Amt. 24 hrs. XXXIV ℥.

Albumen Trace by Heat & HNO3 & Tannic

Sugar None.

Microscop. Large amt. Triple Phosphates. Amor. urates - Mucus Casts. & bladder Epithelium.

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, Can not determine.

Brothers or Sisters,

Personal and Medical History of Amelia Grady.

1897

This patient was brought here by Sheriffs Deputy P.J. Mussen attended by her brother. in fair physical health with the following history:- No history of consanguinity, heridity or intemperance in parents or self. First Symptoms manifested by extravagant delusions - on Apr. 9'97. Disease appears increasing: not variable, no rational intervals: Derangement manifested by destructiveness & by fear of unknown people: Not disposed to injure others, no previous pecularities noted: No severe disease or head injury. For about one week has required watching & partial restraint: Has recived sleeping potions for her sleeplessness, no other treatment. On personal examination health seems to be somewhat impaired: is emaciated. On admission put upon B.W. G.H.M. Rpt. Complexion dark hair brown eyes gray condition of skin normal. Brown birth mark on right shoulder. No scars or bruises: Is clean: Very excited: has delusions)

1897
May 1 Summary Nurse's 14 Day Record:- Upon admission quite noisy & rather sleepless the first night: Apr. 18 - Noisy, Struggling & will not keep her clothing on: put in restraint: Apr. 19. Put in restraint to-day: At times struggles hard: Apr. 20: sleep on the ward struggling considerably and quite noisy: Apr. 21: fed with tube: put in restraint: Struggling and noisy: Apr. 22-30 was in restraint more or less each day: restless, and struggling more or less: was fed with tube a couple of times, but has eaten well since. Original Record preserved.

May 14 Summary Nurses Notes by Dr. A.L. Phelps- Very restless: Talks very incoherently: Quite violent at times. Refuses medicine: Appetite is fair: Bowels irregular: June 3 Patient looks very pale: Complains of being sick: July 5 Gynaecological treatments given every other day: July 12 Attempted to escape: July 30 Fought other patients:

Aug 5 Is improving some mentally, Is quiet on ward most of time. Does some work: Takes outdoor exercise. Gynaecological Treatments given every other day. Aug 11 Patient very quiet & agreable: Trans. to Infirmary.

Aug 16 Operation done - curettment, repair of cervix & retro fixation of uterus. Condition during operation good: reaction good: Put to bed, had no bad symptoms in any way. Sept 13 up on ward; Is convy good & quiet ful. Sept. 21. Must Home

Discharged.

Personal and Medical History of

Personal and Medical History of Josephine Sweeney

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 475 ✓

Residence, St. Paul, Minn.

Date Admission, April 20 / 1897.

Admitted by Dr. R.M. Phelps. Hour, 6 45 P.M.

How Sent, G. Willrich & of P. Ramsey Co.

Sex, Female -

Age, — (38 she says.)

Civil Condition, married (Left husband 18 yrs. ago)

Children, - 3 -

Age Youngest Child, 21 yrs.

Occupation, Housewife

Degree Education, Common school.

Profession Religion, Catholic

Habits, Not intemperate.

Nativity, U.S. (Parents U.S.)

Physicians Committing, E. J. Geer & J. B. Brimhall

Correspondents, none given in papers.

No. for Year, 285

Insane Relatives, None.

Cause Exciting, Mental anxiety

Cause Predisposing, —

Form, General Paresis

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, not.

Date of this Attack, 1 yr. ago

Duration, one year.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, —

Time of Leaving, Nov. 9. 1899

Time in Hospital, 2 yr. 6 m. 19 d

Result, Died. General Paresis.

EXAMINATION ON ADMISSION.

Exam. by R.M. & Ab. Phelps. 4/21/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Dazed.

MEMORY:

Past Events,

Recent Events, } Thinks good.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Sluggish

Own Mental State, Dull.

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Mildly.

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient seems sluggish & a trifle dazed - Insists something is the matter with her "brain". Denies any headaches or bad feelings in head. Says for about one year has had trouble. Has been sick for 3 wks.

Appearance suggests some gross disease - of heart or Kidneys - possibly of brain.

Personal and Medical History of Josephine Sweeney

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3½ in. WEIGHT, 131 lbs. NUTRITION, Apparently dropsical & white.

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Yes. flabby. Coatings, white coat. Promptness Movement,

PUPILS, Equality, Equal Size, normal.

Response Light, yes. Accommodation,

SIGHT, Good

HEARING, Good.

COORDINATION, Arms, Slightly impaired.

Legs,

TREMORS, Hands, Slight feeble uncertain Motor Tongue,

Facial Muscles, General,

REFLEXES, Patellar, ? Equal.

Other

ARTICULATION,

Slurred,

Hesitating, Slow melancholy -

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Sounds weak. Apex beat normal place. Regular.

LUNGS, Full chested - Sounds clear. Complains of soreness in Rt. Side

GYNÆCOLOGICAL EXAM. 4/22/97. Uterus normal position hyperæmia of cervix - very foul discharge - ex Genital genitals red & excoriated.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Apr. 22 '97.

Color Reddish yellow

Character Cloudy.

Reaction Acid

Sp. gr. 1016

Amt in 24 hrs. XVI.

Albumen Trace by Tanrets.

Sugar None.

Microscop. A few pus corpuscles. bladder & vaginal cells. Amor. urates & several Hyaline casts - A few uric acid crystals.

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

CRANIAL MEASUREMENTS,

HISTORICAL, Used to have headaches - none now.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual.

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any insanity in family

Mother or Mat. Relations, Living

Father or Pat. Relations, Dead.

Brothers or Sisters, 3 children. married at 16.

Personal and Medical History of Josephine Sweeney

1897

This patient was brought here by Sheriff's deputy Frank Roberts Jr. attended by Mrs Sylvester, in fair physical health with the following history:- No history of consanguinity, heredity or intemperance in parents or self: First symptoms of attack manifested about one year ago - when she became quiet & sullen, lost interest in her work, etc. Disease appears increasing: Not variable: no rational intervals: Is demented, worried about house rent & bills which she could not pay. Not disposed to injure others: Not filthy or destructive: No previous peculiarities except as stated above: No severe disease or head injury. Has not been confined or restrained except while at city Hospital for 3 weeks. On personal examination found that patient refuses to eat: has staring expression: is losing weight rapidly: is poorly nourished. On admission put upon B"W (Gen. Rpt Complexion dark: hair black: eyes brown: condition of skin normal: No marks, scars or bruises noticed, Is rather dirty: behavior quiet: Talks very little but sensibly.)

1897
May 4 Summary Nurse's 14 Day Record:- Was quiet and quite well behaved: Apr 21 Appetite good; behavior good, though quite melancholy: During the succeeding days of the fourteen day period patient was quite depressed, making no especial resistance or trouble seemingly, in a quiet, rather feebleminded state, with many delusive ideas. Original Record Preserved

May 12 Patient quiet in behavior: Is very dull & resists when dressed or undressed: Bowels constipated: Gynaecological treatments given every other day.

June Appetite good: Bowels constipated. July 29 Very dirty in habits: Very dull mentally: Seems to realize very little. Continued by Dr. Rob. Phelps.

Oct 20/97 Visited by sister. Nov. 29 Dirty in habits & quiet & stupid. Mch 13 Had a convulsion during night & three the following morning. Mch 14 Visited by priest.

Mch 15 Visited by son Aug 19 Improved after convulsions, quieted down & trans. today to A'.

Nov 18 Trans. to B'. Rather noisy in talk & troublesome in her ways. Feb 25 99 Patient drifting along in a very demented somewhat excitable way.

Mch 1 - Aug 3 1899 Cont. by Dr. Betts. General condition fair: Appetite quite good: Sleeps well: Is subject to convulsions Apr 17 had a convulsion, seemed weak & helpless & could not use left leg & arm. Aug 7 again had convulsion affecting left leg & arm Temp. 102°. Usually takes outdoor exercise: Is very incoherent in speech & at times quite noisy: Occasionally answers simple questions sensibly.

Oct 28 Appetite good: Sleeps well: Takes outdoor exercise: Menstr. regular. Very incoherent at times very much excited, noisy & irritable: often talks to herself. Today (29th) again had convulsion & seemed very weak & helpless. Put to bed. Temp 101.8 Pulse 105 R. 24. Refused food: quite stupid. Trans. to Infirmary.

Nov. 3 Very quiet all day. Slept during night: Temp. 100°. Pulse 112: Resp. 36. Took some milk: Nov 4 Visited by sons: Very quiet: Slept most of time during day.

Personal and Medical History of Josephine Sweeney.

Does not talk intelligently & did not seem to recognize her sons at all. Temp. Nov. 8 104. Resp. 40. Pulse 148. Takes nourishment until Nov 7. when she was fed by tube. Nov 4: Sunk into a stupor - did not seem to recognize her friends. Seemed very stupid. Nov 8 Died at 10:30.

Died.

Personal and Medical History of Margetta Chesley.

EBERT, FUCAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4753
Residence, Claremont, Minn.
Date Admission, April 21 1897.
Admitted by Dr. R.M. Phelps. Hour, 6th P.M.
How Sent, Asst Olson Jail Dodge Co.
Sex, - Female -
Age, - 36 -
Civil Condition, - married -
Children, 5
Age Youngest Child, - 3½ -
Occupation, Housekeeper.
Degree Education, Common school.
Profession Religion, None.
Habits, Not intemperate.
Nativity, Wisconsin (Parents Penna.)
Physicians Committing, L.L. Bigelow + O.F. Way.
Correspondents, none given in papers.

No. for Year, 286
Insane Relatives, None
Cause Exciting, Hysteria
Cause Predisposing, —
Form,
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, Not.
Date of this Attack, About 6 wks. ago.
Duration, about 6 weeks.
No. of Attack, 1st.
No. of Admissions, 1st
Age First Attack, 36.
Time of Leaving, June 1. 1897
Time in Hospital, 1 mo. 11 ds.
Result, Much Improved

EXAMINATION ON ADMISSION.

Exam. by Dr. R.M. Phelps 4/22/97

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS: Delusive ideas.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Very depressed - Cries + fusses continually - At times can hold her attention so that she will talk fairly sensibly. Complains of feeling pain in her side + abdomen. Rather hysterical in her complaints. Her physical condition is much impaired - Refuses all solid food. Drinks milk, eggnog etc.

Personal and Medical History of Margetta Chesley.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in. WEIGHT, 101 lbs. NUTRITION, Impaired.
WOUNDS OR ABNORMALITIES,
Skin dry + scaly.
TONGUE, Tremors, Irritated + Coatings, somewhat coated Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Normal. Accommodation,
SIGHT, Says impaired.
HEARING, Seems impaired.
COORDINATION, Arms, Impaired.
Legs, Cannot walk without help. Very unsteady.
TREMORS, Hands, Very unsteady Tongue,
Facial Muscles, General, General unsteady movements.
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Slurred. +
Hesitating, Hesitating.
FACIAL EXPRESSION,
SENSIBILITY,
Arteries - Some atheroma.
HEART, No murmurs.
Sounds weak.
LUNGS, Chest symmetry stoop shoulders. Expansion Impaired Breath sounds Impaired shallow
GYNÆCOLOGICAL EXAM., 4/23/97 Uterus retroverted + bound down hypertrophy of uterus - some erosion of os laceration of perineum - Some Haemorrhoids.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

EXAM. URINE, May 6/97
Color Red
Character Cloudy
Reaction Neutral
Sp. gr. 1029
Amt. in hrs. XXXII ½
Albumen None
Sugar. By Bismuth
Microsc. Mucus Sands - Bladder Epith - Few cells + amor. urates

TAKEN,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Had typhoid fever when 8 yrs. old. Says had Pneumonia. Headaches + Vertigo a good deal
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Died of old age
Father or Pat. Relations, Died in Army.
Brothers or ~~Sisters,~~ Brother not healthy - has rupture. Sister nervous.

Personal and Medical History of Marjetta Chesley

1897

This patient was brought here by Sheriff's Deputy J. Tucker attended by Mrs. Hitchcock in feeble physical condition with the following history: No history of consanguinity, heredity or intemperance in parents or self. First symptoms of attack manifested about 6 weeks ago by pain: Disease appears increasing: not variable; no rational intervals. Derangement manifested by constant crying: Complaint of abuse of attendants & desires to go home. Not disposed to injure anyone: No filthy or destructive habits: No previous peculiarities: Father a moderate drinker & smoker. No severe disease or injury to head: Has not been confined or restrained. Has received tonics & nerve sedatives. On personal examination cries constantly, fails to remember important events.

On admission put upon Infirmary West (G.K.N. Rpt.) Complexion dark: hair brown eyes blue: Condition of skin hot & dry: No marks, scars or bruises: Is clean: Abdomen & stomach very hard & swollen: Is quiet: Has delusions.)

1897 May 5 Summary Nurse's 14 Day Record: Patient put to bed on admission: was apparently salivated: was tremulous & nervous, crying and talking: Had to be feed in bed: Apr. 22: Refused breakfast: Had to be fed with gruel, egg-nogs and milk during the day: Appeared quite weak and unable to walk without help. Has a seeming incoordination: tremulousness & weakness seem to be combined in her case: Crying most of the day: occasionally will answer questions sensibly: Pulse rather weak: very restless & out of the bed part of the time during the night: received alcohol baths, salts, & enema: rather hysterically active: General character of mental state that of depression: Apr. 24. Temperature which was a little elevated yesterday (100.2) is to-day normal: Patient still restless, out of the bed a great deal, tremulously trying to get about although too weak to do so: Imagines her food is poisoned: Apr. 25 Taking generally liquid food with tonics: very hard to get her to take nourishment: At times will answer sensibly, although the bewildered, agitated & tremulous manner is still constant: During the rest of the two weeks patient's temperature went up to 100, only once being practically normal. The agitated, tremulous & bewildered condition quieted down some what although it still continues to a considerable extent: So doing considerably better: usually fed by nurse. Original record preserved.

May 13 Summary Nurses Notes by Dr. H. Phelps. Was very violent this afternoon: Complains of headache & sore throat. Temp. 100 Pulse 90 Resp. 24. May 24 Was up part of day. Appetite better, Gruels & eggnogs given: Coughs some, talks quite sensibly. Salt baths daily & electrical treatments every other day. Seems much better.

May 26 Massage given: Appetite fair: Very anxious to go home. June 21 Visited by husband who took her home.

Discharged.

Personal and Medical History of

Personal and Medical History of Mary Strapp.

HERBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. H755
Residence, St. Paul, Minn.
Date Admission, April 24th 1897.
Admitted by Dr. R. M. Phelps Hour, 6 Hrs P.M.
How Sent, J. Millrid J. of P. Ramsey Co.
Sex, Female.
Age, 34.
Civil Condition, Single.
Children, -
Age Youngest Child, -
Occupation, None.
Degree Education, Common school.
Profession Religion, Catholic.
Habits, Not intemperate.
Nativity, St. Paul, Minn.
Physicians Committing, John B. Darling & H. J. O'Brien.
Correspondents, J. J. Strapp 486 Pleasant Ave. St. Paul, Minn.

No. for Year, 288.
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing,
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, 20 yrs ago.
Duration, 20 yrs (never entirely recovered)
No. of Attack, 1st
No. of Admissions, 2nd
Age First Attack, 14
Time of Leaving, July 17. 1899
Time in Hospital, 2 yr. 2 m. 23 d.
Result, Discharged. Feb. 7. 1900 Improved.

EXAMINATION ON ADMISSION.

Exam. by R.M. & D.L. Phelps 4/26/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish,
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive.
REASONING POWER:
Ordinary Subjects, Much impaired.
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Mind wanders from one thing to another. Does not answer questions. Weak-minded for years. Childish in manner.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, at times.
Depressed,
DELUSIONS:
Systematized or Not, Very many & varied.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Very silly & Childish.
Coherent or Incoherent, Incoherent.
Voluble or Reticent, Talks Continually

Personal and Medical History of Mary Strapp.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good.
WOUNDS OR ABNORMALITIES, Scalp in bad condition.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Accommodation,
SIGHT, Normal.
HEARING, Seems normal.
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, General, "
REFLEXES, Patellar, 3.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,

SENSIBILITY,
Arteries normal.
HEART, No murmurs. Sounds rather weak. Regular.
LUNGS, Normal.

TAKEN,

EXAM. URINE, May 6/97
Color Red
Character Cloudy
Reaction Acid.
Sp. gr. 1030
Albumen Trace by Tanrets.
Sugar. Trace by Bismuth & Haines
Microsc. Exam. Some. Amor. urates Pus cells.

GYNÆCOLOGICAL EXAM., 5/3/97 Uterus somewhat antiflexed - otherwise normal.
MENSTRUATION, Regular
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, Poor, Very - Up & around room all night. 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,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Mary Strapp.

1899

This patient was brought here by Sheriffs deputy P. J. Meiers attended by Mrs. Sylvester, in fair physical condition, with the following history:- No history of consanguinity, lunacy or intemperance in parents or self: First symptoms of disease appeared 20 yrs. ago when patient was taken to St. Peters Hospital, (remained about one year) there was a slight improvement for a time but patient never fully recovered: Disease appears increasing: is slightly variable: no regular rational intervals: Derangement manifested on subject of religion: Is disposed to injure others: Is filthy & destructive in habits: No previous peculiarities: No severe disease or injury to head: Was confined at St. Peter as above stated: Has received both hospital & private treatment. No further particulars noted on personal examination. On admission put upon Bd & W.

(Gen. N. Rpt. Complexion dark: Hair & eyes brown: Skin normal condition: No marks, scars or bruises: Is rather dirty: Behavior quiet but very destructive: Has delusions.)

May 6 1899. Summary Nurse's 14 Day Record: Patient entered on ward, put to bed, was very quiet in behavior: Slept only 3 hours. Apr. 25. Patient is To-day destructive, talking the greater part of the time in a noisy incoherent way: Apr 26 - Is still destructive and quite noisy: Apr. 27-29 Patient more quiet, although dirty in habits and unreliable: During remainder of the 14 days patient is part of the time quiet but uniformly unreliable, & occasionally noisy, restless & silly. Original Record Preserved.

May 1 Summary Nurses Notes by Dr. H. Phelps Appetite good: Habits untidy, Noisy & restless - very silly, talks incoherently: May 27 Is violent & destructive at times - Talk is incoherent: Mental condition is that of an imbecile.

June 99 Patient has been very noisy for past week, singing & talking to herself - works in mending room: Aug 29 Taught nurses: Is very erratic in behavior; also silly - Continued by Dr. Wm. Phelps. Sept 29 Patient fairly well behaved altho somewhat stubborn. Health seems quite good at present. Jan 7 '98 Wt. 185# Has been at times somewhat noisy & silly. May 7 Has of late been quite violent. July 30 Was taken sick. Seemed rather stupid & complained of pain. Aug 30 Up on ward: Seems to be feeling better. Sept 16 '98 Visited by brother & taken home. Feb 3 '99 Returned. Complained of left arm & leg being sore & stiff. Remained in bed a few days. Feb 13 Up on ward. Seems rather weak: Appetite somewhat better than when in bed. Is quiet & agreeable & talks sensibly: Sleeps well: Bowels constipated. Feb 17 Trans. to 6th. Feb 22 To A3.

1899 May 4 Is rather depressed, cries continually & asks to go home: May 16 Complained of pain in chest & sore throat. Remained in bed a few days. May 29 Converses freely: Assists some with ward work: Bowels regular: June 11 & July 8

Personal and Medical History of

1899

menstruated: assists in employees dining room: Is quite cheerful. July 7 Taken home by brother.

Discharged.

Personal and Medical History of Corline Almquist

BRADY, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4760

Residence, Waterford, Minn.

Date Admission, May 3rd 1897.

Admitted by Dr. R.M. Phelps Hour, 6th P.M.

How Sent, Thos. J. Moran J. of P. Dakota Co.

Sex, Female.

Age, 40

Civil Condition, married.

Children, 3

Age Youngest Child, 2½ yrs.

Occupation, Housewife (husband miller)

Degree Education, college graduate.

Profession Religion, Methodist

Habits, Not intemperate.

Nativity, Denmark. (Parents Denmark)

Physicians Committing, J.C. Fitch + H. Van Beek.

Correspondents, J.A. Almquist (husband)
Waterford, Dakota Co. Minn.

No. for Year, 293.

Insane Relatives, Father's sister or aunt.

Cause Exciting, Overstudy followed by pregnancy.

Cause Predisposing, - Heredity?

Form,

Accompanying Bodily Disorder, none mentioned.

Suicidal or Not, Has attempted it. Propensity not active now

Date of this Attack, -

Duration, -

No. of Attack, Has had several. 1st in '91.

No. of Admissions, Has been in hospitals in Ill. + Wis.

Age First Attack, 35 yrs.

Time of Leaving, Aug. 27 1896

Time in Hospital, 2 yr. 3 mo. 24 d.

Result, Discharged Apr. 17. 1900
Improved.

EXAMINATION ON ADMISSION.

Exam. by R.M. + H. Phelps 5/4/97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Impaired

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Partially correct.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, quite.

DELUSIONS: Many + varied.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Talks in half coherent way. partly to herself. When asked a question will answer fairly well. Seems quite depressed about her condition
Married when 32 yrs. old.
Physical condition somewhat impaired. Looks pale + rather stoop shouldered.

Personal and Medical History of Corline Almquist.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, Scar on left wrist where she cut herself some years ago.

TONGUE, Tremors, Coatings, White coat. Promptness Movement,

PUPILS, Equality, Equal Size,

Response Light, Slowly Accommodation,

SIGHT, Weak.

HEARING, Good.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None Tongue, None.

Facial Muscles, General,

REFLEXES, Patellar, Both from 7 to 1

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Sounds normal. Is regular.

LUNGS, Normal.

TAKEN,

EXAM. URINE, May 7/97

Color Brownish Red
Character Cloudy
Reaction Acid
Sp. gr. 1030
Albumen Trace by Tanrets
Sugar, None
Microsp. Exam. Urine. Amor. urate.
Amount quan. pus + bladder
Epith. cells

GYNÆCOLOGICAL EXAM., Uterus Normal position. Laceration of cervix + perineum. Endometritis. Rectocele + cystocele. erosion of os.

MENSTRUATION, Regular. Says is more depressed at these times.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,		Careless,
BOWELS, Normal, now at times constipated	Constipated,		Irregular,
APPETITE, Good,	Medium,		Poor,
SLEEP, Good,	Very Poor,		Irregular,
PULSE,	Resp.,		Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Had inflammatory rheumatism in 1872 + again in 1882. Has severe headaches - vertigo at times.

LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, died consumption - Step mother insane.

Father or Pat. Relations, had rheumatism

Brothers or Sisters,

Personal and Medical History of Corbine Almquist

1897

This patient was brought here by Sheriff Knighten attended by Mrs. A.B. McNamis in fair physical condition with the following history:- No history of consanguinity; First attack occurred in 1892, others in 1895 + 1896. First lasted 9 mos. 2nd 2 years was in hospital at Mendota, Wisconsin. First symptoms manifested by melancholia was about 6 months advanced in pregnancy at the time of 1st attack. Disease appears increasing not variable, no rational intervals. Derangement manifested by acute mania. Not disposed to injure others: In 1892 attempted to take her own life by means of a razor - severed radial artery. No disposition to filthy or destructive habits: No previous peculiarities so far as known: Parents were occasionally addicted to intemperance: No severe disease or head injury: Has been confined in hospitals In Illinois 2 months first time, in Wisconsin 2 wks, 2nd time. Improved while under hospital treatment.

On personal examination shows Acute mania, incoherency etc.

On admission put upon B[r] W. (G.H.U. Rpt. Hair brown, eyes gray, skin normal condition: Left arm + both knees bruised: To clean: Behavior excited)

1897 May 10. Summary Nurse's 14 Day Record:- Patient admitted in a State of wild acute mania: rather active, incoherent + full of delusions: May 4th - Did not sleep very well the first night: was quite noisy for Six hours: kept in bed during the day + was rather destructive + violent, also dirty in habits: was in restraint 12 hours. May 5th - Has been in restraint all day: Has eaten quite well, but is active + destructive: May 6th: Has been in restraint more or less every day since coming: Has struggled considerably, talk has been usually incoherent and rambling: at times very noisy: To, however, some what improved: May 16: Patient has been in restraint during night more or less every night, but of late has been out some during the day: Is still, however, quite noisy + incoherent, rather dirty in habits + full of delusive ideas. Original record preserved

May 28 Patient very noisy most of the time: Quite excitable: Has many delusions: Talk quite incoherent: clean in habits: Untidy in personal appearance. Takes tonic + cathartic: Appetite fair: bowels quite regular: In restraint every night since the 3rd. June 27 Noisy most of time: Bowels quite regular - Takes outdoor exercise: Appetite good: July 6 Assists with work: Has been improving: Takes outdoor exercise. July 19 Visited by husband. Sleeps well: Works in dining room: July 28 Operation done. Trachelorraphy + curettement, cystocele, repair of perineum. Patient took ether well: Reaction good: Put to bed, was very quiet, caused no trouble at all during stay in bed: Able to sit up on Aug. 12 - Recovery good: No bad symptoms - Aug 17 Patient went home recovered both mentally + physically. Dec. 15 '97 Quite disturbed + noisy. Feb 16 Has quieted down some: Assists with the work. Seems to be over this spell. Mch 28 Visited by husband: Has for a month or so been quite sane in behavior. June 1898 Again very talkative + noisy: To going into another spell. June 19 Extremely active, noisy + troublesome. July 4 Visited by husband. Aug 20 Quiet in behavior, takes parts in amusements + is doing well. Oct 20 Visited by husband + taken home.

Dec 25 Very noisy most of time, + destroys clothing. Feb 8 '99 Has for the past week been growing very quiet: Is again working in dining room. Comm. Cont. by Dr. Bro.

1899 May 31 Appetite fair: sleeps well: Is very agreable on ward: Neat + clean in habits. Takes outdoor exercise: Converses freely. Apr 23 Trans. to A[2]. Received massage. May 7: Quite disturbed: talked incoherently + cried: Refused to eat. May 9 Trans to B[2]. From 11[th] to 31[st] extremely noisy, fought nurses + patients: Put in restraint: Slept very little: Required laxatives. Appetite continued fair: Temp. 99[2]. Pulse 64 Resp. 20. Continued more or less depressed + very noisy at times. Taken out walking + seems quieter after being out.

Personal and Medical History of Corbine Almquist.

1898

Personal and Medical History of Amelia C. Carlson

BERRY, FISCAR & CHUMBERS, DAVENPORT, IOWA

Whole No. 4761

Residence, Pilot Grove, Faribault Co.

Date Admission, May 3rd 1897.

Admitted by Dr. H. H. Herzog Hour, 7:30 P.M.

How Sent, J. F. Winship J. of P. Faribault Co.

Sex, Female.

Age, 21 yrs.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Housework. (Father farmer)

Degree Education, Can read & write

Profession Religion, Yes Lutheran

Habits, Not intemperate.

Nativity, Indiana (Parents Sweden)

Physicians Committing, F.B. Hunt & A.J. Franklin.

Correspondents, Brother. Frank C. Carlson
Elmore, Minn.

No. for Year, 294.

Insane Relatives, None.

Cause Exciting, Was assaulted when ten yrs old

Cause Predisposing,

Form,

Accompanying Bodily Disorder, Convulsions for 10 yrs.

Suicidal or Not, Yes.

Date of this Attack, April 28. 1897.

Duration, 6 days.

No. of Attack, 2nd

No. of Admissions, 1st

Age First Attack, 18 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. by Drs. A.M. & A.L. Phelps. 5/4/97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, Rather sluggish.

MEMORY:

Past Events, Fair

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Very dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Very poor

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Slightly

DELUSIONS: None manifested.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS: None.

ILLUSIONS: None.

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Has had epileptic fits since a child but they have been more severe & more frequent of late. She has been quite violent at times & at others suicidal.

Personal and Medical History of Amelia C. Carlson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ WEIGHT, 132 usually 123 NUTRITION, Good.

WOUNDS OR ABNORMALITIES, 2 scars on left Arm. 1 scar on nose between eyes.

Condition of skin normal.

TONGUE, Tremors, Coatings, Yellow. Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Accommodation,

SIGHT, Says good.

HEARING, "

COORDINATION, Arms, Some tremor

Legs, "

TREMORS, Hands, Fair Tongue,

Facial Muscles, General, All over.

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Slurred & hesitating.

Hesitating, Slow.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries normal.

HEART, No murmurs. Sounds normal. & regular.

LUNGS, Normal

TAKEN,

EXAM. URINE, May 7/97

Color Yellowish red

Character White flaky sediment

Reaction Neutral

Sp. gr. 1020

Amt. in 24 hrs. XXII ℥

Albumen Trace by heat & Nitric

Sugar None

Microsc. Large quant Triple Phosphates & amor. Urates. Bladder epith. & pus cells.

GYNÆCOLOGICAL EXAM., 5/8/97 Uterus normal position & in every way condition normal.

MENSTRUATION, regular but very profuse & abnormal. - very foul odor.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Epileptic fits since 7 or 8 yrs. old. Vertigo.

LENGTH OF INVASION, Long - since a child 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 Amelia C. Carlson.

1897

This patient was brought here by Sandy McDonald Sheriff, attended by Mrs Anna McDonald, in fair physical condition, with the following history:- No history of consanguinity, heredity or intemperance in parents or self. First attack occurred in 1894 lasting 2 days; First symptoms of present attack manifested April 28'97 when patient became violent & tried to kill the family. Disease appears decreasing: is variable: no rational intervals but is less violent at times: Derangment manifested on subject of religion, sings & prays almost constantly: Is disposed to injure others, is suicidal: No disposition to filthy or destructive habits for some days. Has been very irritable for past two years: Has been very zealous on religious subjects: Has had chronic convulsions for past ten years: Has not been confined but has been bound for an hour or two at a time. Has been treated by without benefit. No further information obtained on personal examination.
On admission put upon C & W (Dem. Ppt. Complexion fair: eyes blue: hair light brown: Condition of skin normal: 2 scars on left arm, one caused by burn. Sore on left knee: Is clean: behavior quiet: Talks sensibly.)

1897 May 16 Summary Nurses 14 Day Record:- During the two weeks just past patient has remained fairly quietly on the ward with little variation in behavior. Appetite has been good throughout: Temperature normal: patient rather weak & childish, having a very slight range of mental power, but fairly quiet: On the 8th had two fits during night: on the 9th had one in the afternoon & two during the night: On the 10th had one fit during night May 11th had one in the afternoon: May 13. Two fits during night: May 16 one fit during night: May 16. One fit during night: The fits seem quite frequent and account fully for the feeble minded condition in which patient is. There is nothing of especial note otherwise. Original Record Removed

May 20. Patient is quiet in behavior: talks sensibly: Takes out door exercise: appetite good: bowels regular: Has about 2 or 3 fits a day: May 23: Patient is menstruating.

June 1 Summary Nurses Notes by Dr. J. L. Phelps - Appetite good. Bowels regular: Takes outdoor exercise: Assists some with work: Has had four epileptic fits during week. July 18 Had 17 fits - was very restless to day. Confined to her bed. Aug 4 Appetite good, bowels regular: Assists with work: Menstruation regular. Continued by Dr. W. M. Phelps. Nov 30'97 Has a great many Epileptic convulsions but seems to change very little in mental or physical state on account of them. Dec 8 Very noisy & violent, was put in restraint. July 7 '98 Fought with other patients. Dec 7 '98 Wt. 107# Patient has at times fought quite actively altho for the most part she is quiet & silly.

Jan 1- Aug 31 '99 - Cont. by Dr Bass Appetite good: sleeps well: Takes outdoor exercise: Bowels regular: Assists with work in dining room: converses & spends part of time reading. Has Convulsions frequently, often during night. Usually quiet in behavior: neat in habits

Personal and Medical History of

1899

& appearance: At times irritable & disagreeable: on Mch 8th Tried to kill herself. Menstr. regular. Medicine given daily, at times refuses it. Aug 29. Wt. 110#

Sept 1- Feb 28 1900. (Dr Heyerdale) Very disagreeable: Oct 4 fought & attempted to to escape while out walking. Expresses desire to kill herself. Nov 28. Has frequent convulsions: neat in habits, appetite good: Sleeps well. works on ward: menstruates regularly: Cathartics given Jan 17 108# Feb 28. Fought. had to be held & then secluded several hours.

Mch 1- Aug 31 1900 - (Dr Linton) Untidy in habits. Has convulsions often during night sometimes very disagreeable & cross: & has to be held. but at other times is pleasant & agreeable: Appetite variable: Requires cathartics for bowels: menstruates regularly: Takes exercise: assists with work. Feb 27 Fought nurses & attempted to escape. Held 2½ hrs. Apr 24 had convulsion. May 1-16 Sick in bed. Temp. 100-99°. Pulse 84-62. Resp. 18- during this time had a swelling around eye which opened on may 1 & discharged - face bathed with bichloride & painted daily. & internal medicine given. Took liquid diet. May 16 up on ward. July 21 Vaccinated. Aug. 9 Had a convulsion July 24 Complained of feeling sick coughed some. given expectorants Aug 25 Had 2 convulsions

Sept 1- Nov 30 (Dr Heyerdale) Neat. Works on ward: Frequently has convulsions during night. expresses many delusions: Appetite poor: Bowels somewhat constipated: Takes outdoor exercise: Nov 20 Wt 111#.

Mar. to June 1901 No change in mental or physical condition May 29 Wt 106#.

June to Sept. July 16 Patient is failing somewhat physically; complains of pain in left side also headache, has some rise of temperature, Mentally patient has been very irritable and troublesome scolds a great deal and threatens to kill herself, is profane in her language, is constipated, has epileptic seizures after which she is always more irritable, occasionally has trouble with other patients, July 17 transferred to Infirmary West, July 24 patient somewhat improved transferred to B. 2. Aug 30 Wt. 107#.

Sept. to Dec. Nov. 18 visited by lady friends, patient coughs and expectorates some has nocturnal convulsions, after which she is always very irritable and disturbed mentally and is then inclined to be somewhat violent. menstruates regularly, takes out door exercise, Nov. 15 Visited by lady friends Wt. 108½#.

Dec to Feb 03 No change in condition. Wt about 106#. Patient is an epileptic & has frequent convulsions.

Personal and Medical History of Kate White

ROBERT, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4762

Residence, St. Paul, Minn.

Date Admission, May 10th 1897.

Admitted by Dr. Le B. Eby Hour, 6 45 P.M.

How Sent, G. Willrich J. of P. Transcript

Sex, Female.

Age, 60.

Civil Condition, Single.

Children,

Age Youngest Child,

Occupation, Cook.

Degree Education, Can read & write

Profession Religion, Yes. Catholic.

Habits, Unknown.

Nativity, Ireland. (Parents Ireland)

Physicians Committing, Haldor Sneve & F. A. Kantzer

Correspondents, Mrs. James Hogan (niece)
Lafond Street St. Paul (Near House Good Shepherd.

No. for Year, 295

Insane Relatives, None?

Cause Exciting, Unknown

Cause Predisposing, Unknown.

Form, Paranoea

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, 1 year ago.

Duration, About 1 year.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 60 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. by P. M. & L. Phelps 5/11/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events, Seems good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Only partially correct.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Talks very willingly. Thinks there was no reason for sending her here. That her mind is all right. Feels perfectly well. The neighbors say she is up & around all hours of the night & they are to blame for all her trouble. They had her sent here. Hears voices that bother her night & day.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, rather

DELUSIONS:

Systematized or Not, Of persecution

Special Subjects,

Transitory or Not,

HALLUCINATIONS: of hearing

ILLUSIONS: Hears voices at night.

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Copy
Notice of hearing Petition for Guardian filed with papers.
Dated May 13' 97.

...Y ON ADMISSION, CONTINUED.

...SICAL CHARACTERISTICS.

...GHT, 110½ lbs. NUTRITION, Fair

...atings, None. Promptness Movement, Prompt.

Size, Normal

Accommodation, Sluggish

SIGHT, Says good - Slight arcus senilis.

HEARING, Seems good.

COORDINATION, Arms, None.

Legs, "

TREMORS, Hands, Some fine Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal 5

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Sounds - both rough. Intermittent.

LUNGS, Chest Symmetry Normal. Sounds in apex of R. lung rough

GYNÆCOLOGICAL EXAM., 5/14/97 Uterus retroverted & somewhat atrophied - some redness of external genitals - otherwise normal

MENSTRUATION, Menopause passed 7 years

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, May 14/97

Color Reddish yellow

Character. Flaky sediment.

Reaction Acid

Sp. gr. 1016

Amt. 24 hrs. XXIII ℥j

Albumen Trace by Tanrets

Sugar. Trace by Bismuth & Haines.

Microsc. Uric acid crystals. Amorphous phosphates oxalate of lime

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, ✓ Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Restless at night thinks she hears voices 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 Ka

ROBERT, FISCHER & CHARBUCK, DAVENPORT, IOWA

Whole No. 4762

Residence, St. Paul, Minn.

Date Admission, May 10th 1897.

Admitted by Dr. Le B. Eby Hour, 6:45 P.M.

How Sent, G. Wilrich J. of P. Transcript

Sex, Female.

Age, 60.

Civil Condition, Single.

Children,

Age Youngest Child,

Occupation, Cook.

Degree Education, Can read & write.

Profession Religion, Yes. Catholic.

Habits, Unknown.

Nativity, Ireland. (Parents Ireland)

Physicians Committing, Haldor Sneve & F. A. Kantor

Correspondents, Mrs. James Hogan (niece)
Lafond Street St Paul (Near House Good Shepherd.

No. for Year

Insane Relat

Cause Excit

Cause Pred

Form,

Accompan

Suicidal or Not, Not.

Date of this Attack, 1 year ago.

Duration, About 1 year.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 60 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. by P. M. & L. Phelps 5/11/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events, Seems good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Only partially correct.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, rather

DELUSIONS:

Systematized or Not, Of persecution

Special Subjects,

Transitory or Not,

HALLUCINATIONS: of hearing

ILLUSIONS: Hears voices at night.

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Talks very willingly. Thinks there was no reason for sending her here. That her mind is all right. Feels perfectly well. The neighbors say she is up & around all hours of the night & they are to blame for all her trouble. They had her sent here. Hears voices that bother her night & day.

Personal and Medical History of Kate White.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. WEIGHT, 110½ lbs. NUTRITION, Fair

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Condition of skin Normal. Coatings, None. Promptness Movement, Prompt.

PUPILS, Equality, Equal Size, Normal

Response Light, Sluggish Accommodation, Sluggish

SIGHT, Says good - Slight arcus senilis.

HEARING, Seems good.

COORDINATION, Arms, None.

Legs, "

TREMORS, Hands, Some fine Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal 5

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Sounds - both rough. Intermittent.

LUNGS, Chest Symmetry Normal. Sounds in apex of R. Lung rough

GYNÆCOLOGICAL EXAM., 5/14/97 Uterus retroverted & somewhat atrophied - some redness of external Genitals - otherwise normal

MENSTRUATION, Menopause passed 7 years

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, May 14/97

Color Reddish yellow

Character. Flaky sediment.

Reaction Acid

Sp. gr. 1026

Amt. in hrs. XXIII-3.

Albumen Trace by Tanrets

Sugar. Trace by Bismuth & Haines.

Microsc. Uric acid crystals. Amor. urates Phosphates oxalate of Lime

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, Restless at night thinks she hears voices.	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 Kate White

1897

This patient was brought here by Sheriffs deputy P.J. Mieun attended by Mrs. Dufraster, in fair physical condition with the following history:- No history of consanguinity or heredity. First Symptoms manifested one year ago by hallucinations of hearing - voices + noises: The disease appears increasing: Derangement - hears strange noises day + night. Is abused + villified by neighbors - who are trying to take her property away from her. Is disposed to injure others: Not suicidal, filthy or destructive: No information concerning previous peculiarities: No head injury nor acute disease: Has not been confined or restrained. Has received no treatment.

On personal examination says some voice is constantly repeating in her ear "Kate White, White etc"

On Admission put upon 3rd W. (G.H.U. Ept. Complexion - hair gray: eyes brown: Condition of skin normal: No marks or scars. No bruises: Is clean: Behavior quiet: Has delusions of persecution)

1897 May 13 Summary Nurse's 1st Day Record: During the two weeks just following her admission here patient has been fairly quiet + well behaved in every way. Is rather timid but talks quietly + intelligently + seems to be very little disturbed or troubled: - takes things a good deal as a matter of course: Appetite has been good: Temperature normal: Original Record Reserved

May 98 Patient very quiet + agreeable in behavior: Has delusions: Clean in habits: neat in personal appearance: Appetite fair: vomits quite often after meals: bowels regular: Sleeps well: Does no work on ward - works some for herself - Transferred to A-

Aug 98 Summary Nurses Notes by Dr. H. Phelps. Is nervous: has many delusions: Talks sensibly on most subjects: General health is fairly good: She has not been: Works some on ward. also sits in room a good deal - sewing + working for herself. Continued by Dr. H.M. Phelps. Sept 16 '97 Has a cold, coughs a good deal + complains in a somewhat hypochondriacal way. Always quiet + well behaved. Mch 21 '98 Wt. 105#. Jan 17 '99 Patient sits most of time in her room on A?. Is very quiet + well behaved, but has many delusions + hallucinations.

Mch 1- Aug 31 99. Cont by Dr Phelps. General health + appetite fair: Bowels require laxatives: Takes out door exercise: Assists with ward work at times: Delusions + hallucinations still present: Thinks that people talks to her from under her pillow at night. Usually gets along quietly but is very quarrelsome at times: Is exceedingly anxious to go home + thinks she is very unjustly detained here. From June 2 - July 9. Had cold + sore throat.

Sept 1 - Feb 1900. (Dr Heyendale) Takes out door exercise: Takes cathartics: Irritable at times: Neat in habits + appearance: Jan 19. Wt. 131#. Feb 26. Pleasant + agreeable on ward: does fancy work. Mch 1 - Nov 30 1900 Neat, quiet: appetite good: Bowels regular Sleeps well: Apr. 19. Had a severe cold: In bed during day. May 27. Expresses

Personal and Medical History of

many delusions + hallucinations: Think that people talk to her under her pillow also thinks she is kept here because people wish to deprive her of her property, + May July + took table knife from dining room + denied having it until searched. Became very much excited when it was taken from her. July 17 Vaccinated result negative. Nov 16. Wt. 125# No change Dec - Feb 28 1901 General health good: Has hallucinations of hearing: Expresses delusions freely. Feb 28 Wt. 126#.

Mar. to June 1901 No change in mental or physical condition Wt. 129# May 30.

June to Sept. Neat in habits and appearance, converses freely, is quiet and agreeable, has hallucinations of hearing, and talks about them freely, has delusions of persecution assists some with the ward work, takes out door exercise, reads more or less. November 30 Wt 131#

Sept. to Dec Nov. 28 no change. Wt. 130#.

Dec. to Feb. 1903. No change in condition. Wt about 122#.

Personal and Medical History of Catherine Egan.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4763
Residence, St. Paul, Minn.
Date Admission, May 11th 1897.
Admitted by Dr. R. M. Phelps Hour, 6 45 P.M.
How Sent, G. Willrich J. of P. Ramsey Co.
Sex, Female.
Age, 55.
Civil Condition, Widow.
Children, Four.
Age Youngest Child, 16 yrs.
Occupation, Housewife.
Degree Education, Common School.
Profession Religion, Catholic
Habits, Not intemperate.
Nativity, Ireland Parents Ireland.
Physicians Committing, Arthur Brown & J. J. Baker.
Correspondents, None given in papers.

No. for Year, 296.
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, "
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Yes.
Date of this Attack, About April 20th 97
Duration, About 3 Weeks.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 55
Time of Leaving, Sept. 28 1898
Time in Hospital, 1 yr. 4 m. 17 d.
Result, Discharged Oct. 8. 1899 Unimproved.

EXAMINATION ON ADMISSION.

Exam. by R.M. & A. Phelps 5/13/97.

MENTAL CHARACTERISTICS.

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

MEMORY:
Past Events,
Recent Events,
Special Subjects,
} Too confused to test.

PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,

REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
} Very much impaired.

GENERAL DESCRIPTIVE REMARKS: Patient seems somewhat senile though only 55. + atheroma not well marked - Chance seems toward fatty degeneration - Appearance is that of atheroma of brain by reason of vertigo, incoordination + confusion. Her talk is rambling + uncertain. Looks about in dazed manner. Does not realize much of anything. Flat - footed

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 Catherine Egan.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1 in. WEIGHT, 149 lbs. NUTRITION, Full weight - slightly senile
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Condition of skin - Slightly puffy. Coatings, Red, cracked, irritated. Promptness Movement,
PUPILS, Equality, Equal. Slight Arcus senilis. Size, Normal.
Response Light, Accommodation,
SIGHT, Uses glasses - Probably impaired.
HEARING,
COORDINATION, Arms, Considerable inco-ordination.
Legs, "
TREMORS, Hands, Coarse tremors Tongue, Coarse tremors
Facial Muscles, " General, "
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Rather thick - slightly
Hesitating, Hesitating.
FACIAL EXPRESSION,

SENSIBILITY,
Arteries possible atheroma
HEART, No murmurs - Sounds weak.
LUNGS, Fairly normal.

TAKEN,

EXAM. URINE, May 14/97
Color. Yellow
Character. Flaky deposit
Reaction Acid.
Sp. Gr. 1018
Amt. 24 hrs. XXXII ℥
Albumen Trace by heat + Nitric acid Large quantity by Esbachs.
Sugar None
Mic. Amor urates - Large quantity pus + bladder epith. a few fat globules.

GYNÆCOLOGICAL EXAM., Some endometritis: Uterus Normal position. Discharge, Excoriation of external genitals.
MENSTRUATION, Menopause past
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, Very Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL, Has had gynaecological operation - Has headaches + vertigo.
LENGTH OF INVASION, Some months ONSET GRADUAL OR SUDDEN, Comparatively sudden.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any insanity
Mother or Mat. Relations, Dead - old age
Father or Pat. Relations, Dead
Brothers or Sisters,

Personal and Medical History of Catherine Egan.

1897

This patient was brought here by Sheriff's deputy P. J. Mieun attended by Miss Cummings, in fair physical condition, with the following history:- No history of consanguinity, heredity or intemperance in parents or self. First symptoms manifested about April 20'97 by despondency + delusions of money troubles: disease appears stationary: Not variable: no rational intervals: Derangement manifested by delusion that she is totally ruined + children are to be arrested for debt. Not disposed to injure others. No filthy or destructive habits: Threatens to kill herself + tries to secrete weapons: No previous penitentiaries noted: No severe disease or head injury: Has not been confined or restrained but has been treated at St Josephs hospital for past 2 weeks without benefit.
On personal examination is rather weak + talks incessantly on her delusions of financial ruin. On admission put upon

May 11 On Admission put upon B" W (Gen. Apt. Hair gray: Eyes blue: Condition of skin normal: A few scars on abdomen: No eruptions bruises or ulcers: So clean behavior quiet: Talks quite sensibly.)

May 14. Summary Nurses 14 Day Record: On admission patient was quite restless + attempted suicide the first day. Is in a state of somewhat agitated melancholia, quite actively suicidal: Attempted to choke herself with sheet. May 12:- Patient just about the same during the day: was placed in restraint to prevent suicidal attempts. During the two weeks following admission patient has quieted down some what, but has slept for the most part in restraint as she cannot be trusted even for a few minutes during the night: Sick is rather incoherent + senile + although she is able to answer a good many questions yet she wanders on to delusive ideas: Case is evidently a senile one. Original record preserved.

May 31 Summary Nurses Notes by Dr L. Phelps. Has been in restraint about 10 hrs. every day. Appetite has been very poor. fed with spoon. Tries to commit suicide whenever she has a chance. June 25 Visited by daughter: Has many delusions worries a good deal. Feet are badly swollen: Sleeps very little.

Aug 5 Visited by father-in-law: Appetite very poor. Has to be fed by nurses. Refuses medicine. Sleeps very little. Sick in in bed with diarrhoea and fever. visited by sister + daughter. Aug 6 Up + dressed on ward.

Aug 10 Went home with relatives - improved. Dec 15'97 Patient has been home: Returned today. Feb 16'98 Wt. 140#. Fairly well physically: Silly + demented;

May 21'98. Visited by daughter: July 4 Visited by sister: Sept 28 Went home on trial. Quiet + fairly well behaved altho somewhat demented.

Discharged.

Personal and Medical History of

Personal and Medical History of Johannah O'Brien (or Josephine)

EGBERT, FISCAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4764

Residence, Rochester, Minn.

Date Admission, May 12 1897

Admitted by Dr. R.M. Phelps Hour, 6¼ P.M.

How Sent, J.A. Leonard Jo[illegible] Olmsted Co.

Sex, Female.

Age, 30.

Civil Condition, Single

Children, -

Age Youngest Child,

Occupation, Housework.

Degree Education, Common school.

Profession Religion, Catholic.

Habits, Not intemperate

Nativity, Rochester, Minn.

Physicians Committing, J.P. Mosse & C.J. Granger.

Correspondents,

No. for Year, 297.

Insane Relatives, None. (Father intemperate)

Cause Exciting, Unknown.

Cause Predisposing, Previous attack.

Form,

Accompanying Bodily Disorder, Dyspepsia, Hæmorrhoids, Leucorrhœa, Neurasthenia

Suicidal or Not, Not

Date of this Attack, 1 week ago

Duration, About a week.

No. of Attack, 2nd

No. of Admissions, 2nd

Age First Attack, 24

Time of Leaving, June 1. 1897

Time in Hospital, 19 da

Result, Discharged Dec. 1. 1897 Recovered

EXAMINATION ON ADMISSION.

Exam. by R.M. & Ch. Phelps. 5/12/97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Somewhat confused.

Quick or Sluggish,

MEMORY:

Past Events, Impaired

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Seems alert at times then becomes

Correct or Illusive, dull.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State, Seems to realize her condition.

Special Subjects, Impaired.

GENERAL DESCRIPTIVE REMARKS: Patient young. Had previous attack some years ago. It is of adolescent character. Has been for 4 months quite sick & run down with a complication of complaints, possibly with mental failure as a complicating element. For past week has been most disturbed mentally.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS: Many & varied.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Johannah O'Brien.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 4 in. WEIGHT, 125½ lbs. NUTRITION, Impaired - pale

WOUNDS OR ABNORMALITIES, None.

TONGUE, Skin Normal Condition Tremors, Coatings, Very heavy yellow coat Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Normal Accommodation, Normal.

SIGHT, Good.

HEARING, Says good

COORDINATION, Arms,

Legs,

TREMORS, Hands, Rather uncertain from general Tongue,

Facial Muscles, Weakness. General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs.

Pulse normal rate - weak.

LUNGS, Stoop shouldered - rather poor

TAKEN,

EXAM. URINE, May 15/97.

Color Yellowish red.

Character Clear w/ White flaky deposit

Quant 24 oz. XVI ℥.

Sp. gr. 1016

Reaction Acid.

Albumen Trace by Tanrets ?

Sugar. None.

Micros. Large quantity Amor. urates

Large quantity bladder epith.

a few pus corpuscles

GYNÆCOLOGICAL EXAM., Uterus retroverted - Some endometritis - Cystic degeneration of cervix.

MENSTRUATION, Somewhat irregular - painful

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has had typhoid fever. Has vertigo a great deal.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Johanna (or Josephine) O'Brien

Personal and Medical History of

1891

This patient was brought here by Sheriff's deputy John Posy attended by Rachel O'Brien, in a somewhat emaciated condition, with the following history:- No history of consanguinity or heredity. Patient was confined in this (Rochester) hospital from Jan 2nd 91 to April 19th 91 & left here improved. First symptoms of present attack were manifested about a week ago - talks excitedly & sings - is profane - followed by melancholy: Disease appears increasing: Is variable & with irregular rational intervals. - Derangement manifested by excited & profane conversation & Melancholia - wanders from home also: Is disposed to injure others. Not filthy or destructive: No previous peculiarities: No head injury but has dyspepsia, haemorrhoids, neurasthenia & leucorrhoea: Has not been confined or restrained since leaving here: Nothing known as to treatment. On personal examination is quiet & rational at this time but shows depression & lack of confidence.

May 12 On admission put upon B'W (G.H.A. Rpt. Hair brown - eyes gray. Condition of skin normal: No marks, scars nor bruises. Is clean, behavior quiet. Talks sensibly.)

May 25 Summary Nurse's 14 Day Record: On admission patient was quite agreeable & quiet, able to talk about herself, but appearing quite exhausted: Slept quite well during the night: May 13. Had a noisy spell changing quite suddenly & being quite different from her condition of yesterday: May 14: Rather melancholy, but mostly quiet: May 15. Extremely noisy & even violent: Put on C.H.: May 15: Patient during the rest of the two week has quieted down & been for the most part very quiet & well behaved: The noisy & violent attacks were rather sudden & hysterical in form although quite severe: Has had none of late: Has received gynaecological treatment & has taken considerable medicine: Appetite has been quite Good & has Gradually built up. Original Record Preserved.

June 3 Patient quiet & agreeable on ward, sleeps well, appetite poor, bowels irregular: Takes out of door exercise: Takes tonic after meals: Egg-nog twice a day. Visited by her sisters quite often. Does no work. Gone home for a few days.

Discharged.

Personal and Medical History of Augusta Trickow.

EGBERT, FISCAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4770
Residence, St. Paul, Minn.
Date Admission, May 15th 1897.
Admitted by Dr. H.N. Herzog. Hour, 6.45 P.M.
How Sent, G. Dittrich Jr. Capt. Ramsey Co.
Sex, Female.
Age, 19.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Sewing (Father Laborer.
Degree Education, Fair.
Profession Religion, Lutheran.
Habits, Not intemperate.
Nativity, Germany
Physicians Committing, J.A. Meregge & Fredk Leavitt.
Correspondents, Father St Paul.

No. for Year, 303.
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, Previous attack.
Form,
Accompanying Bodily Disorder, Insomnia.
Suicidal or Not, Not.
Date of this Attack, May 9th 97.
Duration, About 1 week.
No. of Attack, 2nd
No. of Admissions, 2nd
Age First Attack, 14 yrs.
Time of Leaving, Nov. 1 - 1897.
Time in Hospital, 5 mo. 16 d.
Result, Died Tuberculosis.

EXAMINATION ON ADMISSION.

Exam. by P.M. & H. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish,
MEMORY:
Past Events, Impaired
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive.
REASONING POWER:
Ordinary Subjects, ?
Own Mental State,
Special Subjects, Much impaired
GENERAL DESCRIPTIVE REMARKS: Mind wanders from one subject to another.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS: Many & varied.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Rather silly in manner & talk
Coherent or Incoherent, Incoherent.
Voluble or Reticent,

Personal and Medical History of Augusta Trickow.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, 135 lbs. NUTRITION, Good.
WOUNDS OR ABNORMALITIES, None
TONGUE, Tremors, Coatings, Heavy yellow. Promptness Movement,
PUPILS, Equality, Equal Size, Normal.
Response Light, Normal Accommodation, Normal.
SIGHT, Says good.
HEARING, Seems good.
COORDINATION, Arms, Good.
Legs, Normal.
TREMORS, Hands, None. Tongue,
Facial Muscles, General, None.
REFLEXES, Patellar, Normal.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Regular.
LUNGS, Normal.
GYNÆCOLOGICAL EXAM., Normal condition
MENSTRUATION, regular.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, ~~Thru~~ 4/97
Color, Yellow red.
Character Clear
Quant. 24 hrs. XXXIII z.
Sp. gr. 1025
Reaction Acid
Albumen Trace by heat & nitric acid
Large quantity by Tanets
Sugar. Trace by Bismuth & Haines
Large quantities hus- & amon urates - Bladder & vaginal cells - a few uric acid crystals

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

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Long 2nd attack ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations, Living
Brothers or Sisters,

Personal and Medical History of Augusta Trichow.

1897

This patient was brought here by Sheriffs deputy John Arndt attended by Mr. Trichow, her father, in fair physical condition, with the following history. No history of consanguinity, heredity or intemperance in parents or self: Patient had previous attack - was confined in this Rochester [x] hospital from Sept 20'92 until April 1st 1893: First symptoms of present attack manifested May 9th 1897 by religious delusions etc. Disease appears increasing: Not variable, no rational intervals. Derangement manifested on subject of religion: Patient not disposed to injure others, not filthy or destructive in habits: No previous peculiarities except on subject of religion: No severe disease or injury to head. Has not been confined or restrained: Has received no treatment.

May 15/97 On personal examination shows Religious delusions, insomnia, refusal to partake of food. On Admission put upon B'r W (G.H.W. Rpt. Complexion dark: Hair brown: Eyes gray: Condition of skin normal: No marks or scars: Several small bruises on arms: Is rather dirty: Behavior quiet: Has delusions)

Note May 28 For particulars see Vol. 21. Fol. 93 No 3134. —

Summary Nurse's 14 Day Record: On admission rather quiet & even stupid in behavior: Eats poorly, & is sluggish in every way: May 19 - Has eaten so poorly that to-day it is necessary to feed her with tube: Very dull, stupid, & dirty: May 28 - Patient still stupid & stubborn, eating part of the time: Is rather stuporous in general condition. Original Record Preserved.

June 15. Admitted on Infirmary Ward: Temperature 104.2: Respiration 34. Expectoration slightly streaked with blood: Sponge baths given every half hour: moaning & restless: Procured dose of Calomel & some hypodermics of Strychnine: June 3: Temperature down to 101.6 & going down during day: Complains of pain in bowels: vomited considerable in afternoon: Nourishment was given with tube together with some attempts to feed her: June 4 - Patient fed with tube: Temperature very nearly normal: vomited some: complains of severe headache: Enema given: Strychnine given frequently: June 5 - Fed with tube: Temperature as high as 100: baths & liquid nourishment given: June 6:- Sitting up part of the day: Temperature little over 99: June 14: Patients temperature has been for the most part a little above 99: She has grown more active & occasionally noisy & has been up on the ward a good deal of the time: Has improved some in physical condition but in a kind of stuporous way: Is stubborn & very troublesome.

June 28 Summary Nurses Notes by Ch Phelps M.D. Fed with tube every day: Requires catheterizing most of time. Bowels constipated. July 21 Is inclined to be violent: Undresses herself & resists in every way. July 30 Still refuses to eat Fed with tube daily. In restraint. Aug. 9 Has been fed with tube daily ever since last note. Aug 10 Up & dressed at her meals. Very untidy - Aug 13 Up & around the room greater part of night & Requires constant attention: Bowels regular.

Personal and Medical History of

Sept. 30 Nurses Notes: Very stubborn & hard to manage: refused to eat for about one week: Filthy Habits dirty: requires 3 or 4 nurses to dress & undress her: Struggles & resists continually: Is in seclusion the greater part of day: kneeling down or standing day & night. Is quite destructive & violent: bowels constipated: Oct. 2. Has diarrhoea: no cough, but expectorates a great deal: refused to eat: fed with tube: has abscess on knee: in restraint: Oct. 13-14-15 Fed with tube: bowels constipated: cathartic given:

Oct. 16/97 Fed with tube: bowels moved freely: catheterized: seems to lose strength daily:

Oct. 18/97 20 Visited by father: refused to talk: Oct. 20 & 21 About the same: expectorates a great deal: Sputum streaked with blood part of time: Oct. 27 Ate some. Oct. 30. Ate breakfast, dinner & supper. Oct. 24 Has diarrhoea: In bed in restraint: refused to eat: fed with tube: complains of severe pain in left side: A.M. T. 103 1/5: R. 40: Sponge bath given: Struggled & resisted: 4 p.m. T 104 1/5. R. 44: Strychnia given every 4 hrs: Oct. 30 Growing weaker: out of restraint: 8:30 a.m - T. 102. 3 p.m. 103 1/3. Resp. 30. Coughs some & expectorates a great deal: Oct. 31. a.m.- T. 102. - 3 p.m. T 103 1/3 Resp. 30. Pulse 132. 7 p.m. T. 105 1/5 - pulse 132.: Nov. 1. 2 a.m. 106 1/5. - 7 a.m. Died.

Died

Personal and Medical History of Kate Healey.

EBBERT, FIOLAR & DIAMBERS, DAVENPORT, IOWA

Whole No. 4771

Residence, St. Paul, Minn.

Date Admission, May 22nd 1897.

Admitted by Dr. Wm. Phelps Hour, 6.45 PM.

How Sent, J. Willrich Jop? Ramsey Co.

Sex, Female.

Age, 46.

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, Cook.

Degree Education, Common School.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Massachusetts (Parents Ireland)

Physicians Committing, E. A. Borchard & Jno B. Brimhall.

Correspondents, Maggie Healey 369½ W. 7th St. St Paul. (Sister)

No. for Year,

Insane Relatives, None given.

Cause Exciting, None given.

Cause Predisposing, Previous attack.

Form, Agitated Melancholia

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, May 19. 1897.

Duration, 3 days.

No. of Attack, 2nd

No. of Admissions, 1st

Age First Attack, 26.

Time of Leaving, June 7. 1898

Time in Hospital, 1 yr. 16 d.

Result, Died. Tuberculosis Pulmonalis.

EXAMINATION ON ADMISSION.

Exam by Drs. E. A. & Wm Phelps 6/7/97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Dull.

MEMORY:

Past Events, Blurred.

Recent Events, Blurred.

Special Subjects, Blurred.

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Incorrect.

REASONING POWER:

Ordinary Subjects, Very poor.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Dull.

DELUSIONS: Many.

Systematized or Not, Somewhat.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient began as an agitated melancholia: Very extreme- took four to bring her down. The activity was most extreme but chiefly in the way of resistance. Has fears & resists everything. Since coming has gradually quieted down. Is still restless & fearful though much better as regards resisting. Has a drawny swelling under lower jaw - Rt. side - which has been growing for several days. Causes considerable fever & constitutional disturbance - Is in bed.

DID NOT GO TO ROCHESTER.

Train Left While She Was Struggling With the Officers.

Kate Healey, aged forty-six, living at 261½ West Seventh street, was committed to the insane asylum at Rochester yesterday by Judge Willrich, of the probate court. She was suffering from acute mania and was strongly insane on financial topics. She was taken to the union depot by a deputy sheriff, but refused to leave the carriage when she arrived there. The assistance of four policemen was necessary to get her out of the carriage. When she was finally taken out the train had left and she was returned to the county jail. She will be taken to Rochester to-day.

Personal and Medical History of Kate Healey.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 191 lbs. NUTRITION, Fairly normal.

MALITIES, Condition of skin - Some pallor.

Coatings, on Edges - red in centre Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Probably good.

HEARING,

COORDINATION, Arms, Indeed

Legs,

TREMORS, Hands, None noted. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Not tested.

Other

ARTICULATION,

Slurred, Will not talk.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Struggled - did not test well.

LUNGS, No good examination

Taken,

GYNÆCOLOGICAL EXAM.,

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

EXAM. URINE, June 4/97

Color. Yellow

Character. Clear

Amt. 24 hrs. XXIX Z.

Sp. gr. 1020

Reaction. Acid

Albumen Trace by heat & Tannic

Sugar. None.

Microscop. Amor. urates Oxal lime crystals - a few bladder & vaginal cells - large quantity pus

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

CRANIAL MEASUREMENTS,

HISTORICAL, 20 yrs ago an attack - Probably not so severe.

LENGTH OF INVASION, Few weeks ONSET GRADUAL OR SUDDEN, Quite sudden.

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") ? Can't tell

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Kate Healey.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4771

Residence, St. Paul, Minn.

Date Admission, May 22nd 1897.

Admitted by Dr Wm. Phelps Hour, 6.45 Pm.

How Sent, J. Willrich Jopl. Ramsey Co.

Sex, Female.

Age, - 46 -

Civil Condition, Single

Children, -

Age Youngest Child, -

Occupation, Cook.

Degree Education, Common School.

Profession Religion, Catholic.

Habits, Not intemperate

Nativity, Massachusetts (Parents Ireland)

Physicians Committing, E. A. Barchard & Jno B. Brimhall.

Correspondents, Maggie Healey 367½ W. 7th St. St Paul. (Sister)

No. for Year,

Insane Relatives, None given.

Cause Exciting, None given.

Cause Predisposing, Previous attack.

Form, Agitated Melancholia

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not

Date of this Attack, May 19 1897.

Duration, 3 days.

No. of Attack, 2nd

No. of Admissions, 1st

Age First Attack, 26.

Time of Leaving, June 7. 1898

Time in Hospital, 1 yr. 16 d.

Result, Died. Tuberculosis Pulmonalis.

new, Fairbanks's highest grade; cost $82 50 easy terms, cash $62 50 St. Peter street.
LADY'S ADLAKE—THE FINEST cycle made; 1897 pattern; cost $75 00 on easy terms, or $60 cash. St. Peter street.
1896 ROMAN—GENT'S WHEEL—MAJESTIC; cost $50 00 on easy terms, or $40 cash. St. Peter street.
1896 Hur—GENT'S WHEEL—Model 20; cost $50 00 on easy terms, or $40 cash. St. Peter street.
$37.50 wears cost $75 00 on easy terms, or $60 cash.
HARTFORD—LADY'S WHEEL—Model 20; cost $50 00 on easy terms, or $40 cash. St. Peter street.
1897 TEMPLE SCORCHER—GENT'S WHEEL—Model 20; cost $50 00 on easy terms, or $40 cash. St. Peter street.
$26 cost $60 used less than thirty days; guaranteed perfect; weighs thirty pounds; splendid climber; easy terms or $25 cash.
1896 GENT'S ADLAKE—COST $100—USED ONLY A FEW WEEKS; almost ninety days' trial allowed; will sell for $50 cash or on easy terms. St. Peter street.

EXAMINATION ON ADMISSION.

Exam by Drs. E. A. & Wm Phelps 6/17/97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Dull.

MEMORY:

Past Events, Recent Events, Special Subjects, } Blurred.

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Incorrect.

REASONING POWER:

Ordinary Subjects, Very poor.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓ dull.

DELUSIONS: Many.

Systematized or Not, Somewhat.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient began as an agitated melancholia: Very extreme- took four to bring her down. The activity was most extreme but chiefly in the way of resistance. Has fears & resists everything. Since coming has gradually quieted down. Is still restless & fearful though much better as regards resisting. Has a drawny swelling under lower jaw - Rt. side - which has been growing for several days. Causes considerable fever & constitutional disturbance - Is in bed.

Personal and Medical History of Kate Healey.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 6 in. WEIGHT, 141 lbs. NUTRITION, Fairly normal.

WOUNDS OR ABNORMALITIES, Condition of skin - Some pallor.

TONGUE, Tremors, Coatings, on Edges - red in centre Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Probably good.

HEARING,

COORDINATION, Arms, Indeed

Legs,

TREMORS, Hands, None noted. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Not tested.

Other

ARTICULATION,

Slurred, Will not talk.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Struggled - did not test well.

LUNGS, No good examination Taken,

GYNÆCOLOGICAL EXAM.,

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

EXAM. URINE, June 4/97

Color. Yellow

Character. Clear

Amt. 24 hrs. XXIX Z.

Sp. gr. 1020

Reaction. Acid

Albumen Trace by heat & Tannic

Sugar. None.

Microscop. Amor. urates. Oxal. lime crystals - a few bladder & vaginal cells - large quantity pus

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

CRANIAL MEASUREMENTS,

HISTORICAL, 20 yrs ago an attack - Probably not so severe.

LENGTH OF INVASION, Few weeks ONSET GRADUAL OR SUDDEN, Quite sudden.

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") ? Can't tell

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Kate Healey.

1897

This patient was brought here by Sheriffs Deputy P.J. Mirsin attended by Mrs Sylvester, J Duncan + E.B. Watson in fair physical condition: with the following history: No history of consanguinity: First attack occurred 2 years ago - was of short duration: First symptoms of present attack manifested May 19 1897 by Acute Mania: Disease appears increasing: Not variable, with no rational intervals: Derangement manifested on subject of finances: Not disposed to injure others, Not filthy or destructive: No severe disease or head injury: No information concerning previous peculiarities or Confinement or restraint: Has received no treatment: On personal examination shows restlessness, dullness, Pallor, loss of memory.
On admission put upon 6^{3} W. (G.H.W. Pt Complexion dark: hair brown: eyes gray: Condition of skin normal: No marks or scars noticed: Large bruises on right knee + on both arms)

June 4 Summary Nurse's 14 Day Record:- Patient very restless: put in restraint during the afternoon: Is very active in her resistance: May 25: Ate rather poorly, takes liquid diet: Is apparently a form of agitated melancholia:
May 25 May 26 Given Egg nog every two hours: Temperature 101: Vomited slightly: Slept but little: Has been in restraint on account of her acutely agitated behavior: Was taken out of restraint some this afternoon: Slept 5 hrs.: Took egg-nog, coffee + toast: May 28:- Patient very restless again to-day, although up on the ward:
June 3 Has been up and around considerable, but is quite a restless patient: Has been eating better: Still agitated + melancholy. Original Record Preserved.
June 30 July 9 Summary Nurses Notes by H.K. Phelps M.D. Has been in bed all month - Temp. Varying from 99 to 102. Face + neck very much swollen with phengenous erysipelas which on the neck broke + discharged - sloughing out leaving a large abscess below chin. This is dressed every few hours day + night. Mental condition has been some better since she has been in bed. July 4 Has been restless most of time Takes dressings off of ulcers: Takes regular meals - Temp. has been normal the last few days - July 7 Was violent this morning - Very noisy: Appetite good. July 9 Able to sit up in room part of time Ulcers doing well - Very little pus discharging.
Sept. 6 Nurses Notes: Fought nurses: restless all day: Sept. 13 Restless + violent: could not be quieted: put in restraint: Sept 29 Usually very restless, at times violent: has delusions: very stubborn: seems to be running down physically: appetite good: bowels apt to be constipated: Nov 4 Seems to be loosing flesh, also failing mentally: Dec 4: Fought nurses: put in restraint: Dec 5 Taken out of restraint:
Dec. 6 Habits clean, but very untidy in appearance: always very restless: Very much run down physically: mentally about the same: Appetite good: bowels regular: goes neither riding nor walking: Apr 15 Very dirty in habits: violent: only speaks

Personal and Medical History of

when spoken to: Physical condition very poor: Appetite good: bowels usually constipated:
May 28 29 Failing quite fast.
Physicians Note by Dr. Abbett: There was a gradual failure in patients health during Spring: Had been expectorating for some time: body quite emaciated but no other marked physical signs apparent until June 1st: About that time she developed a slight cough + appeared to fail very rapidly: Appetite had been good but failed somewhat at this time also + she was somewhat weak, lying down part of the time: June 2 + 3: Temp. in evening was 100 +: June 4: Seemed much worse: Temp. in evening 103: June 6: Refused Supper: aside from this no change was noticeable during night: Died quite suddenly June 7 1898 - at 5:30 a.m.

Died

Personal and Medical History of Hattie Catlin

HERBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4774

Residence, Minnesota Lake, Minn.

Date Admission, May 27th 1897.

Admitted by Dr. H.H. Herzog. Hour, 6.45 P.M.

How Sent, Josiah T. Winship Supt. St. Faribault to

Sex, -Female-

Age, -28-

Civil Condition, -Single-

Children, -

Age Youngest Child, -

Occupation, Housework. (Father farmer)

Degree Education, Common school.

Profession Religion, Methodist Episcopal.

Habits, Not intemperate.

Nativity, Minnesota (Parents New York).

Physicians Committing, Wm. Corson & Wm. Grund both M.D.

Correspondents, Millie A. Catlin, Minnesota Lake, Minn.

No. for Year, 307

Insane Relatives, Maternal Great Grandfather only.

Cause Exciting, Unknown.

Cause Predisposing, Heredity?

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, March 15th 1897.

Duration, over 2 months.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 28

Time of Leaving, Aug. 4 1897

Time in Hospital, 2 mos. 8 das.

Result, Discharged Sept. 4 1898 Recovered

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps. 6/7/97.

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, Febrile delirium. little attention.

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, State is one of delirium-

Special Subjects, (mild) with lack of

Transitory or Not, attention & coherence.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: History of "Scrofulous" condition with running sores. Nurses Notes Kept show a steady, febrile condition which in conjunction with her mental & physical state, indicates quite strongly a chronic meningitis possibly a tubercular condition. Also there is hint of somewhat of inability to learn well & of spasms in infancy. A defective constitution is thus hinted at.

Personal and Medical History of Hattie Catlin

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ WEIGHT, 135 NUTRITION, Some impairment.

WOUNDS OR ABNORMALITIES, Skin - rather pale.

TONGUE, Tremors, Coatings, dark brown - dry, Like typhoid Promptness Movement,

PUPILS, Equality, Equal. Size, Dilated.

Response Light, Accommodation,

SIGHT, ?

HEARING, Probably good.

COORDINATION, Arms, -

Legs, -

TREMORS, Hands, Tremulousness + trembling movements Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Exists

Other

ARTICULATION,

Slurred, Not Talk

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries normal.

HEART,

Fairly Normal.

LUNGS, No lesion.

EXAM. URINE, June 4/97

Color Reddish yellow

Character Cloudy with ropy deposit

Amt. 24 hrs. XXIX Z.

Sp. gr. 1029

Reaction. Acid

Albumen Good test by heat + Nitric acid Large Quantity by Tanrets

Sugar. Trace by Fehlings + Bismuth.

TAKEN,

GYNÆCOLOGICAL EXAM., 6/28/97 Uterus normal position. External genitals normal.

MENSTRUATION, ~~Irregular~~ Suppressed.

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, Said to be comparatively sudden ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") ? Most likely.

Mother or Mat. Relations, Came with her - Apparently healthy. Great grandfather insane

Father or Pat. Relations, "

Brothers or Sisters,

Personal and Medical History of Hattie Catlin.

1897.

This patient was brought here by Sheriffs deputy Allen Catlin attended by Millie A. Catlin (father + mother) in fair physical condition, with the following history: No history of consanguinity: First symptoms manifested about March 15th 1897 by hallucinations: Disease appears increasing: Is variable with irregular, rational intervals: Derangement manifested by always thinking she has some dispute or misunderstanding to settle: Is not disposed to injure others: Not suicidal, filthy or destructive: Previous peculiarities,— impressed by religious impressions: No history of intemperance in parents or self: Patient had spasms when only a few days old: Has not been confined or restrained: Has at times been given sedatives with temporary benefit. On personal examination has hallucinations.
On admission put upon 3rd W (John. Pat Complexion fair: hair brown: eyes blue. Condition of skin normal: No marks noticed: Small scar on left wrist: Is clean: Behavior rather hysterical: has delusions.)

June 9. Summary Nurse's 14 Day Record:- Admitted May 27: At first very restless, crying a good deal: Out of bed till mid night: May 28: Temperature 97.4: Ate three meals during day: Was given cathartic dose: Cried most of the time in an incoherent way: Had to be fed with spoon: May 29.- Rather more quiet: up on the ward: Had to be fed, however, + was awake + out of bed most of the night: June 9:- Patient during the two weeks has been extremely restless + agitated + stubborn most of the time: Has been in restraint some to prevent trouble: would otherwise be up + restless by moving about all night: Has refused to eat a good deal of the time + had to be fed by nurse. Original Record Preserved.

June 30 Summary Nurses Notes by Dr. S.L. Phelps. Patient fed with tube daily. Temp. has ranged from 101 to 103. Has been in restraint most of time Visited daily by Mother. June 30 T. 100.4 - P. 100. R 26. Very restless + noisy most of day. Has been given cold sponge baths for rise of temp. ever since put to bed. July 4 Temp. 102.8 P. 100 R 25 Fed with tube ate a little fruit. Most of day struggled very hard - unable to keep her in bed when out of restraint. Cold applications applied to head. July 8 A.M. Temp 101.2 P.M. 102.6 - R. 36 Slept six hrs. July 9 up on ward most of day. Rather excited at times T. 99.8 P 110 R 20.

July 30 Up on ward part of time: At times talks quite sensibly: at other times quite excited: Visited often by mother: Aug. 4: Went Home

Discharged.

Personal and Medical History of

Personal and Medical History of Bridget Quinn

EGBERT, FIDLAR & STAMBERG, DAVENPORT, IOWA

Whole No. 4776

Residence, St. Paul, Minn.

Date Admission, May 28th 1897.

Admitted by Dr. H. H. Herzog Hour, 6:45 P.M.

How Sent, J. Willrich J. of P. Ramsey Co.

Sex, Female.

Age, 32.

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, Domestic.

Degree Education, Common school.

Profession Religion, Catholic,

Habits, Not intemperate - (Father drank)

Nativity, St. Paul. (Parents Ireland)

Physicians Committing, Chas. J. Meade, J. B. Wilson M.D.

Correspondents, M. Walsh (uncle) #9 Grace St. St. Paul Minn.

No. for Year, 209.

Insane Relatives, Mother.

Cause Exciting,

Cause Predisposing, Heredity.

Form,

Accompanying Bodily Disorder, Emaciated.

Suicidal or Not, Not.

Date of this Attack, One week ago.

Duration, About one week.

No. of Attack, 3rd ?

No. of Admissions, 2nd time. 1 in St. Peter.

Age First Attack, ?

Time of Leaving, Mar. 1. 1898

Time in Hospital, 9 mo. 1 da.

Result, Discharged July 30 '98 Recovered.

EXAMINATION ON ADMISSION.

Exam by R. M. & D. L. Phelps 6/18/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Much Confused.

Quick or Sluggish,

MEMORY:

Past Events, Much impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Much impaired.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Very incoherent & noisy in her talk. Talks constantly to herself. Mind wanders from one thing to another. Attacks resembles the former one which she had here.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, & noisy

Depressed,

DELUSIONS: Many,

Systematized or Not,

Special Subjects,

Transitory or Not, Yes.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Bridget Quinn.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1½ in WEIGHT, 107 lbs. NUTRITION, Somewhat impaired.

WOUNDS OR ABNORMALITIES, None. Condition of skin normal.

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Good.

HEARING, "

COORDINATION, Arms, -

Legs, -

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal.

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Normal.

HEART, No murmurs. Sounds blurred. Regular.

LUNGS, Chest sym. appears normal Expansion fair R. Sounds clear normal.

TAKEN,

EXAM. URINE, June 4/97

Color Yellowish red

Character Cloudy, flaky deposit

Amt. 24 hrs. XXX ℥j

Sp. gr. 1022

Reaction Acid.

Albumen Trace by Sanita

Sugar. None

Mic. Large quantity pus bladder cells amorphous. Mucous Casts

GYNÆCOLOGICAL EXAM., 6/4/97 Hymen intact. Uterus seems normal. External genitals normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, ~~Good~~, Very noisy & restless most of night.	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN, 3rd attack.

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Cant get full information

Mother or Mat. Relations, Mother insane.

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Bridget Quinn.

1891

This patient was brought here by Sheriffs deputy P. J. Meisn, attended by M. H. Wolch (cousin) in fair physical condition, with the following history:- No history of consanguinity: First attack occurred in 1885. was confined in this Rochester[x] hospital from December 19: 1891 until July 19: 1892. + Went away recovered. First symptoms manifested one week ago by violence + hallucinations: Disease appears increasing: Not variable: no rational intervals. Derangement manifested by being excited + irritable. Not disposed to injure others: not suicidal, filthy or destructive: Nothing known as to previous peculiarities: No severe disease or head injury. Was confined at St Joseph's Hospital for one week. Has received no treatment. On personal examination is emaciated, irritable + excited. On admission put upon B[x] W (Q.H.A. Rpt Complexion dark: hair brown: Eyes blue: Condition of skin normal: No marks or scars noticed: So dirty: behavior quiet: Very incoherent) [x](Note:- for further particulars see Vol. 18. Fol. 193 No. 3903)

June 10. Summary Nurses 14 Day Record: Patient entered in a state of acute mania talking rather incoherently + wildly. although able to answer some questions with fair correctness: June 10. Patient during the two weeks has been rather active + violent + is growing more so: Talks noisily: does not very often do any damage or injury but is very noisy + incoherent: is untidy: Temperature has been about normal: Appetite good: Original Record Received.

Summary Nurses Notes by Mrs. Phelps.

June 25 Very stubborn, untidy in habits: Quite violent: Bowels constipated: Menstruation regular. July 27 Destroyed bed: Noisy at times Transferred to B[4] on 18th Continued by Dr. P.M. Phelps. Sept. 20'97 Rather noisy + violent at times: is a case of acute mania: Oct 30 Has quieted down considerably: Is working some in dining room Nov 8'97 Trans. to B'. March 1'98 Out house on trial

Discharged.

Personal and Medical History of

Personal and Medical History of Julia Jorgenson

HERBERT, PUCAN & CHAMBERS, DAVENPORT, IOWA

Whole No. 4777

Residence, Olmsted Co. Minn.

Date Admission, May 31st 1897.

Admitted by Dr. H. H. Herzog Hour, 3:15 P.M.

How Sent, J. A. Leonard J. of P. Olmsted Co.

Sex, - Female -

Age, - 33 -

Civil Condition, - Married -

Children, - 4 -

Age Youngest Child, 2 yrs.

Occupation, Housewife.

Degree Education, Common school.

Profession Religion, Lutheran

Habits, Not intemperate.

Nativity, Olmsted Co. Minn. Became resident at birth (Parents Norway)

Physicians Committing, W. W. Mayo, Chas. F. Granger.

Correspondents, Andrew Dimmitt (father) Rock Dell, Minn.

No. for Year, 310.

Insane Relatives, None.

Cause Exciting, Puerperal mania

Cause Predisposing, —

Form,

Accompanying Bodily Disorder, none mentioned.

Suicidal or Not, yes - attempted by drowning & strychnine

Date of this Attack, About 5 mos. ago.

Duration, 5 mos.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 33

Time of Leaving, June 13. 1897

Time in Hospital, 14 d.

Result, Discharged Nov. 3. 1897. 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 Julia Jorgenson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION,

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT,

HEARING,

COORDINATION, Arms,

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

EXAM. URINE, June.

Not examined.

GYNÆCOLOGICAL EXAM.,

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Julia Jorgenson.

1897

This patient was brought here by Sheriff C.N. Stewart attended by Mrs. Andrew Sivits in fair physical condition: with the following history:- No history of consanguinity, heredity or intemperance in parents or self: First symptoms manifested about 5 months ago- puerperal mania. Disease appears stationary: is variable with rational intervals: she is mentally deficient & suicidal: Derangement manifested by melancholia & by suicidal tendencies: Not disposed to injure others: Suicidal propensity active: Not filthy or destructive in habits: No previous peculiarities manifested: No severe disease or injury to head: Has not been confined or restrained, but has required careful watching: Has received general hygienic treatment. On personal examination no special conditions noticeable.

May 31 On admission put upon 3rd W. (G.W.N. Kept. Complexion dark: hair brown: eyes blue: Condition of skin normal: No marks or scars noticed: A slight eruption on face: Is clean: Behavior quiet but nervous: Has delusions & talks of killing herself.)

June 13 Summary Nurses 14 Day Record: Patient seems quite melancholy & nervous: Temperature normal: Has been quite melancholy & restless: Has complained of no especial physical ailment, although there has been a tendency toward constipation: Appetite has been fairly good at times, at others she has eaten rather poorly: always restless & worrying: complains at times of her throat about which there seems to be some delusive idea: Some tendency toward suicide. Original record preserved.

June 15 Summary Nurses Notes by Dr. A. L. Phelps. June 5 Visited by Sister & husband. on the 16th husband took her out to drive & she remained at home. Her condition was unimproved.

Discharged.

Personal and Medical History of

Personal and Medical History of Kate Pine.

Whole No. 4778	No. for Year, 311.
Residence, St. Paul, Minn., 286 Duke St.	Insane Relatives, No Knowledge.
Date Admission, June 3rd 1897.	Cause Exciting, Unknown.
Admitted by Dr. H.H. Herzog. Hour, 6.45 P.M.	Cause Predisposing, "
How Sent, G. Wellrich J. of P. Ramsey Co.	Form, Mel. Ac.
Sex, Female	Accompanying Bodily Disorder, None mentioned.
Age, 51 yrs.	Suicidal or Not, not
Civil Condition, married.	Date of this Attack, 3 months ago.
Children, 11.	Duration, About 3 months.
Age Youngest Child, 8 yrs.	No. of Attack, 1st
Occupation, Housekeeping. (Husband Expressman)	No. of Admissions, 1st
Degree Education, none.	Age First Attack, 51
Profession Religion, Catholic.	Time of Leaving,
Habits, Not intemperate.	Time in Hospital,
Nativity, Newyork (Father Ireland - mother?) became resident of state in 1863	Result,
Physicians Committing, D. Pool & H.J. O'Brien.	
Correspondents, Michael Pool. 286 Duke St. St. Paul, Minn.	

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:	EMOTIONAL STATE:
Clear or Confused, Confused.	Normal, Calm,
Quick or Sluggish,	Indifferent,
MEMORY:	Exalted,
Past Events, ?	Depressed, & surly.
Recent Events,	DELUSIONS: Many.
Special Subjects,	Systematized or Not,
PERCEPTIVITY:	Special Subjects,
Alert or Dull, Rather dull.	Transitory or Not, Largly transitory
Correct or Illusive,	HALLUCINATIONS:
REASONING POWER:	ILLUSIONS:
Ordinary Subjects, Poor.	CONVERSATION:
Own Mental State,	Coherent or Incoherent,
Special Subjects,	Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient seems a senile case & undoubtedly is of long duration. Has run with incoherence. Transitory delusions & feebleness of mind. Is surly, suspicious & resists. Will talk but little.

Personal and Medical History of Kate Pine.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 2 in. WEIGHT, 143 lbs. NUTRITION, Fair - slightly fleshy.

WOUNDS OR ABNORMALITIES, Condition of skin fair - except slight senile condition.

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size, Dilated some.

Response Light, Accommodation,

SIGHT, ? Uses glasses.

HEARING, Quite deaf.

COORDINATION, Arms, Seems steady - cant test very well.

Legs, "

TREMORS, Hands, No marked tremors. Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Fair.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries rather full, soft.

HEART, no murmurs.

Apparently normal.

LUNGS, Normal.

EXAM. URINE, June 7/97

Color Light yellow

Character Clear

Quant. & Rec. XVIII oz.

Sp. gr. 1019

Reaction Acid

Albumen Trace by Tanrets

Sugar None

Mic. Amor urates - Jens - Oxal-of Lime crystals

TAKEN,

GYNÆCOLOGICAL EXAM., 3/22/97 Uterus normal position. Laceration of cervix: General hypertrophia of vaginal walls & cervix. bleeds on touch. some hypertrophy of perineum. excoriation of external genitals from discharge.

MENSTRUATION, Menopause 4 past.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, fairly	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, Noisy & restless at times	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Said 3 mos. probably longer ONSET GRADUAL OR SUDDEN, Gradual.

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Cant get much history from her.

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters, Has 11 children 9 boys 2 girls.

Personal and Medical History of Kate Pine

1897

This patient was brought here by sheriff's deputy P.J. Nissen attended by P.J. Haudrais + patients daughter, in fair physical condition with the following history: No information concerning consanguinity or heredity. First attack. First symptoms manifested 3 months ago. Disease appears increasing: not variable. No rational intervals. Derangement manifested by fear of bodily harm. Is disposed to injure others. Not filthy or destructive in habits. No previous peculiarities noted. No history of intemperance in parents or self. No severe disease or injury to head. Has not been restrained or confined. Slight medicinal treatment pursued. On personal examination no further particulars noted.

May 3d On admission put upon B+W. (Gotn. Rpt Complexion dark. hair gray; eyes blue. Condition of skin hot + dry. No marks, scars or eruptions noted. Is dirty very noisy in Centre. begging that she need not be hung very quiet after going on ward.)

June 16 Summary Nurse's 14 Day Record. Patient is rather old, somewhat melancholy, was crying some during the first day. Appetite was rather poor. Temperature taken only a couple of times + then normal. resisted any attempt to take it. imagines some one is going to kill her. During the first week was noisy, rather stubborn, + at times very violent, especially upon going to bed. During the second week was noisy at times; talked to herself considerably; rather stubborn. Visited by her husband + daughter on the 16th. Original Record Preserved.

Summary Nurses Notes by Dr. M. Phelps. June 25 Extremely noisy most of day. Fought + June 21/97 was very stubborn. Appetite good. Bowels regular. July 20 Usually very to noisy, uses very bad language. Appetite good. Very stubborn. Sept 1/97 Aug 23 Visited by husband; refused to talk to him tho she recognized him. Physical condition is good. Mentally she is about the same, - stubborn + at times violent in behavior. Continued by Dr. M. Phelps. —

Sept 8/97. Clean + tidy in habits; has many delusions; is at times noisy. Feb 98 143#.
Apr 2. Is at Annex. Talks noisily at times, is incoherent + has many delusions.
Feb 10/99 Patient still at annex; behaves the same in every way.

Mch 1 - Aug 31/99 Cont by Dr Bass. General health good. Takes outdoor exercise. Appetite good. Sleeps well. Neat in habits + appearance. Has delusions + is quite incoherent. Scolds + uses profane language, + is quite violent at times. Often very noisy. Aug. 18 - 156#. Sept 1 - Feb 28 1900 (Dr Reynolds) Neat in habits + appearance. Expresses delusions. Talks incoherently. scolds + is vulgar + profane. Violent at times. Eats + sleeps well. Takes outdoor exercise. Jan 1, Wt. 157#. Jan 9 Visited by husband + son. Mch 1 - Nov 30 1900 (Dr Linton) Neat. very disagreeable at times, noisy + profane. Appetite good. Health good. Bowels irregular. Sleeps well. Takes outdoor exercise. May 9. Complained of head + back ache + chills. Temp 104°. Pulse 108. Resp 36. Put to bed + cathartics given. Ord draftmary until May 14. Slight rise of temp. able to

Personal and Medical History of

Menstruation regular. Assists with ward work. July 20 Vaccinated. Is quite deaf. Has delusions. Sept 20. Visited by son. Nov 24. Wt 149½#
Dec 1 - Feb 28 1901. Appetite good. Bowels regular. Sleeps well. Takes out door exercise. Dec 31 Visited by son. Wt 154#. Mar 1 - June 1 1901
Assists with work on ward. May 30 visited by friends. May 30 Wt 151½# No change in mental or physical condition.

June to Sept Takes out door exercise, attends chapel and amusements, does no work, Sept. 2. Wt. 150#. Sept. to Dec. Assists with the work on the ward shows no change mentally Nov. 30 Wt 151#.

Up to Feb. 1, 1903. General health good: appetite good; bowels regular; sleeps well: generally takes exercise: assists with the work: is very delusional about everything, also has hallucinations: is usually quiet but is at times noisy: tidy in habits and appearance: Dec. 1st, Wt. 149#. Jan. 29th visited by husband and son.

Personal and Medical History of Catharine McDonough

HERBERT, PUGLAR & GOINDICHS, DAVENPORT, IOWA

Whole No. 4779
Residence, St. Paul, Minn.
Date Admission, June 4th 1897.
Admitted by Dr. F.S. Herzog Hour, 6.45 P.M.
How Sent, Gillick & Co. P. Ramsey Co.
Sex, Female.
Age, 70.
Civil Condition, Widowed.
Children, 2
Age Youngest Child, About 40 yrs. old.
Occupation, Housework.
Degree Education, — —
Profession Religion, Catholic.
Habits, Not intemperate.
Nativity, Ireland. Became resident of State or Co. 3 yrs. ago, from
Physicians Committing, W.F. Briggs J.C. Marcon.
Correspondents, No relatives known
7/7/97, Miss Annie McDonough Butte, Montana
John McDonough Hancock Minn

No. for Year, 312.
Insane Relatives, Unknown.
Cause Exciting, Unknown
Cause Predisposing, "
Form, Senile Dementia
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, not
Date of this Attack, 3 yrs. ago. or more.
Duration, over 3 yrs.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, Unknown.
Time of Leaving, Jan. 9. 1900
Time in Hospital, 7 yr 7 m. 5 d
Result, Died - Diabetes Mellitis.

EXAMINATION ON ADMISSION.

Exam. by Asst. Dr. D.L. Phelps. June 18/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Impaired.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Illusive.
REASONING POWER:
Ordinary Subjects, Much impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Mental condition that of Senile dementia - Feeble & infirm from age. Talk incoherent. Dementia quite profound. Behavior is quiet & normal now. Claims to have Gravel. Has Prolapsus. Healthy in appearance

EMOTIONAL STATE:
Normal, Calm, Quiet
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Varied - [illegible]
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: wandering talk.
Coherent or Incoherent,
Voluble or Reticent,

John McDonough
(Egan) Rosemound - Minn -
Get hist & story age and [illegible]
Mrs. Cath. McDonough

ON, CONTINUED.

RISTICS.

NUTRITION, Fairly pale
Fairly good condition for her age.
Promptness Movement,
Normal.
Accommodation,

COORDINATION, Arms, Somewhat impaired by age.
Legs,
TREMORS, ~~Hands~~, No marked tremors somewhat Tongue,
~~Facial~~ Muscles, Feeble from age. General,
REFLEXES, Patellar, both 2
Other
ARTICULATION,
Slurred, not especially - Fairly
Hesitating, Normal.
FACIAL EXPRESSION,

SENSIBILITY,
Arteries - Some atheroma
HEART, No murmurs - Sounds muffled
Complains of heart trouble.
Regular -
Chest sym. Not by age.
LUNGS, Expansion rather impaired
Sounds Fairly normal.

TAKEN,

EXAM. URINE, June 5/97
Color Light yellow
Character Ropy deposit
Sp. gr. 1016
Reaction Alkaline
Albumen Trace by heat - Good test by Nitric Acid - Large Quantity by Esbach
Sugar None
Microscop. Tubes, large quantity - A few bladder & vaginal cells. Cancer cells - Triple phosphates

GYNÆCOLOGICAL EXAM., 6/7/97 Uterus in complete prolapsus: Extensive laceration of perineum & some haemorrhoids
MENSTRUATION, Menopause past many years
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Probably some years. ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Patient quite deaf - Talk rambling
Mother or Mat. Relations, no satisfactory information obtained from her.
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Catharine Mc

BERRY, FISLAR & GILMORE, DAVENPORT, IOWA

Whole No. 4779

Residence, St. Paul, Minn.

Date Admission, June 4th 1897.

Admitted by Dr. H.S. Sturgis Hour, 6.45 P.M.

How Sent, Gilfillen J. of P. Ramsey Co.

Sex, Female.

Age, 70.

Civil Condition, Widowed.

Children, 2

Age Youngest Child, About 40 yrs. old.

Occupation, Housework.

Degree Education, — —

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Ireland. Became resident of State Yrs. ago, prom

Physicians Committing, W.F. Briggs — J.C. Markoe.

Correspondents, No relatives known

7/7/97 Miss Annie McDonough Butte Montana. John M. McDonough Hancock Minn

No. for Year, 312.

Insane Relatives, Unknown

Cause Exciting, unknown

Cause Predisposing, "

Form, Senile Dementia

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, not

Date of this Attack, 3 yrs ago, or more.

Duration, over 2 yrs.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, unknown.

Time of Leaving, Jan. 9. 1900

Time in Hospital, 7 yr 7 m. 5 d

Result, Died. Diabetes Mellitis.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by Rev. D.L. Phelps. June 18/97.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Much impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Mental condition that of Senile dementia - Feeble & infirm from age - Talk incoherent Dementia quite profound Delusion is quiet & normal Now. Claims to have Gravel. Has Prolapsus. Healthy in appearance

EMOTIONAL STATE:

Normal, Calm, Quiet

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Varied. ~~Has~~

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION: wandering talks.

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Catharine McDonough.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fair but pale

WOUNDS OR ABNORMALITIES, Cystopexis uteri Skin - Fairly good condition for her age.

TONGUE, Tremors, Very large deviates to right Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Sluggish Accommodation,

SIGHT, Impaired

HEARING, Very deaf.

COORDINATION, Arms, Somewhat impaired by age.

Legs, "

TREMORS, ~~Hands~~, No marked tremors somewhat Tongue,

Facial Muscles, feeble from age. General,

REFLEXES, Patellar, both 2

Other

ARTICULATION,

Slurred, not especially - Fairly

Hesitating, Normal.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries - Some atheroma

HEART, No murmurs - Sounds myfeeble Complains of heart trouble. Regular -

LUNGS, Chest sym. Distort by age. Expansion rather impaired Sounds Fairly normal.

TAKEN,

EXAM. URINE, June 5/97

Color Light yellow

Character Ropy deposit

Sp. gr. 1016

Reaction Alkaline

Albumen Trace by heat - Good test by Nitric Acid - Large Quan. by Esbach

Sugar None

Microscop. Exs. large quantity - Pus bladder & vaginal cells. Amor urates - Triple phosphates

GYNÆCOLOGICAL EXAM., 6/10/97 Uterus is complete prolapsus: Extensive laceration of perineum & some haemorrhoids

MENSTRUATION, Menopause past many years

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Probably some years. ONSET GRADUAL OR SUDDEN, Gradual.

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Patient quite deaf - Talk rambling

Mother or Mat. Relations, no satisfactory information obtained from her.

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Catharine McDonough.

1894

This patient was brought here by Sheriff Deputy P. J. Nissen, attended by Miss Cummings. in fair physical condition, with the following history:- No information concerning Consanguinity, heredity or intemperance in parents or self: First attack - when first observed three years ago was insane. Disease appears increasing: not variable, no rational intervals: Patient is perpetly incoherent in conversation & is always talking: Not disposed to injure others: Not suicidel, filthy or destructive in habits: No previous peculiarities noted: No information concerning severe disease or injury to head: Has not been restrained or confined: No treatment pursued for relief of patient: On personal examination incoherent in conversation & continually talking.

June 4 On admission put upon B'N. (G'tu. Pt Complexion dark: hair & eyes gray: No marks scars or eruptions noted: Is very dirty: Very hard of hearing: Behavior quiet: Has delusions, thinks people want to burn here: is incoherent.)

June 17 Summary Nurses 14 Day Record: Patient aged: somewhat weak: full of delusions: at times rather noisy during the first week: Appetite good & seemed in fair health: During second week appetite & physical condition made no trouble, but patient was somewhat noisy: Is quite deaf & quite melancholy:- a case of senile dementia. Original record preserved-

July 1/97 to Sept 1/97 Summary Nurses Notes by Dr Phelps July 20 General physical condition remains good: Is very demented in mind & has many delusions. Takes out of door exercise - Aug 20 Is noisy at times: Talks a good deal to herself in an incoherent manner: Is very demented. Continued by Dr. Wm. Phelps. Sept 20 '97 Has many delusions: At times talks very noisily: Takes exercise & seems in fair health. Jan 1 '98 Visited by son.

Feb 20 '98 Mt. 137th Aug 7th Fell on floor (slipped) & bruised her arm. Jan. 2 '99 About the same in every way. Visited in December by her son: Is at times rather noisy. Feb. 1 '99. to Aug 31 '99 Cont. by Dr. Bibb. Appetite good: sleeps well: bowels regular: goes riding: Is extremely noisy at times: Has many delusions: General health is failing. Sept 1. Jan 19 1900 (Dr. Kuypendall) Sep. 18. Appetite fair: Bowels regular: Extremely noisy at times. Feet & limbs swollen all the time: Nov. 26 Struck E. Klock cutting nose slightly & discoloring eye. Dec 10 Extremely noisy: expectorates a great deal. feet & limbs swollen: Jan 7 Slipped & fell causing intracapsular fracture of right hip. Trans. to Infirmary. Jan 3 Very noisy at times during day: Takes but little nourishment: Slept well all night with aid of hypnotic. Jan 4. Seems much weaker: Extension put on fractured limb. Jan 5. Noisy, slept 5 hours. Jan 6 Somewhat weaker: Extremely noisy at times during night Jan 7 Failing rapidly: Very quiet all day. Died at 11:25 P.M.

Died.

Personal and Medical History of

Personal and Medical History of Catharina Mileski

BERGEY, PHILAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4785

Residence, Clinton Falls, Steele Co. Minn.

Date Admission, June 11th 1897.

Admitted by Dr. Hartzog. Hour, 10 40 A.M.

How Sent, W.A. Eggleston J. of P. Steele Co.

Sex, Female -

Age, 52

Civil Condition, Married

Children, - 5.

Age Youngest Child, Twelve years.

Occupation, Housewife (husband farmer)

Degree Education, Can read but not write.

Profession Religion, Catholic.

Habits, Not intemperate -

Nativity, Poland. Became resident of state & Co. in 1878

Physicians Committing, F. M. Dwersh & Theo. L. Hatch M.D.

Correspondents, John Mileski (husband)
~~Clinton Falls, Minn.~~

No. for Year, 318

Insane Relatives, None.

Cause Exciting, Husbands illtreatment & local trouble.

Cause Predisposing, -

Form, Mania Chronic -

Accompanying Bodily Disorder, Laceration of perineum & prolapsus of uterus.

Suicidal or Not, Has attempted it. Propensity not action.

Date of this Attack, Two years ago.

Duration, About 2 yrs.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 52.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam 6/11/97 by Drs. R.M. & L.L. Phelps

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events, Approximately Correct.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Incorrect.

REASONING POWER:

Ordinary Subjects, Rather poor.

Own Mental State, "

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent, Dilly, dallies apparently

Exalted, Noisy at times. Cranky, quarrelsome

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient has appearance suggesting imbecility - History states, however, that trouble began after birth of last child. She had some disease which has caused contraction of tendons under Knees. This causes inability to walk. Joints seem clear & bodily health good.
States that they call her crazy but she is all right. Admits not talking for two years.

Personal and Medical History of Catharina Mileski.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

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

WOUNDS OR ABNORMALITIES, Contraction of tendons under knees - Can't straighten legs. Joints seem good.

TONGUE, ~~Tremors~~, Fairly normal Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Sluggish. Accommodation,

SIGHT, Normal.

HEARING, Normal.

COORDINATION, Arms, Legs, } Probably good - can't test well.

TREMORS, Hands, Some at times. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Can't Test.

Other

ARTICULATION,

Slurred, Fair - (in german)

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries None noted.

HEART, no murmurs.
Fairly normal.

LUNGS, Normal.

TAKEN,

EXAM. URINE, June 26/97

Color Pale yellow

Character. Clear

Amt. 24 hrs. XVI Z.

Sp. gr. 1010

Reaction. Acid

Albumen None

Sugar.

Microsc. Amor urates - Oxal. lime Crystals - a few bladder epith. Cells.

GYNÆCOLOGICAL EXAM., 6/26/97 Uterus in normal position: Extensive laceration of cervix: some laceration of perineum: some Hæmorrhoids.

MENSTRUATION, Menopause past 3 yrs.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Said to have been in bed for 20 years.

LENGTH OF INVASION, Two years ONSET GRADUAL OR SUDDEN, Gradual.

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Can't get any full information

Mother or Mat. Relations, dead.

Father or Pat. Relations, dead.

Brothers or Sisters, 5 children.

Personal and Medical History of Katharina Mileski.

1897

This patient was brought here by Sheriff's deputy M.A. McAndrews attended by Charles Mizgen + patient's daughter, in poor physical condition, with the following history:- No history of consanguinity: heredity or intemperance in parents or self: This is first attack: First symptoms manifested two years ago - attempted suicide by hanging: Disease appears increasing: Is not variable, no rational intervals: Derangement manifested by singing hymns + reading religious books. Is disposed to injure others: Has attempted suicide by hanging: propensity not now active: No previous peculiarities noted: Has not been confined or restrained: Has received no treatment. On personal examination Continually sings 'Hallelujah' + reads religious books - at times sings incoherently.

June 11 On admission put upon B'd W. (Gth. Apt. Complexion dark: hair partly gray: eyes brown: Condition of skin normal: no marks, scars or eruptions noted. little finger of right hand bruised: Is clean: Knee joints stiff + both feet swollen Behavior noisy: Talks sensibly.)

June 24 Summary Nurse's 14 Day Record: Patient seems to be a chronic case- Temperature normal during first week: appetite good: physical condition presents nothing for complaint: rather noisy: legs week swollen: Slept well nearly every night but was rather resistive + fought several times: During 2nd week delusions were prominent; noisy, talk + manner disagreeable.

Original record preserved.

June 26/98 to Sept 28/97 Summary Nurses Notes by Mrs. Phelps June 26 Extremely noisy at times: Appetite good: habits clean: Is quite disagreeable on ward: Complains a good deal about the nurses, her food etc. July 25 Extremely noisy, fought nurses; refused to keep her clothes on + when dressed became very much excited. Refused dinner + tea. July 26 More agreeable - Aug 20 Her physical condition continues as good as usual: Mentally she is still very disagreeable on ward finding fault with her food + resisting nurses. Sept. 28 Visited by son + daughter who took her home. Continued by Dr. Phelps.

Nov 13/99 Trans. to Annex. Has been in seclusion several times: Is at times very noisy. Is quite demented. Dec 15 Complained of being sick yesterday; Temperature found to be about normal; was put to bed. Dec. 19 Had a swollen throat, tonsilitis. Dec. 21 Is today about well. Taken back to annex:

May 25 Commenced to work in laundry June 11 Has been to the Infirmary for last few days. Is back again at annex. Does no work now: Is very demented + troublesome. Feb 8 '99 No change of any note during period.

March 1 - June 3, '99. Cont. by Dr. Bebb. General health good. Appetite good: sleeps well: Takes outdoor exercise. Neat in habits + appearance: Very disagreeable + scolds a great deal especially when physicians are present. Has many delusions + is often very irritable + fault finding: Complains about food + clothing. Does no work. Sept 1 - Feb 28, 1900 (Dr. Heyendale) Oct 3 Neat: Eats + sleeps well. Very disagreeable: Scolds a great deal: General health excellent:

Personal and Medical History of

1900

Visited by two daughters: Jan 12 Wt 180#. Feb 16 Very disagreeable: Helps some on ward. March 1 - Nov 30, 1900 (Dr Linton) Neat: Very disagreeable + noisy at times: uses profane language: Appetite good: sleeps well: bowels regular. Takes outdoor exercise: May 9 Complained of head + back aching. + chills Temp. 102°. Pulse 108. Resp 36. Put to bed + cathartics given: On Infirmary until 14. up on 17th May 24 Visited by friends. July 20 Vaccinated Aug 26 While out walking escaped from crowd was gone two hours before recaptured Complains of not feeling well + not getting enough to eat Nov 4. Wt 179#

Dec 1 - Feb 28, 1901. Appetite good: bowels regular: assists with work: Cross + scolds at times - spits on patients going down stairs. Trans. to C'. while there quite agreeable: assisted with work: + very much more tractable. Jan 3 Trans. to D3. Jan 10 Trans to D' in order that she might assist with dining room work. Very much improved since on C'. Wt. 183 inch 4.

March 1 - June 1 - 1901 Assists with work in dining room. otherwise no change in condition May 31 Wt. 190#. June to Sept. June 5 visited by daughter, assists with ward work, is disagreeable and sometimes quite disturbed, Sept. 3. Wt. 198#.

Sept. to Dec. No change. Nov. 30 Wt. 195#

Jan 1st to Feb. 1, 1903. General health good: inclined to excessive eating and for this reason is sometimes dieted: bowels regular: sleeps well: does no work: scolds a great deal. is disagreeable: Sept 6th visited by son. Dec. 1st. Wt. 172½ #.

Personal and Medical History of Mary Madden #2.

SEBERT, PELAN & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4787

Residence, St. Paul, Minn.

Date Admission, June 12th 1897.

Admitted by Dr. H.H. Herzog Hour, 6.45 P.M.

How Sent, G. Millrick J. of P. Ramsey Co.

Sex, female.

Age, 30.

Civil Condition, married.

Children, Four.

Age Youngest Child, one year.

Occupation, House Keeper.

Degree Education, Common.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Ire. Became resident of State &c. 5 yrs. ago.

Physicians Committing, C.E. Riggs & H.J. Brin M.D.

Correspondents, Mike Madden 583 Ramy St. St. Paul Minn.

No. for Year, 320

Insane Relatives, no knowledge.

Cause Exciting, "

Cause Predisposing, "

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, not.

Date of this Attack, 3 yrs. ago.

Duration, about 3 yrs.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 27.

Time of Leaving, Dec. 29. 1897

Time in Hospital, 6 mo. 15 d.

Result, Discharged May 4. 1898 Improved.

EXAMINATION ON ADMISSION.

Exam by Drs. Rice & D.L. Phelps 6/7/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Somewhat confused.

Quick or Sluggish,

MEMORY:

Past Events, Fair.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dull

Correct or Illusive, Incorrect.

REASONING POWER:

Ordinary Subjects, Slightly impaired.

Own Mental State,

Special Subjects, Very poor.

GENERAL DESCRIPTIVE REMARKS: Patient's condition probably quite chronic from her own statement - No heredity ascertained - A strong predisposition seems probable. There is nothing notable in her present mental or physical symptoms as far as noted.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Somewhat.

DELUSIONS:

Systematized or Not,

Special Subjects, People keep coming in house & Transitory or Not, bothering her, men & women.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Mary Madden #2.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8 in. WEIGHT, 130 lbs. NUTRITION, Slightly impaired.

WOUNDS OR ABNORMALITIES, Skin - good condition.

TONGUE, Tremors, Normal. Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms, Good

Legs, "

TREMORS, Hands, Some not very important. Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Sounds fair

Arteries Normal.

LUNGS, Somewhat flat chested but says never has any trouble or cough.

GYNÆCOLOGICAL EXAM., 6/21/97 Uterus normal position: laceration of cervix & erosion of os.

MENSTRUATION, Normal

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Says never has been sick except at birth of children

LENGTH OF INVASION, Has been bothered for 2 yrs. - a kind of "coming in" not so bad at first. 2 yrs. ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, Died neuralgia of heart, at 55 + consumption Uncle

Father or Pat. Relations, Living. Been in hospital - 60-70.

Brothers or Sisters, 2 sisters & 2 brothers, thinks healthy.

TAKEN,

EXAM. URINE, June 17/97.

Color Yellow

Character Clear

Amt. 24 hrs. XX oz.

Sp. gr. 1022

Reaction Acid

Albumen None

Sugar. "

Microscop. Amor urates a few bladder Epith. Cells

Personal and Medical History of Mary Madden #2.

1897

This patient was brought here by Sheriffs Deputy P.J. Mieny attended by husband, in fair physical condition, with the following history: No knowledge concerning Consanguinity or heredity: First symptoms manifested 3 yrs. ago by delusions of persecution: Disease appears increasing: Not variable, no rational intervals. Derangement manifested by delusions of persecution: Not disposed to injure others: Not suicidal: Filthy + destructive in habits: No previous peculiarities No history of intemperance in parents or self: Has not been confined or restrained: Has received no treatment. On personal examination no further particulars learned.

June 14 On admission put upon Bd W. Gtn. Apt. Complexion dark: Hair partly gray: Eyes blue: Condition of skin normal: No marks or scars noted: Both legs bruised: Is dirty: Rinsted some when bathed: Talks incoherently).

June 27. Summary Nurse's 14 Day Record: Temperature taken the first four days shows itself to be normal: Appetite good during first week + no physical symptoms of note were presented: Had delusions, was somewhat melancholy: talked rather incherently to herself + others: Slept somewhat poorly: During 2nd week appetite good: Slept well most of the time, occasionally talking to herself + always a little wandering in her talk. Original record preserved

July + August. Summary Nurses Notes by Dr. A.C. Phelps. Appetite fair: Bowels regular: Takes out door exercise: Has many delusions: Talks to herself: Is clean in habits + appearance: Works in employes dining room: Is usually quiet but at times becomes excited over her delusive ideas.

Sept. 9 Nurses Notes: Patient has delusions: is quite talkative: takes tonic after meals: takes out door exercise: bowels quite regular: Oct. 1 Quite disturbed: very talkative: uses bad language. Nov. 12 Very noisy + talkative most all the time: quite restless part of night: Appetite is Good: constipated: Nov. 20. Tried to escape: Nov. 30 Is disturbed the greater part of the time: Clean but not neat about person: appetite Good: Sleeps well part of night: takes out door exercise: bowels regular: Dec. 24 Has a great many delusions: Incoherent at times: Gen. health fair: appetite good: At times assists a little with dining-room work: Dec. 31: Visited by husband. Dec. 38 Went Home

Discharged.

Personal and Medical History of

Personal and Medical History of Emily Young.

ROBERT, FIELD & CHAMBERS, DAVENPORT, IOWA

Whole No. 4788
Residence, Milton, Minn.
Date Admission, June 19th 1899.
Admitted by Dr. D. L. Phelps Hour, 3 P.M.
How Sent, Asst Oscar J. of P. Dodge Co.
Sex, Female.
Age, - 51 -
Civil Condition, - married -
Children, - none -
Age Youngest Child, -
Occupation, House wife - (Husband Cabinet maker)
Degree Education, very slight
Profession Religion, not a church member.
Habits, Not intemperate.
Nativity, Wisconsin.
Physicians Committing, D.H. Vanderen & Edwin D. Knight M.D.
Correspondents, Wm. Wallace (bro) Alma, Neb.
Geo. Wallace, Topeka, Kansas.

No. for Year, 321
Insane Relatives, None.
Cause Exciting, Unknown
Cause Predisposing,
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 (In poorhouse for 1½ yrs.)
Age First Attack, 50 yrs.
Time of Leaving, Feb. 14. 1899
Time in Hospital, 1 yr. 7 m. 26 d.
Result, Transfered to Fergus Falls.
A.L.P.

EXAMINATION ON ADMISSION.

Exam. by D. L. Phelps M.D. 6/22/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Seems clear.
Quick or Sluggish,
MEMORY:
Past Events, Seems good.
Recent Events, Good.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Good.
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Patient, aside from feebleminded-ness shows freely on all subjects. Says she wanted to run away from poor house because they all spoke German & she never heard a word of English. She was tired of it & would not stay there. Says that is the reason they brought her here. Has no relatives to look after her & no money to take care of herself. This seems chief reason for bringing her here.

EMOTIONAL STATE:
Normal, Calm, Normal
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, None.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,
Rather feebleminded.
no mental symptoms. Talks readily & freely.

Personal and Medical History of Emily Young.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 in. WEIGHT, 127½ lbs. NUTRITION, Good.
WOUNDS OR ABNORMALITIES, None. Skin - normal condition
TONGUE, Tremors, Coatings, Coated quite heavily Promptness Movement,
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT, Wears glasses - Sight impaired
HEARING, impaired in both ears.
COORDINATION, Arms, Normal.
Legs, Normal.
TREMORS, Hands, None Tongue, None.
Facial Muscles, None General, None
REFLEXES, Patellar, Normal
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries: Some tendency to atheroma
HEART, No murmurs noted Sounds normal. Regular.
LUNGS, Normal.

EXAM. URINE, June 27/99
Color, Light yellow
Character Cloudy
Amt. 24 hrs. XX ℥.
Sp. gr. 1024
Reaction - Acid
Albumen None
Sugar "
Microscop. Amor. urates - Triple phosphates - Bladder & vaginal Epith. cells.

TAKEN,

GYNÆCOLOGICAL EXAM., Uterus normal position: abnormal: no children.
MENSTRUATION, Menopause past 7 yrs. Always painful
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, dead.
Brothers or ~~Sisters~~, healthy

Personal and Medical History of Emily Young

1897

This patient was brought here by Sheriff Joel Tucker attended by Elizabeth Scudelly in fair physical condition, with the following history:- No history of consanguinity; heredity or intemperance in parents or self. First symptoms of attack manifested about one year ago: Disease appears increasing: Is variable with rational intervals: Not disposed to injure others: not suicidal: Is filthy & destructive in habits: Patient has had to be watched all the time: No severe disease or head injury: Has not been confined or restrained: No information concerning treatment pursued. On personal examination no further particulars noted.

Note by Dr Phelps - on commitment papers - "Patient has no special friend in County: Has been in poorhouse for 1½ years - now runs away.

June 19 On admission put upon B'd'd (Gen'l Apt. Complexion dark: hair brown, partly gray: eyes brown: Condition of skin normal: No marks, scars or eruptions noted: Is clean: Behavior quiet: Talks sensibly.)

July 3 Summary Nurse's 14 Day Record: Patients temperature taken during the first week normal: appetite good & no physical symptoms of especial note are seen: patient fairly quiet & agreable for the most part: Commenced working in the sewing room of the 4th day: During second week complained of head ache some but for the most part is fairly quiet & well behaved: works in sewing room. Original Proof Preserved.

July 27 to Sept 14 '97 Summary Nurses Notes by Dr. P. M. Phelps. Patient sick in bed: Complains of sour stomach trouble. Is quite demented in mind. Aug 27 Works in sewing room: Appetite fair: Is quite reticent & talks very little: Takes out door exercise: Bowels regular. Continued by Dr. P. M. Phelps. Oct 2d At times very nervous. Thinks she has worms: General appearance of fair health altho' complains of being weak. Feb 9 W. 1898. Feb 14 '99 Trans. to Fergus Falls Has been quite quiet & slightly incoherent & foolish in manner.

Personal and Medical History of

Personal and Medical History of Augusta Borlk.

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4789
Residence, Wabasha, Mower Co. Minn.
Date Admission, June 19th 1897.
Admitted by Dr. Ker B. Eby. Hour, 7:50 P.M.
How Sent, D. D. Washburn, J. of P. Mower Co.
Sex, - Female -
Age, - 39 -
Civil Condition, - married -
Children, - 10 -
Age Youngest Child, 2 yrs. 7 mo.
Occupation, Housewife (Husband farmer)
Degree Education, Common school (German)
Profession Religion, Ufs Lutheran.
Habits, Not intemperate.
Nativity, Germany. Became resident of State & Co. in April 1895
Physicians Committing, Drs. A.W. Allen & A. Robinson.
Correspondents,

No. for Year, 322.
Insane Relatives, - None.
Cause Exciting, Probably partially female trouble.
Cause Predisposing, not stated.
Form, Chronic Melancholia
Accompanying Bodily Disorder, Female trouble.
Suicidal or Not, Not.
Date of this Attack, About Apr. 1st 1897.
Duration, About 2½ Mo.
No. of Attack, 2nd
No. of Admissions, 1st?
Age First Attack, 37.
Time of Leaving, Mar. 26 1898
Time in Hospital, 10 mo 7 d.
Result, Discharged Aug. 10' 98 Much Improved.

EXAMINATION ON ADMISSION.

Exam by Dr. H. Phelps June 22'97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused Concerning her Condition
Quick or Sluggish,
MEMORY:
Past Events, Good.
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Good
Own Mental State, Very much impaired.
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS:
Systematized or Not, Thinks her husband is untrue to
Special Subjects, her: that he has married another
Transitory or Not, woman: Says the minister & church
HALLUCINATIONS: People say that it is so.
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Talks very willingly: Is sensible on all ordinary subjects but thinks her husband is untrue to her & is the cause of all her trouble. Says the trouble began in 1895. Has lost flesh during the past two years. Circulation is poor. Looks blue & thin.

Personal and Medical History of Augusta Borlk.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. 4 in. WEIGHT, usually 130 to 140 (not taken) NUTRITION, Impaired - circulation poor.
WOUNDS OR ABNORMALITIES, None. Skin rather dry.
TONGUE, Tremors, Coatings, Quite heavy coat. Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Normal. Accommodation, Normal.
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms, Normal
" Legs, "
TREMORS, Hands, None Tongue, None
" Facial Muscles, " General, "
REFLEXES, Patellar, Both Normal
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,

TAKEN,

EXAM. URINE, June 24/97
Color Yellowish red
Character Flaky deposit
Amt 24 hrs XX Z
Sp. gr. 1021
Reaction Acid
Albumen. Trace by Tests.
Sugar None
Mic. Amor urates, a few fat Globules - Bladder epith. & a few pus corpuscles

GYNÆCOLOGICAL EXAM., Uterus Normal position: Endometritis: Extensive laceration of perineum
MENSTRUATION, Irregular past two years. Has 10 children Hard labor.
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Has Headaches at times
LENGTH OF INVASION, About 2 yrs. ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") None.
Mother or Mat. Relations, Very healthy
Father or Pat. Relations, died of Cancer of stomach
Brothers or Sisters, 3 1 sister rheumatism. 10 children

Personal and Medical History of Augusta Boelk

1897

This patient was brought here by Frank Boelk, (husband), sheriffs deputy, in fair physical condition, with the following history: No history of Consanguinity, heredity or history of intemperance in parents or self: First attack occurred in 1895 + 96. lasted about six months: First symptoms of present attack manifested about April 1st 1897: thought her husband guilty of witchcraft etc: Disease appears increasing: is variable. but with no entirely rational intervals: Derangement manifested by thinking that house is surrounded by witches + that any pain which she suffers comes from her husband whom she considers a witch: Not suicidal: filthy or destructive: No previous peculiarities: Had Puerperal fever in 1883, sick one year: no head injury: Cause of disease probably partially female trouble: Has been treated by several physicians, without effect: Has not been confined or restrained: On personal examination - seems rational in nearly everything excepting the cause of her pains, which she claims are due to witch craft + says her husband has that power by the making of an oath + writing his name in blood.

June 19 On admission put upon B'd W. (G.H.) Apt Complexion dark: Hair brown: eyes gray: Condition of skin normal: No marks or scars noticed: Is clean: Behavior quiet: Talks sensibly)

July 2. Summary Nurse's 14 Day Record: Patients temperature taken the first five days normal: Appetite good without variation during first week: Did not sleep very well at first: In fact, slept very little the first two nights, but later slept quite well: patient very quiet, slightly melancholy during the day: Has an intelligent manner: appears to realize everything well: During second week appetite good: patient very quiet + agreeable in manner: not very assertive: quietly anxious to go home: Seems to have only one or two delusive ideas, at least that are prominent as yet. Original record preserved

Aug '97 Summary Notes by Dr. R.H. Phelps. Aug 8 Patient very quiet + agreeable: Does no work: Tidy in habits + appearance: Appetite good: Bowels regular: Takes out door exercise: Still has delusions with regard to her husband. Aug 24 General physical condition seems good: Is quite melancholy + anxious to go home. Continued by Dr. Wm. Phelps. Oct 10 '97 Visited by husband: Has been quite well behaved, always rather melancholy: Talks quite rationally: Feb 1 '98 Child born today: Mch 28 '98 Sent home with baby on trial: Has been getting along well since confinement.

Mch 28/98

Discharged.

Personal and Medical History of

Personal and Medical History of Anna Salzer

Whole No. 4792	No. for Year, 326.
Residence, Wasseca, Minn.	Insane Relatives, None.
Date Admission, June 22nd 1897.	Cause Exciting, Not known.
Admitted by Dr. R.M. Phelps Hour, 6:45 P.M.	Cause Predisposing, Previous attack.
How Sent, Geo. A. Wilson J. of P. Wasseca Co.	Form,
Sex, Female.	Accompanying Bodily Disorder, None mentioned
Age, 55	Suicidal or Not, not.
Civil Condition, Widow	Date of this Attack, About June 17'97.
Children, - 3 -	Duration, About 5 days.
Age Youngest Child, 21 yrs.	No. of Attack, 2nd (1st 5 mo. ago)
Occupation, Housework.	No. of Admissions, 1st
Degree Education, None.	Age First Attack, 55
Profession Religion, yes. Catholic.	Time of Leaving, Sept 6th, 1897
Habits, Not intemperate.	Time in Hospital, 1 mo 15 da.
Nativity, Austria (parents also born there)	Result, Died Heart Failure.
Physicians Committing, J.A. Swartwood & D.J. McMahon M.D.	
Correspondents,	

EXAMINATION ON ADMISSION.

Exam. by R.M. & H. Phelps 6/23/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
- Clear or Confused, Confused about her condition.
- Quick or Sluggish,

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

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

REASONING POWER:
- Ordinary Subjects, Impaired
- Own Mental State,
- Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Complains of pain in her back almost constantly. Some headache at times. Talks sensibly on ordinary subjects. Has some delusions about people trying to poison her.

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

DELUSIONS:
- Systematized or Not,
- Special Subjects, Thinks folks are trying to poison her
- Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

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

Personal and Medical History of Anna Salzer.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION,

WOUNDS OR ABNORMALITIES, Fingers deformed from hard work. Skin normal.

TONGUE, Tremors, Coatings, Pale Promptness Movement,

PUPILS, Equality, Equal. Size, Somewhat dilated.

Response Light, Accommodation,

SIGHT, Good.

HEARING, Much impaired

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None. Tongue,

Facial Muscles, General, None.

REFLEXES, Patellar, Both Normal.

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Some tendency to atheroma

HEART, No murmurs, sounds normal Regular.

LUNGS, Normal.

TAKEN,

EXAM. URINE, June 24/97

Color Pale yellow
Character Flaky deposit
Amt. 24 hrs. XXXII 3.
Sp. gr. 1020
Reaction Alkaline
Albumen Trace by Tsuretts
Sugar None
Mic. Amor urates - a few pus cells - Uric acid crystals ✓ bladder epith.

GYNÆCOLOGICAL EXAM., 6/24/97 Uterus normal position: some laceration & some hyperaemia & discharge of cervix - external genitals normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has had typhoid fever.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters, Has 3 children

Personal and Medical History of Anna Dalzer.

1897

This patient was brought here by Sheriffs deputy G. Goodspeed: in fair physical health, with the following history: No knowledge concerning consanguinity: First attack occurred about 5 months ago, lasted one week: First symptoms of present attack manifested about June 17: Claims that daughter, son & physician are trying to poison her: Disease appears increasing: is variable: Derangement manifested on no particular subject except that of poisoning: Is disposed to injure others: Not suicidal: filthy or destructive: No history of heredity or intemperance in parents or self: No severe disease or head injury: Has not been confined or restrained: Has received bromide & tonic treatment.

June 23 On personal examination appears to be emotional & excitable. On admission put upon Dr. W's Gen. Rpt. Complexion dark: Hair brown: Eyes brown: Condition of skin normal: No marks or scars noticed: Large bruise on left arm: Is rather dirty: Behavior quiet: Has delusions.)

July 5. Summary Nurse's 14 Day Record: Temperature during the first five days shows itself to be normal twice being registered as low as 97, somewhat subnormal. Appetite was good & patient apparently healthy: was quite active & appeared to appreciate her condition fairly well: Talked no English but upon interpretation seemed to have some delusive ideas rather vague in character: During 2nd week appetite & physical health good: patient rather neat in habits, rather quiet & fairly intelligent in appearance, although perhaps a little more worrying or melancholy during this week. Original record preserved.

Aug. Summary of Case by Dr. S. L. Phelps:- Patient was moved to a convalescing ward behavior was very quiet: ate fairly well. Sept 5th: For the last few days patient has refused to eat & it has been necessary to feed her with a tube: color has been bad & patient seems to be failing: Sept 6th - 8 A.M. patient died suddenly: Temperature had been 102.4, pulse 120: Patient had been noticed to be failing for past two or three days: was very melancholy & refused all food: upon being put to bed on the evening of the 5th Nurse noticed that she was very weak: was very restless through the night: slept very little: seemed to have difficulty in breathing: failed gradually until she died.

Died-

Personal and Medical History of

Personal and Medical History of Agnes Knair.

BRIGHT, FISCAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4795
Residence, St. Paul, Minn.
Date Admission, June 24th 1897.
Admitted by Dr. R.M. Phelps Hour, 6 45 P.M.
How Sent, G. Willrich J. of P. Ramsey Co.
Sex, Female.
Age, not stated (31 yrs)
Civil Condition, Married
Children, none (3 children born out of wedlock.)
Age Youngest Child, –
Occupation, Housewife.
Degree Education, Common School.
Profession Religion, Lutheran.
Habits, Not intemperate.
Nativity, Wisconsin: President of State + Co. 1889. Parents born in Germany.
Physicians Committing, Drs. Fark Ricke + V.J. Hawkins.
Correspondents, Father.

No. for Year, 328
Insane Relatives, None
Cause Exciting, Family trouble.
Cause Predisposing, Previous attack
Form, High grade Imbecile
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, One week ago.
Duration, one week.
No. of Attack, Papers say 2nd previous history makes it 5th
No. of Admissions, 2nd
Age First Attack, about 25.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by R.M. + Dr. Phelps 6/25/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Fairly clear.
Quick or Sluggish,
MEMORY:
Past Events, Fair.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Probably correct.
REASONING POWER:
Ordinary Subjects, Much impaired.
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Silly + weak minded. Inclined to run away. Has been feeble-minded for years.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, rather.
Exalted,
Depressed,
DELUSIONS: No definite
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Talk silly + childish.
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Agnes Knair.

4795
3/5/98 M. Agnes Knair

Copy of Order for Hearing Petition of Albert V Enke for appointment of as guardian for Agnes Knair insane; served and service admitted 16th March 1901 (2nd)

(Papers filed with commitment papers.)

EXAMINATION ON ADMISSION, CONTINUED.

MENTAL CHARACTERISTICS.

NUTRITION, Good.
Skin normal condition.
Promptness Movement,
Size, Normal
Accommodation,

COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None.
Facial Muscles, "
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, ✓
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Tongue, None.
General,

EXAM. URINE, July 24/97
Color Yellow
Character Cloudy
Sp. gr. 1024
Reaction Acid.
Albumen None
Sugar None
Microscop. Amor. urates. Large quantities pus & bladder epith. Small amt blood corpuscles & pus globules – oxal. lime crystals

TAKEN,

Arteries normal,
HEART, no murmurs. Sounds exaggerated at base: Apex beat not marked. Nervous + jerky action.
LUNGS, Normal.
GYNÆCOLOGICAL EXAM., Uterus in normal position. Some hæmorrhoids: otherwise normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Fits before – about a year ago.
LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN, Imbecile for years.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations, Healthy
Brothers or Sisters, 1 sister living.

Personal and Medical History of Agnes Knair.

HERBERT, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4795

Residence, St. Paul, Minn.

Date Admission, June 24th 1897.

Admitted by Dr. R.M. Phelps Hour, 6 45 P.M.

How Sent, G. Willrich J. of P. Ramsey Co.

Sex, Female.

Age, ~~not stated~~ (31 yrs)

Civil Condition, Married

Children, none (3 children born out of wedlock.

Age Youngest Child, –

Occupation, Housewife.

Degree Education, Common School.

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Wisconsin: Resident of State + Co. 1889.
Parents from in Germany.

Physicians Committing, Drs. Fark Richie + V.J. Hawkins.

Correspondents, Father.

No.

Ins

Cat

Cau

Fort

Acc

Suici

Date

Durat

No. o - this way 2nd previous history, Matron 5th

No. of Admissions, 2nd

Age First Attack, about 25.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. by R.M. + Dr. Phelps 6/25/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Fairly clear.

Quick or Sluggish,

MEMORY:

Past Events, Fair.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Probably correct.

REASONING POWER:

Ordinary Subjects, Much impaired.

Own Mental State, "

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Silly + weak minded: Inclined to run away. Has been feeble-minded for years.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, rather.

Exalted,

Depressed,

DELUSIONS: No definite

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION: Talk silly + childish.

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Agnes Knair.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None. Skin normal condition.

TONGUE, ~~Tremors,~~ Fair condition. Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None. Tongue, None.

Facial Muscles, " General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, ✓

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries normal,

HEART, no murmurs. Sounds exaggerated at base: Apex beat not marked. Nervous + jerky action.

LUNGS, Normal.

TAKEN,

EXAM. URINE, July 24/97

Color Yellow

Character Cloudy

Sp. gr. 1014

Reaction Acid.

Albumen None

Sugar None

Microscop. Amor. urates. Large quantities pus + bladder epith. Small amt. blood Corpuscles a few globules – axal. lime crystals

GYNÆCOLOGICAL EXAM., Uterus in normal position: Some haemorrhoids: otherwise normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Here before – about a year ago.

LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN, Imbecile for years.

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

Mother or Mat. Relations,

Father or Pat. Relations, healthy

Brothers or Sisters, 1 sister living.

Personal and Medical History of Agnes Knair.

1897

This patient was brought here by Sheriff's deputy C.B. Mixon attended by father in fair physical condition with the following history:- No history of consanguinity or heredity: Patient was confined in this (Rochester) hospital from September 25th 1895 until June 16' 96. & commitment papers at that time stated that she had had three previous attacks. Present papers state that this is 2nd attack: First symptoms of present attack manifested about one week ago: by delusions & by running away from home: Disease appears stationary: Is variable with irregular rational intervals: Derangement manifested on the subject but by Melancholia: Not disposed to injure others: Not suicidal, filthy or destructive: Patient thinks she had three children born out of wedlock: No history of intemperance in parents or self: No severe disease or injury to head: Has not been confined or restrained: Has received no treatment: Cause of disease, family trouble. On personal examination exhibits a mild melancholia.

June 24 On admission put upon Ward W. (G.H.H. Plot. Complexion dark: hair & eyes brown: No marks, scars, bruises etc. Is clean: Behavior hysterical: Remarks very silly!

× Note: For further particulars concerning previous commitment see Vol. 28 P. 369. No. 4209.

July 7. Summary Nurse's 14 Day Record: Temperature first 5 days normal: appetite good: Patient has been here before & returns as rather silly & half imbecile in manner: maintains the same behavior as at her previous stay here: Patient continued the second week the same as during the first. Original Record Preserved.

July & August '99 Summary Nurses Notes by Dr. H. Phelps. July 27 Behavior quiet: Habits neat & clean: many delusive ideas. Good appetite: Is imbecile in mind: Sleeps poorly. Takes out door exercise: Assists some with ward & room work. Is very quiet.
Aug 20 No change mentally or physically since last note: General health good. Talks in a silly & incoherent manner. Aug 21 Lungs & Heart examined Chest expansion normal: Resp. 20: Percussion note normal: Breath sounds normal: Heart sounds normal but rather weak: Pulse 80; normal.
Continued by Dr. Wm. Phelps. Nov 28 '99 Complains some of sore throat: Is on the whole, however, in fair health & is growing fleshy: Is always very silly:

Feb 7 '99 Wt. 170#. July 27 Is working in the laundry at present. Feb 7 '99 General condition about the same. Still works in the laundry.

Mch 1- Aug 31 '99. General health excellent: appetite good: sleeps quite well: Works in laundry most of time. Is neat in habits: Has delusions & is very silly & childish in manner. Talks a great deal & is very noisy, profane, abusive & at times resistive & violent. Aug 14-18 Had a mild attack of indigestion. Remained in bed. Aug 14. Wt. 181½#.

Personal and Medical History of

Sept 1. Feb 28. 1900. Neat: works in laundry: expresses delusions: Eats & sleeps well: general health good: Is childish in speech & manner: & often too loud in talk. Trans to C3 Nov 7. Mch 1- Nov 30 1900 (Dr Linton.) Neat: sometimes noisy & disagreeable & quite disturbed: Has delusions: Talks incoherently: Eats & sleeps well Bowels sometimes constipated: Works in center dining room: July 20 Vaccinated During August more disturbed: Worked in laundry. Nov. 24 209# Dec 1- Feb 28 1901- No change in condition: Still at laundry: General health good, often obstinate & disagreeable.

Mch 1 Wt. 204½ #. Mar. 1 - June 1 - 1901 Work in laundry menstruates. No change in mental or physical condition. May 30 Wt. 200#. June to Sept. Assists with the laundry work, menstruates regularly. Wt. 188½ #. Sept. to Dec no change during quarter Nov. 30 Wt. 188½ #

Up to Feb. 1, 1903. General health good: appetite good: bowels regular: sleeps well: takes exercise: attends amusements: works in the laundry neat and clean in habits and appearance. Generally agreeable expresses many delusions: is childish in deportment: generally answers questions intelligently. Dec. 1st. Wt. 208½ #

Personal and Medical History of Catharine Murphy

BERRY, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4797

Residence, Caledonia, Houston Co., Minn.

Date Admission, June 26th 1897.

Admitted by Dr. R. M. Phelps Hour, 10:45 A.M.

How Sent, J. A. Leonard J. of P. Olmsted Co.

Sex, Female.

Age, 60 - 70.

Civil Condition, Widowed.

Children, - 3 -

Age Youngest Child, None living.

Occupation, No occupation.

Degree Education, None.

Profession Religion, Catholic.

Habits, Intemperate.

Nativity, Ireland: (Parents also born there) Became resident of State & Co. about 10 yrs ago.

Physicians Committing, J. G. Croes & C. F. Granger.

Correspondents,

No. for Year, 330

Insane Relatives, None.

Cause Exciting, Intemperance - senility

Cause Predisposing, -

Form, Dementia Chronic (Inebriate)

Accompanying Bodily Disorder, none mentioned.

Suicidal or Not, Not.

Date of this Attack, Several years ago.

Duration, Excessive drinking for 10 yrs.

No. of Attack, 1st

No. of Admissions, 7th (1st as Inebriate)

Age First Attack, between 60 & 70.

Time of Leaving, May 19 - 1902

Time in Hospital, 4 yrs 10 mos 23 ds.

Result, Died: Chronic Senile Dementia

EXAMINATION ON ADMISSION.

Exam. by Drs. R. M. & D. L. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused on some things.

Quick or Sluggish,

MEMORY:

Past Events, Poor.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Rather dull & illusive.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Mental condition that of mild senile dementia. Memory very poor.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, rather.

Exalted,

Depressed,

DELUSIONS: Some delusive ideas

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Catharine Murphy.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good

WOUNDS OR ABNORMALITIES, None Condition of skin normal.

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size,

Response Light, Accommodation,

SIGHT, Seems fair - uses glasses to sew.

HEARING, Slightly impaired.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, No special Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Absent

Other

ARTICULATION,

Slurred, Somewhat slow.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Aortic murmur. Irregular.

LUNGS, In fair condition

TAKEN,

EXAM. URINE, Subj

GYNÆCOLOGICAL EXAM., Uterus 2nd degree prolapsus. Hæmorrhoids

MENSTRUATION, menopause past.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has been a drinker

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 Catharine Murphy.

1897

This patient received at hands of John Poez attended by Lizzie Randall in fair physical condition, with the following history:- No knowledge concerning consanguinity: Patient has been drinking to excess for past 10 years: First symptoms of attack manifested several years ago. Had been living alone & neglecting herself for 8 yrs. (No previous history) & on March 18'97 was admitted to this Hospital on an Inebriate warrant. Was discharged under Chapter 235 Laws of '97 on June 16'97 (For further particulars see Vol. 32 Page 359 No. 4712) Disease appears increasing: Not variable, no rational intervals: Derangement manifested by lack of memory: occasional delusions & general feebleness of mind: Not disposed to injure others: not suicidal, filthy or destructive: No knowledge concerning severe diseases, injury to head or previous peculiarities: Has been confined in jail several times & in this (Rochester) hospital, as above stated: Has received treatment here!

June '98 On personal examination has occasional delusions: statements inaccurate. On admission but upon Bth W (Gen Rpt. Complexion dark: hair gray: eyes blue: Condition of skin normal: Scars on upper part of both legs: Both feet have been badly frozen: Is clean: Quiet: Talks sensibly but is weak minded

July & Aug. '99 Summary Nurses Notes by Dr. H. Phelps. July 9 Behavior quiet. Has loss of memory & many delusions. Appetite good. Bowels constipated. Eats & sleeps well. Works in dining room. Is very quiet. Takes outdoor exercise. Aug. 20 No change. Still works in dining room: General health good. Continued by Dr. Wm. Phelps. Nov. 30 '99 Patient fairly active: at times somewhat disagreable. Jan 31 '99 Trans. to Annex - Feb 9. Wt. 145. Works some in the dining room: Feb 28 '99 Drifts along quietly & manifests little or no change. General health fairly good. March 1 - Aug 31 '99 General health good. Neat in habits but careless in appearance: usually wears 3 or 4 aprons: At times is very noisy & scolds & is very troublesome with other patients: Has stopped working in dining-room: Expresses many delusions which seem to worry her constantly. Apr 16 Found lying on floor during night with cut over right eye: also complained of shoulder & had scratch on right ankle. She may have fallen out of bed but it was thought that possibly Caroline Lawton pulled her out. Sept 1 — Feb 28 1900 Neat in habits but careless in appearance: Very disagreable & noisy most of time: Has delusions: Bowels constipated: Eats & sleeps well. General health good. Jan 1 '00 Wt 140½#

March - Nov 30 1900. (Dr. Linton) Has delusions about property: Sometimes talks incoherently: will converse & answers questions but sometimes disturbed, disagreable & noisy: At times refuses to have hair combed: Appetite fair: Sleeps well most of time: Bowels require cathartics. June 2 — Struck nurse with shoe in seclusion July 11 Struck patient with shoe: held by nurses. July 23 Vaccinated. Dec. 18 Fought nurses. In seclusion. Is in good

Personal and Medical History of

physical health. Nov 23 Wt. 128#. Nov 27. Pushed down by another patient. Complains of pain in back - but not bruised. Dec 1 - Feb 28 1901 General health good. No change mentally or in behavior: Jan 19 Complained of pain in back: plastered & liniment applied. & massage given daily. Jan 26 Back much worse: unable to go to dining room. Trans. to Infirmary unable to walk: Given massage & Farad. electrical treatment given cathartics. Appetite fair. Habits untidy. Feb 28 Wt 126½#

March - June 1 - 1901 Patient is receiving faradic electrical treatment daily, also massage for back, otherwise physical and mental condition unchanged. Weight not taken. June to Sept. June 19 quite disturbed, her back and left hip strained in the struggle put to bed, liniment applied also massage. twice daily, June 24 sitting up. July 8 began to assist in the dining room. Sept. 22 Wt. 122#.

Sept. to Dec No change during quarter. Nov. 30 Wt. 118½#.

Dec. to Mar. 1902. Patient is unclean and careless requires constant watching: is mischievous and hides food and clothing about her person has to be searched occasionally and plunder removed from her at such times becomes very angry and sometimes violent: is very delusional and at times disagreeable though is usually pleasant: requires cathartics: goes riding: does no work: converses quite readily: is sometimes noisy and uses profane language: Feb. 9 slipped and fell on the floor complained of pain in hip and back: transferred to Inf. left hip badly sprained but no bones broken: was given massage and liniment applied several times daily and stimulants given. Feb. 26 began to sit up on the ward a little every day. Mar. to June Mar. 30 patient fell out of bed and bruised right side of forehead: spends most of the time in bed because she is so helpless and grows very tired when sitting in a chair. Failed very rapidly during April and early part of May: was afflicted with large bed sores on body, hips and over the sacrum. May 19 patient died at 6:00 A.M.

Personal and Medical History of Carrie Johnson (or Lillie)

BARNEY, FICKAR & SHAMBERG, DAVENPORT, IOWA.

Whole No. 4799.
Residence, Minneapolis Minn.
Date Admission, June 29th 1897.
Admitted by Dr. R.M. Phelps Hour, 6th PM.
How Sent, E.G. Butts & asst. Washington Co.
Sex, Female.
Age, 23.
Civil Condition, Single.
Children, -
Age Youngest Child, -
Occupation, Housework.
Degree Education, Common school.
Profession Religion, Lutheran.
Habits, Not intemperate.
Nativity, Sweden (Parents also born there. Resident of State for more than one year.
Physicians Committing, M.C. Clark & J.H. Haines.
Correspondents, Andrew Johnson (Brother) - Wash. Co.

No. for Year, 332.
Insane Relatives, None.
Cause Exciting, Unknown
Cause Predisposing, Unknown
Form, Melancholia Acuta.
Accompanying Bodily Disorder, Had Inflammatory Rheumatism etc May. Headaches. Constipation & Uterine trouble.
Suicidal or Not, Not.
Date of this Attack, Some time in May.
Duration, About 2 months.
No. of Attack, 1st
No. of Admissions, 1st here. (has been in City & Co. Hospital)
Age First Attack, 23.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by Drs. Clark & Phelps 6/30/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Much confused.
Quick or Sluggish,
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Much impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Refuses to talk. Will not answer questions. Talks to herself in an incoherent way at times. Very restless & tries to grab everything near her. Does not seem to realize anything.

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

Personal and Medical History of Carrie Johnson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good
WOUNDS OR ABNORMALITIES, Lateral Curvature of spine toward right. Scars of old ulcers on both legs. Skin - Eruption all over back & chest.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal Size,
Response Light, Accommodation,
SIGHT, Seems good.
HEARING, "
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None Tongue,
Facial Muscles, " General, None
REFLEXES, Patellar,
Other
ARTICULATION, Will not talk.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries Normal
HEART, No murmurs. Palpitation of heart.
LUNGS, Chest Form. Normal Expand "
Breath Sounds "
TAKEN,

EXAM. URINE, July 3/97.
Color Reddish yellow
Character Flaky deposit
Amt. in hrs. XX 3.
Sp. gr. 1020
Reaction. Acid
Albumen Trace by Tannets
Sugar None
Microscop. Epithel. uratic - Mucus Casts. Oxal. lime crystals - Bladder & Vaginal cells.

GYNÆCOLOGICAL EXAM., 7/4/97 Uterus retroverted Some adhesions on left side. External genitals Normal.
MENSTRUATION, Regular.
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, 6 weeks. ONSET GRADUAL OR SUDDEN, Rather 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 Carrie (or Lillie) Johnson

1897

This patient was brought here by Sheriffs deputy Dr. J.S. Haines, attended by Mrs. Young. in fair physical condition, with the following history:- No history of consanguinity, heredity or intemperance in parents or self: This is first attack: First symptoms were manifested in May, when patient was sent to City & County Hospital (St. Paul) for inflammatory rheumatism: She was peculiar in her actions at that time & has gradually been growing worse: Disease appears increasing: Not variable: No rational intervals: Derangment manifested by delusions that she has lost a lover & has animosity against the girl, whom she thinks love him away: She thinks that people are talking about her: Talks & prays continually: Not disposed to injure others: Not suicidal: So filthy or destructive: No previous peculiarities noted: No head injury: had a severe attack of inflammatory rheumatism in May: Had to be tied to bed to prevent her escape from hospital: Has been given sedatives: On personal examination:- has a good deal of headache: Foul discharge from vagina: bowels constipated: General appearance wild & irrational On admission put upon B'd W (Gen'l Rpt. Complexion dark: hair brown: eyes gray: Condition of skin normal: Scars on both legs from ulcers: Eruption on back & chest: So clean: Has curvature of spine: Behavior quiet: (will not talk)

June 29

Summary Nurses Notes by H. Phelps 1897

July

Takes regular meals: Temp. normal: Sleeps very little & is very restless. July 12 Refused her meals today: Quiet the greater part of day: Slept well during night: Her talk is very incoherent: At times becomes quite excited & violent in behavior: July 30 Very noisy: Appetite poor: So destructive & requires constant watching.

Aug

Aug 18 Still very restless, destructive & violent at times: Very incoherent in talk: General health good. Continued by Dr. W.M. Phelps.

Aug '99

Oct 13 '99 Trans. to C3: Has been rather restless & restless. Dec 6 Wt. 134#.

Apr 5 '99. Trans. to Annex. Apr 21 Trans. to C3, rather destructive of clothing: Patient is becoming rather demented & dirty: Feb 7 '99 Wt. 141.# Still rather demented & disturbed & untidy: Has to be watched.

Mch - Aug 3 '99. Cont. by Dr. Britt. General health good: Appetite good: Sleeps quite well: Takes outdoor exercise: Menst. regular: So fed on tray: Very violent at times often attacking other patients & nurses. Mch 20 Complained of pain in abdomen, nurses, in bed for a day or two. Very untidy in habits & destructive: At times stupid at others violent: seldom talks. Sept - Feb 8 '900 Dr. Heyerdale Patient violent at times: is untidy & destructive: appetite good: fed on tray: menstruates: takes outdoor exercise. Nov 11-17. fought nurses: In restraint. Jan 18 Wt. 131½#

Mch 1 - Nov 30 '900 (Dr. Linton) Very dirty & untidy: Quiet on ward: Does not converse: but sometimes will answer questions reasonably by working kept Rings at times & General

Personal and Medical History of

Menstruates regularly. Fed on tray: eats & sleeps well. July 16 vaccinated. Oct 27 taken sick: pain in side: Temp 107⁶ Pulse 98. Resp 22 Cathartics given & baths to reduce temp: put on milk diet: Trans. to Infirmary Oct. 29 while sick Temp. very irregular - highest 101⁸. lowest 96. highest pulse 99. Resp. 25. Temp. reached 104⁶ before trans. to Infirmary. On liquid diet with frequent cathartics & tea baths given often for temps. Bowels regular: Had a hard, rigid appendix & tenderness over area but Dr Mayo did not think it sufficient to cause such temp. but she has organic heart trouble & is quite anaemic: Cardiac stimulants were administered. Very untidy in habits: retained in bed with difficulty until transferred to C' on Nov. 28. Dec 1 - Feb 28 1901 General health good: menstruation regular: usually sleeps well: habits very filthy day & night: usually in restraint at night & part of day. Does not converse: at times destructive & violent. occasionally takes cathartics. Mch. 3 Wt. 123#. Mar 1 - June 1 - 1901 Menstruates regularly. Does no work. no change in mental or physical condition May 29 - Wt. 128#. June to Sept. No change in any respect, Sept. 28 Wt. 128#. Sept. to Dec. no change. Nov. 23 Wt. 137#. Up to Feb. 1, 1903. General health good: eats and sleeps well: bowels regular: menstruates regularly: does no work: takes exercise: is at times destructive: very untidy and careless: does not converse or answer questions: Nov. 29 th. Wt. 128#.

Personal and Medical History of Anna Simonson

FOREST, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4800

Residence, Pine Island, Minn.

Date Admission, June 30th 1897.

Admitted by Dr. B.M. Phelps Hour, 6th P.M.

How Sent, Axel Haller J. of P. Goodhue Co.

Sex, Female.

Age, 51 yrs.

Civil Condition, Single

Children, None

Age Youngest Child,

Occupation, None - Father a farmer.

Degree Education, Common school.

Profession Religion, Not a church member.

Habits, Not Intemperate.

Nativity, Norway (Parents also born there) Became resident of state & Co. in April 1867.

Physicians Committing, A.W. Jones & Geo. Wellmer.

Correspondents, Chris Johnson (Father) (Uncle)
Box 213 Zumbrota, Minn.

No. for Year, 333.

Insane Relatives, A second Cousin.

Cause Exciting, Masturbation.

Cause Predisposing, -

Form,

Accompanying Bodily Disorder, Arthritis deformans.

Suicidal or Not, Yes. Attempted by hanging & cutting herself.

Date of this Attack, May 21st 1897.

Duration, about 5 weeks.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 51

Time of Leaving, Nov. 30. 1899

Time in Hospital, 2 yr. 4 m. 21 d.

Result, Died - Exhaustion in Chronic Dementia.

EXAMINATION ON ADMISSION.

Examn by Dr. B.M. Phelps 6/30/97 — MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused & .

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Impaired.

Recent Events, Much impaired.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull & illusive

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Much impaired.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Physical condition much impaired. Says has pain all over. Has deformity of joints as if had had Rheumatoid Arthritis. Pale & nutrition impaired - Has marks of cupping all over arms & back. Some tendency to hysterical actions. Very restless. Mentally very dull & will not talk.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, Very.

Exalted,

Depressed,

DELUSIONS: No special delusions tho very

Systematized or Not, Confused.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS: Very dull & indifferent

CONVERSATION: Will not talk: Answers "I don't know" to nearly all questions

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Anna Simonson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Poor.

WOUNDS OR ABNORMALITIES, Both hands & fingers deformed as if from Rheumatoid Arthritis. Skin - normal. Nails ragged & pitted along edges.

TONGUE, Tremors, Coatings, heavily coated in center & Promptness Movement,

PUPILS, Equality, Equal Size, Somewhat dilated.

Response Light, Accommodation,

SIGHT, Says not good.

HEARING, Seems impaired.

COORDINATION, Arms, Unsteady.

Legs, Walks as if dizzy: very unsteady on feet.

TREMORS, Hands, Considerable Tongue,

Facial Muscles, General, Considerable.

REFLEXES, Patellar, Somewhat diminished

Other

ARTICULATION,

Slurred,

Hesitating, Hesitates.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Sounds about Normal. & regular.

LUNGS, Chest sym. & normal. Expansion somewhat impaired. Sounds rather shallow - stoop shouldered.

GYNÆCOLOGICAL EXAM., 7/1/97 Uterus retroverted. Some adhesions on left side: Hypertrophy of labia minora.

MENSTRUATION, Menopause past

OPHTHALMOSCOPIC EXAM.,

EXAM. URINE, July 2/97

Color Reddish Yellow

Character Fatty deposit

Amt. 24 hrs. XXX z.

Sp. gr. 1020

Reaction - Acid.

Albumen None

Sugar None

Microscop. Amor. urates - Triple phosphates & oxal. lime Crystals

TAKEN,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Troubled with vertigo.

LENGTH OF INVASION, — 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 Anna Simonson

1897

This patient was brought here by Sheriff's deputy P. J. Lundquist attended by Dorothea Johnson, in fair physical condition, with the following history:- No information concerning consanguinity: This is first attack First symptoms manifested May 21st 97 when patient tried to hang herself. Disease appears increasing: Not variable; no rational intervals: Derangment manifested on no particular subject. Has repeatedly attempted suicide by hanging & by cutting herself. Is disposed to injure others. Not filthy or destructive: No previous peculiarities shown: No recent disease or head injury. Has required constant watching since attack first commenced: Has been given sedatives & improved somewhat under treatment. On personal examination Arthritis deformans. the eroded condition of finger nails of right hand, perhaps result of masturbation.

June 30 On admission Put upon Ward (Gen. Report. Complexion dark: hair black, partly gray: Eyes gray: Condition of skin hot & dry: Scars on back & limbs: bruises on both arms: Is clean: Both hands deformed: finger nails on right hand look as if they had been injured: Behavior quiet: Answers questions sensibly but will not converse.)

July 13 Summary Nurse's 14 Day Record: Temperature taken the first 4 Days is normal: appetite good: Patient rather quiet, thinks herself that she has delusions: Seeks some to herself, sometimes refuses to answer questions: On the 3rd day cut herself with a piece of broken Tumbler: During 2nd week she talked more about wishing to die & her melancholy was more pronounced although for the most part she was quiet: was, however, toward end of 2nd week rather more actively suicidal & troublesome than during the first part of her stay here, refusing to go out of doors & getting excited & troublesome at times. Original Record Preserved.

July & Aug '97 Summary Nurses Notes by Dr. H. Phelps. Patient very much excited: Attempted to commit suicide by hanging: Tried to stab herself in dining room: Sleeps quite well: Refuses medicine at times. Aug 29 Takes medicine: Has not attempted suicide for about a month: More quiet of late: Takes out door exercise: Sept. 1st. Visited by friends. Continued by Dr Phelps.

Sept 1 97. Visited by friends: Sept 29 Visited by son & lady friend: Feb 28 '98 Recently fed by tube. & Very destitute Troublesome & disagreeable. Wt. 87 ~~Mch. 25~~ Trans. to 13s. Very untidy & filthy in habits. Apr 9 Trans. to Infirmary. Mch 30 No restraint a good deal of late. on account of filthy habits. Trans. to 13s. Aug 18 '98 Visited by son & friends. Has been in restraint at various times. Feb 28 '99 Patient rather emaciated. Has had diarrhea several times & looks bad but does not seem to be failing. Behavior shows no improvement.

Mch 1 - Aug 31 '99 Cont. by Dr Bebb. Sleeps well: Is failing rapidly in general health; is much emaciated & expectorates some: Is fed by nurses & eats fairly well: Bowels usually

Personal and Medical History of

1899

constipated: Is usually very noisy & destructive: Filthy in habits: Fractious & restless:

Sept 1 - Nov 20 1900 (Dr Heyndale) Sept 30 No change in habits or condition Oct 21. Received injury to hand. Kicked by M. Johnson. Mrs. Haga Hay only witness laceration required eleven sutures: Patient stupid Appetite good: Fed by nurses: Sleeps well: dirty in habits. Nov 19. Had been growing weaker. today fell on floor bruising face. Nov 20. died of exhaustion in chronic dementia.

Died.

Personal and Medical History of Alma Zabel

EBERT, FIOLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4806

Residence, St. Paul, Ramsey Co. Minn.

Date Admission, July 6th 1897.

Admitted by Dr. Hatterog. Hour, 6.45 P.M.

How Sent, G. Willrich J. of P. Ramsey Co.

Sex, Female

Age, 22

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, Housework &

Degree Education, Common School.

Profession Religion, German Lutheran.

Habits, Not intemperate.

Nativity, Minn. (Parents Germany)

Physicians Committing, L. K. Bacon & C. P. Woolway. Became a resident of Co. in 1894

Correspondents,

No. for Year, 339.

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing,

Form,

Accompanying Bodily Disorder, Sleeplessness. anaemia

Suicidal or Not, Not.

Date of this Attack, 6 weeks ago.

Duration, about 6 weeks.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 22.

Time of Leaving, Sept. 22 - 1897

Time in Hospital, 2 mo. 16 da

Result, Discharged Feb. 9. 1898 Unimproved.

EXAMINATION ON ADMISSION.

Exam by Drs. R.M. & A. Phelps. 7/7/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: -

Clear or Confused, Very dull & sluggish

Quick or Sluggish,

MEMORY:

Past Events, Refuses to talk.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Refuses to talk or answer any questions. Seems to have delusions, very melancholy - Rather pale but in good flesh - Bowels constipated & appetite poor but otherwise her physical condition is good.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS: Probably has but will not talk.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Alma Zabel

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Pale but in good flesh

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Skin - normal. Coatings, Promptness Movement,

PUPILS, Equality, Unequal. Size, Left widely dilated.

Response Light, Accommodation,

SIGHT, Seems good.

HEARING,

COORDINATION, Arms, Normal.

Legs,

TREMORS, Hands, None Tongue, —

Facial Muscles, - General, -

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Refuses to speak.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Normal.

HEART, No murmurs - Sounds normal. Somewhat irreg.

LUNGS, Chest sym. normal. Breath sounds

GYNÆCOLOGICAL EXAM., 7/7/97 Uterus retroverted & bound by adhesions on left side: some discharge: external genitals normal.

MENSTRUATION, unknown.

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, July 9/97

Color Red

Character Flaky Deposit

Quant. 24 hrs. XI ℥.

Sp. gr. 1020

Reaction - Acid

Albumen Trace by Tanrets

Sugar None

Microsc. Exam. Amor urates - bladder epith. Pus. oxal. lime crystals

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, Unknown ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Cannot determine

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Alma Zabel.

1897

This patient was brought here by Sheriffs deputy R.J. Mixon attended by Julia Wenzel, in poor physical condition with the following history:- No history of consanguinity, heredity or intemperance in parents or self: First symptoms of disease manifested six weeks ago, crying despondent, Faltering, loss of sleep & appetite, furred tongue, some elevation of temperature. Disease appears increasing. Not variable: no rational intervals. Derangement manifested by, refusal of food, will not speak, habits filthy, sleeplessness. Is not disposed to injure others: Not suicidal: Is filthy & destructive in habits: No previous peculiarities: No severe disease or injury to head: Has been confined for four weeks to her bed: In house 5 weeks. Has received treatment by means of soporifics, tonics, nourishment & rest.

July 6 On personal examination is anaemic, excitable, pupils dilated, eyes staring. On admission put upon Br W (Gt.N.Rpt Complexion dark: hair light brown: eyes blue: Condition of skin normal: no marks or scars: Left arm bruised: Is clean: Behavior quiet: Refuses to speak.)

July 19 Summary Nurse's 14 Day Record: Temperature first 4 days normal: Refused for the most part to eat during the first week; at times eating nothing, at other times rather poorly; was quiet & rather stupid, would not say any thing; did not move about, but sat stupidly in one place & the expression of her face would indicate that she knew well what was going on. 4th day was fed with tube & the two days thereafter: During 2nd week patient ate somewhat better; was fed usually by nurse, being totally incapable of caring for herself: untidy in habits, slept rather poorly, never spoke, sometimes cried. Original Record Preserved.

July Aug to Sept 22 Summary Nurses Notes by L. Phelps. July 30 Appetite very poor: Requires feeding by nurses. Is very stupid & untidy in habits: Bowels constipated: Refuses medicine: Aug 29 vomits after meals: Bowels constipated, moved by an enemata: Refuses to talk: Screams & cried several times today: Put to bed. Aug 30 Temp. 101 Pulse 114 Bowels moved by enemata. Sept 1st Fed with tube: Temp. 99. Sept 2 Pulse very weak: drank some milk. Sept 3 Takes milk. Sept 5 Still in bed: Coughs some: Bowels move with enema: Sept 8 Very stupid: Temp. 99. Coughs. Sept 10 Pulse quite weak: Milk diet given: Sept 13 Refuses to eat but drinks milk. Sept 14 Trans. to Infirmary. Sept 18 & 19 Visited by Sister. Sept 21 In bed: refuses to eat: Very stupid: Refuses to Talk: Bowels constipated: Sept 22 Was Taken Home Very dull & stupid: Would not Talk & part of time refused to eat. Seems very melancholy: Was Taken much against advice of physicians.

Discharged.

Personal and Medical History of

Personal and Medical History of Mary Nice.

Whole No. 4907
Residence, not given in papers.
Date Admission, July 6th 1897.
Admitted by Dr. R.M. Phelps Hour, 6:45 P.M.
How Sent, G. Willrich J. of P. Ramsey Co.
Sex, Female.
Age, not given
Civil Condition,
Children,
Age Youngest Child,
Occupation,
Degree Education,
Profession Religion,
Habits, Unknown. probably have not been good
Nativity, Not given in papers.
Physicians Committing, C.H. Whitcomb & W. Reis
Correspondents,

No. for Year, 340.
Insane Relatives, no information.
Cause Exciting,
Cause Predisposing,
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Yes. attempted drowning.
Date of this Attack, no information.
Duration,
No. of Attack,
No. of Admissions, 1st here.
Age First Attack, unknown.
Time of Leaving, Aug. 18. 1897.
Time in Hospital, 1 mo. 12 da
Result, Discharged Feb. 18. 1898 Recovered

EXAMINATION ON ADMISSION.

Exam. by R.M. & H. Phelps 7/7/97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Cannot determine.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Answers but few questions. Has a very dull expression. Seems to realize but little. When she speaks it is very indistinctly.

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 Mary Nice.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Skin yellow but well nourished.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, Breath bad. Coatings, Injured, cracked & irritated. Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Accommodation,
SIGHT, Good - uses glasses.
HEARING, Says good.
COORDINATION, Arms, Normal
Legs,
TREMORS, Hands, None Tongue, None.
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating, very - Cannot talk distinctly
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Strength Sounds fair
Arteries Normal.
LUNGS, Chest sym. Normal. Breath Sounds "

TAKEN,

EXAM. URINE, July 14/97
Color Yellow
Character Flaky deposit
Quant. 24 hrs. XL 3
Sp. gr. 1008
Reaction. Acid
Albumen None
Sugar None.
Mic. Amor. urates. Uric acid crystals. Bladder Epith & a few pus corpuscles

GYNÆCOLOGICAL EXAM., 7/14/97. Uterus Normal position: Some endometritis: Some laceration of cervix. Excoriation of perineum: External genitals red & excoriated.
MENSTRUATION, Menopause past 6 yrs.
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 found on street. Says she has not been sick.
LENGTH OF INVASION, Unknown ONSET GRADUAL OR SUDDEN, Unknown.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Says Father, Mother & all brothers & sisters are dead.
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Mary Rice.

1897

This patient was brought here by Sheriffs deputy Charles Gerber, attended by Mary Haenggi, in fair physical condition, with the following history: No information obtainable concerning consanguinity, heredity, intemperance in parents or self: previous peculiarities, severe disease or head injury or treatment pursuit: No knowledge as to number of attack or first symptoms: Disease appears increasing: Derangement manifested by dullness, stupidity, refusal to answer questions & depression: No knowledge concerning disposition to injure others: Has attempted suicide by drowning: Is filthy in habits: On personal examination nothing can be elicited from patient as to personal history, the fact that she is a reformed sporting woman from other witnesses.

July 6 On admission put upon B'd W (Gen. Rpt. – Complexion dark: hair brown: eyes gray: condition of skin normal: No marks, scars or Eruptions. Both legs bruised: Is very dirty: Behavior quiet: Talks very little & not distinctly.)

July 19. Summary Nurse's 14 Day Record: Temperature during first 4 days normal: appetite very good: Patient on coming in was in a quiet, rather stuporous condition, refusing to talk, or seemed to be too stupid to talk: Had a kind of a confused look & appearance: The 4th or 5th day commenced to talk some seemingly with a little difficulty & sluggishness: It was not until about the 10th day, however, that she began to talk very much, after which time, up to the 14th day she was very agreeable: claimed that she was unable to talk before: Had had another attack of similar character, which however was not so bad & from which she recovered under medical treatment.
Original record preserved.

July to Aug 16/97 Summary Nurses Notes by Mr. Phelps. July 21 Appetite quite good: Very agreeable, neat in habits & appearance. Aug 16 Quiet & agreeable on ward: Appetite good: Bowels regular: Sleeps well: Has headaches at times: Takes tonic: Assists with work: Aug 16 Went home apparently much improved.

Discharged.

Personal and Medical History of

Personal and Medical History of Anna Megeras

Whole No. 4808

Residence, Belvidere, Goodhue Co.

Date Admission, July 7th 1897.

Admitted by Dr. P.M. Phelps. Hour, 6.45 P.M.

How Sent, Axel Haller, J. of P. Goodhue Co.

Sex, Female.

Age, 23.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Housework (Father a farmer)

Degree Education, Common School.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Minn (Father Germany, Mother Wisconsin) Became resident of State + Co. by birth.

Physicians Committing, G. Allen + E. Anderson

Correspondents, Nick Megeras (Father's brother)

No. for Year, 341.

Insane Relatives, None.

Cause Exciting, Cross in love.

Cause Predisposing, ——

Form, Melancholia acuta.

Accompanying Bodily Disorder, Tremor of tongue + twitching of muscles of face

Suicidal or Not, Has threatened it.

Date of this Attack, Latter part Dec. '96.

Duration, over 6 mo.

No. of Attack, 1st

No. of Admissions, 1st.

Age First Attack, 23

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. by P.M. + A.L. Phelps 7/9/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Probably impaired

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State, "

Special Subjects, "

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS: None determined but probably

Systematized or Not, Has.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Very reticent. Talks very little + answers questions very reluctantly. Says she will not eat so long as she stays here. Claims that her brother whipped her because she did not behave herself. She has marks upon her body that seem to have been caused by a stick. Pale + constipated. otherwise her general physical condition is good.

Personal and Medical History of Anna Megeras.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fairly good.

WOUNDS OR ABNORMALITIES, None. Skin - normal.

TONGUE, Tremors, Coatings, heavily coated. Promptness Movement,

PUPILS, Equality, Equal Size, Normal

Response Light, Sluggish Accommodation, Sluggish

SIGHT, Says good.

HEARING, Appears good.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Some tremor Tongue, None

Facial Muscles, None. General,

REFLEXES, Patellar, Both q. EXAM. URINE, July 9/97

Other Color Red

ARTICULATION, Character Clear with ropy deposit +

Slurred, Quant. 24 hrs. XLIV Z.

Hesitating, ✓ + Slow. Sp. gr. 1028

FACIAL EXPRESSION, Reaction. Acid

Albumen. None

Sugar. None

SENSIBILITY, Mic. Amor. urates - Bladder Epith.

Arteries Normal.

HEART, No murmurs - Sounds normal + regular.

LUNGS, Chest sym. normal. Lungs seem in good condition tho' says she has some cough.

TAKEN,

GYNÆCOLOGICAL EXAM., 7/9/97 Uterus retroverted: External genitals normal.

MENSTRUATION, Suppressed for about ½ yrs

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor, Refuses food
SLEEP, Good, usually	Poor, at present	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, She says she has never felt very well. Has had La Grippe - No other special disease. Has headaches at times.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, Dead.

Father or Pat. Relations, living

Brothers or Sisters, 4 brothers.

Personal and Medical History of Anna Megaras.

1897

This patient was brought here by Sheriff's deputy Adolph Groos attended by Mrs. M. Anderson, in fair physical condition, with the following history:- No history of consanguinity, heredity or intemperance in parents or self: First symptoms of disease manifested in latter part of December 1896: Disease appears increasing: is variable: Derangement manifested by fear of being poisoned: running away from home: Does not want to associate with others. Not disposed to injure others: No filthy or destructive habits, except that she commenced to cut dress with shears at one time: Previous peculiarities, quick-temper: desire to be alone: No severe disease or injury to head: Has been constantly watched since 2 weeks before Christmas 1896. On personal examination unsteady look, twitching of facial muscles: tremor of tongue: Does not answer questions readily.

July 7 On admission put upon B.W. (G.H.U. Rpt. Complexion dark: hair & eyes brown: Condition of skin normal: No marks or scars: Bruises on both legs & on left eye. Is dirty: behavior quiet: (talks very little.)

July 20. Summary Nurse's 14 Day Record:- Patients temperature during 1st 14 days normal. Appetite good from the start: was however, rather irregular & violent in behavior: 3rd day refused to dress & fought when being dressed: was violent & rather stubborn most of the week: During 2nd week condition varied little: Did not wish to do anything: would resist & fight when it was attempted to get her to do something & would also interfere at other times: Habits were untidy & at the end of a month she was removed to 6th as being so restless and violent. Original Record Preserved.

Above is an error. Following is the correct Summary-

July 20. Temperature taken 1st 14 days normal: appetite rather irregular & poor at first. was fed with tube the 3rd day: afterward ate tolerably well: Refused during first few days to talk: was quiet & rather neat: During 2nd week was quite irritable, would seldom speak & was very anxious to go home: Seems rather dull, stupid & slightly silly in manner. Original record preserved.

July 20 to Sept. 1 Summary Nurses Notes by Dr. Phelps. July 20 Quiet: Appetite good: Bowels constipated: cathartics given: Tidy in habits & appearance: Gyn. treatments given Every other day: Very quiet & agreeable. 8/1/97 Gyn. treatments continued Visited by friend today. Aug 10 Appetite very poor: Bowels usually constipated: Takes out door exercise: Does no work: Has many delusions. Aug 18 Refuses to eat: Fed with tube today: Has many delusions: Takes cathartics. Refuses Gyn. Treatments. Continued by Dr. Wm. Phelps. Nov 29 97 Has been rather quiet & dull & at times resistive. Has received gynaecological treatments quite steadily Dec 97 Wt. 140# Still on treatment: July 18 98 Trans. to B2. Has been receiving treatments most of time: Is still quite stubborn: Aug 6 98 Wt. 130# Sept 1 Trans. to B3. Feb 8 99 Has seemed somewhat sickly of late: on Feb 22 99 Has a mark dizzy spell. Was put to bed. Mch 1 Nov 3099 Cont. by Dr. Bibb. General health good. Refuses to take outdoor exercise: Usually quiet but slightly noisy at times & inclined to be violent. Is restless occasionally at night. Mch 5 Very untidy in dining room, given tray on hall & refused to eat. Stubborn & profane. July Goes out occasionally; rather untidy in habits: Oct 10 Visited by friends - Refused to recognize them.

Nov 1 - Feb 28 1900 (Dr. Heyerdahl) Patient very disagreeable & stubborn at times but as a rule is quiet is untidy: appetite good: General health good. Eats fairly well: Occasionally strikes other patients: Dec 17, Struck Anna Ischida. in dining room: Secluded for a time: Trans. to 6th Dec. 30. Refused nourishment fed by tube. Jan 17. Wt. 145# Still refuses to eat. Feb 7 Trans. to 6s. Habits clean. Very quiet: bowels constipated.

Mch 1 - Nov 30. 1900. Fairly neat: general health good. Seldom talks: Thinks people put Paris green in her food: Mch 3. Quite disturbed - kicked Anna Apr. 16. Struck patient with shoe. Apr. 14 Very violent when nurse tried to take her out on lawn. Menstruation regular: July 21 Vaccinated. Aug 15. Quiet most of time: rarely speaks. Eats & sleeps well: Refuses outdoor exercise. Nov 21. Refused to be weighed

Dec 1 - Feb 28 1901 - General health good: No change mentally.

Mar. to June 1901. June 15 visited by friends, patient shows no change either mentally or physically May 29 Wt. not taken. June to Sept. patients general condition remains unchanged. Sept. to Dec. patient in good general health, eats and sleeps well, takes out door exercise occasionally, bowels regular, scarcely ever talks, is usually incoherent and expresses delusions, at times is very violent, as a rule sits quietly about on a chair taking no notice of her surroundings, refuses to have her weight taken.

Dec to Feb. 1903 No change. Wt about 144#.

Personal and Medical History of Anna Megaras.

Personal and Medical History of Helga Jacobson.

EGGERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4809
Residence, Rushford Minn.
Date Admission, July 9th 1897.
Admitted by Dr. RM. Phelps Hour, 3 PM.
How Sent, Ed Farrington J. of P. Fillmore Co.
Sex, Female.
Age, 51
Civil Condition, Married
Children, Eleven
Age Youngest Child, 8 yrs.
Occupation, Housewife (Husband a farmer)
Degree Education, Can read Norwegian.
Profession Religion, Lutheran.
Habits, Not Intemperate.
Nativity, Norway (Parents Norway
Became resident of State & Co. 29 yrs. ago.
Physicians Committing, G. A. Lee & J. A. Phillips
Correspondents,

No. for Year, 342.
Insane Relatives, Mother & sister died in this Hospital
Cause Exciting, Unknown.
Cause Predisposing, Heredity
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, One year ago.
Duration, About one year.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 50 yrs.
Time of Leaving, June 1- 1900
Time in Hospital, 2 yrs. 10 m. 23 d.
Result, Discharged Nov. 7. 1900
Improved

EXAMINATION ON ADMISSION.

Exam. by Drs. RM & A. Phelps 7/9/97. **MENTAL CHARACTERISTICS.**

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS: Very delusive ideas.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Very much confused & at times silly in Talk. Mind
Coherent or Incoherent, Silly.
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Very incoherent & wanders from one thing to another. Almost complete loss of memory. Does not realize her mental condition. Physical condition seems fairly good. Can obtain no facts from her.

Personal and Medical History of Helga Jacobson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Very good.
WOUNDS OR ABNORMALITIES, Bruises on arms & body. Skin Normal.
TONGUE, Tremors, Coatings, Quite heavily coated Promptness Movement, "
PUPILS, Equality, Equal. Size, Dilated.
Response Light, Accommodation,
SIGHT, Seems good.
HEARING, "
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, No Tremors. Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Normal.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries Normal
HEART, Murmur following 1st sound
Chest sym. normal.
LUNGS, Breath Sounds "

TAKEN,

EXAM. URINE, July 14/97
Color Yellow
Character Cloudy with copy deposit
Amt. In hrs. XXXIV Oz.
Sp. gr. 1006
Reaction Acid.
Albumen Trace by Tanrets.
Sugar None.
Mic. Amor urates. Bladder epith. A few pus corpuscles & blood.

GYNÆCOLOGICAL EXAM., 7/29/97 Uterus bound down by adhesions so that it is unmovable: Cervix hard bleeds upon touch: very little discharge: External genitals red & excoriated
MENSTRUATION, Menopause past. Some symptoms of sarcomatous degeneration of cervix.
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 she has had Pneumonia. Headaches at times.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Can determine Nothing.
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Helga Jacobson

1897

This patient was brought here by Sheriff's deputy Gabriel Jacobson attended by G.D. Lundundberg, in fair physical condition with the following history: No history of consanguinity: First attack occurred 1/3 yrs ago + lasted 2 yrs: First symptoms of present attack manifested one year ago; went to bed + would not eat for 10 days then commenced to talk irrationally: Disease appears increasing: Not variable: No rational intervals: Derangement manifested by delusions on many subjects: Not disposed to injure others: Not suicidal, filthy or destructive: Mother + sister died insane, at this hospital: No previous peculiarities noted: No acute disease or head injury: Has not been confined or restrained: Has received no treatment: On personal examination - "has all the mania".

July 9 On admission put upon B'd (Gth w Rpt Complexion fair: Hair light brown: eyes blue: Condition of skin normal: Both arms bruised: Is clean: Speaks but little English)

July 22 Summary Nurse's 14 Day Record: Patients temperature during first 4 days normal: appetite good from the start: was however, rather irregular + violent in behavior: 3rd day refused to dress + fought while being dressed: was violent or rather stubborn most of the week: During second week condition varied little: Did not wish to do anything + would resist + fight when it was attempted to get her to do something + would also interfere at other times: Habits were untidy + at the end of the two weeks she was transferred to 6th as being so restless + violent: Original Record Preserved

July 30 to Aug 30 Summary Nurses Notes by Dr. H. Phelps. July 30 Appetite good: Sleeps well: Is occasionally violent: Bowels usually constipated: Takes outdoor exercise: Habits clean: Takes Gym. treatments every other day. Aug. 30 Eats + sleeps well: Habits clean: At times violent: Gym. treatments continued: Talks very little: Seems to have delusive ideas. Continued by Dr. Wm. Phelps Oct 30 '97 Patient coughs + expectorates some: Most of the time quiet + fairly well behaved. Feb 30 '98 Appetite good: Seems to be better: Mch 30 '98 Put upon sick ward, had had a slight rise of temperature recently. Mch 22 Up on ward: Trans. to Annex: Seems to be fairly well. July 21 Is working in the laundry: Feb 5 '99 Still at annex: General condition unchanged in any respect. Mch 1 - Aug 31 '99 Cont by Dr. Bibb. General health fair: Appetite good. Sleeps well: Takes outdoor exercise: Neat in habits + appearance. Very quiet: Never speaks except when addressed: Works in laundry: Does not express any delusions: Aug 19 - Wt. 107½ lbs Sept 1 - Feb 28 1900 (Dr. Heyndale) Sept 22 Visited by daughter: Works & is neat in habits has stopped working in laundry: has many delusions: sings + is noisy at times: Appetite fair: General health good: Takes outdoor exercise fair ly. Wt. 109 lbs. Feb 10 Does no work at all.

Personal and Medical History of

1900

March 1 - June 1 1900. (Dr. Linton) Neat in habits but careless in appearance: Quiet on ward: Does not converse but will answers questions sensibly: Sings at times: General health fair: June 1 - went home.

Discharged

Personal and Medical History of Mary McDonald.

COBERT, FOLEY & CRAMBERS, DAVENPORT, IOWA

Whole No. H 813.
Residence, St. Paul, Minn.
Date Admission, July 15th 1897.
Admitted by Dr. R. M. Phelps. Hour, 6:45 P.M.
How Sent, G. Willrich Dep't. Ramsey Co.
Sex, Female.
Age, 51 yrs.
Civil Condition, Widowed.
Children, none.
Age Youngest Child, —
Occupation, Housewife.
Degree Education, None.
Profession Religion, Catholic.
Habits, Not intemperate.
Nativity, Ireland - (Parents also born there)
Has been resident of State or Co. at least 9 mo.
Physicians Committing, Arthur Swinney & J. C. Markoe.
Correspondents, None given in papers.
Little Sisters of the Poor. St. Paul, Minn. (Guardians)

No. for Year, 346
Insane Relatives, Unknown.
Cause Exciting, Old age
Cause Predisposing, —
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, 9 mos. ago
Duration, 9 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 51 yrs.
Time of Leaving, July 29 - 1901.
Time in Hospital, 4 yrs — mo — 14 ds
Result, Died: Pulmonary Hemorrhage.

EXAMINATION ON ADMISSION.

Exam. July 17'97 by Dr. R. M. Phelps

MENTAL CHARACTERISTICS.

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

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

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

REASONING POWER:
Ordinary Subjects, Much impaired.
Own Mental State, "
Special Subjects, "

GENERAL DESCRIPTIVE REMARKS:
Mind flies from one thing to another. Very demented & childish in manner & talk. Very fleshy.

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

DELUSIONS: Many delusions & ideas.
Systematized or Not,
Special Subjects,
Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent, Very incoherent
Voluble or Reticent, Talks constantly.
Very childish with loss of memory

Personal and Medical History of Mary McDonald.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fatty degeneration.
WOUNDS OR ABNORMALITIES, Skin normal condition.
TONGUE, Tremors, None. Coatings, Promptness Movement, Normal.
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT, Blind in right eye - almost entirely blind in left. - (Right eye has been removed)
HEARING, Impaired.
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Normal.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No Murmurs - Sounds weak & muffled as in fatty degeneration. Regular but pulse is weak.
LUNGS, Chest Gym. normal. Percussion note rather flat.
GYNÆCOLOGICAL EXAM., 7/9/97 Uterus Normal position. External genitals red & excoriated from discharge. Cervix hypertrophy of, Vagina. Slight Haemorrhoids.
MENSTRUATION, Menopause part.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, July 20/97
Color Yellow.
Character. Ropy deposits Cloudy
Amt. 24 hrs. XVI 3.
Sp. gr. 1028
Reaction. Acid.
Albumen None
Sugar None.
Mic. - Amor. urates - a few fat Globules - uric acid crystals - Large amt oxal. lime crystals Few Hyaline casts

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

CRANIAL MEASUREMENTS,
HISTORICAL, Has had two operations on eyes
LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Says father & mother Melancholy.
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Mary McDonald.

1897

This patient was brought here by Sheriffs deputy J. Jonson, in fair physical condition, with the following history: No information concerning consanguinity, heredity or intemperance in parents or self. First symptoms of disease manifested nine months ago by general quarrelsomeness & discontent; disease appears increasing, is variable with irregular rational intervals. Derangement is now manifested by belief that she is denied her rights, abused & maltreated by those caring for her. Is not disposed to injure others; not disposed to filthy or destructive habits. No knowledge concerning previous peculiarities. No severe diseases nor injury to head. Has not been confined or restrained. Has received no treatment. On personal examination talks volubly, loudly of injuries done her & believes that she is kept with colored people, wants to go to a hospital to be ready if she should get sick.)

July 15 On admission put upon B^d W. (Gen'l Rpt. Complexion dark. Is blind: hair gray. No marks; scar on back left thigh bruised. Is clean: talks & cries a good deal: talks sensibly)

July 18 Summary Nurse's 14 Day Record: Patient aged, slight by restless & garrulous on tack, crying at times & rather noisy: Slept, however fairly well during the night. During the first week gradually became more satisfied & quiet Asked to go home, but did not at any time seem permanently anxious about it or to be troubled about it. Is perhaps as contented here as any where: During 2nd week continued unchanged: Is somewhat blind & helpless, but is helped some by some of the other old ladies, with whom she sometimes talks: Is very feeble-minded: Original Record Preserved

Aug 1 to 20 Summary Nurses Notes by Dr. M. Phelps. Patient sleeps well: Takes outdoor exercise Bowels regular: Mental condition demented: Aug 20 Is agreeable on ward: Not very clean in habits: Very childish & demented in mind.

Nov 13 '99 (Continued by Dr. B.W. Phelps) Patient has of late been quiet & agreeable & has improved very much in behavior: Feb 10 Visited today by Sisters from the Convent. Was anxious to go home:

May 7 '99 Refused to eat. Has been resistive: May 20 Is eating fairly well again. Aug 31 Was growing melancholy & very obstinate: Jan 5-6 '99 Fed with tube: Feb 28 Patient still rather melancholy & troublesome. Mch 1 - Aug 5 '99 Cared by Dr. Bibb. General health much impaired: has failed of late a good deal: expectorates carelessly about room & furniture: Is secluded much of time on this account. Resists everything done for her & is quite violent at times, using every means in self defense: Is very noisy & destructive & frequently removes clothing: Hair cut (with friends permission) as she would not keep it combed: Wears strong dresses with locked shoes: Often refuses meals & necessary to feed mechanically: Bowels constipated, conditions grow: Has many delusions principally of persecution. Says that all the people about her wish to harm her. Sept 1 - Feb 28 1900 (Dr Heysdale) Refuses Fed with tube twice daily seems to grow weaker each day: . Is secluded most of time on account of

Personal and Medical History of

expectorating over everything: noisy at times & cries: Sits about on floor a great deal: Jan 18 wt 85.# Appetite quite good: Sleeps well: bowels constipated requiring laxatives: Eats from tray: Has many delusions.

March 1 - Nov 30 1900. (Dr Linton) untidy & dirty: always in seclusion - when out clings to nurses & expectorates over floor &c: occasionally noisy at night: Has many delusions: usually refuses to keep clothes on: Appetite variable usually sleeps well: Takes no exercise. July 16 Vaccinated No 16 wt 95#

Dec 1 - Feb 28 1901 - Physically fairly well: Appetite good usually tho refuses food at times Habits dirty. Thinks she is down South & says she is a colored woman. much disturbed - goes about room crying March 1 - June 1 - 1901 No change in mental or physical condition. Weight not taken because too resistive. June to Sept. Patient continues about the same, untidy, noisy, expectorating a great deal, kept in seclusion most of the time. July 27 had hemorrhage of the lungs and died immediately afterwards at 9:55 P.M.

Dead

Personal and Medical History of Josephine Peka.

EDDEY, FICAS & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4815

Residence, Jordan, Fillmore Co. Minn

Date Admission, July 16 1897.

Admitted by Dr. R.M. Phelps Hour, 10:5 A.M.

How Sent, C.V. Farrington J.of P. Fillmore Co.

Sex, Female

Age, 50

Civil Condition, Married.

Children, 8.

Age Youngest Child, 7 yrs.

Occupation, Housewife

Degree Education, None

Profession Religion, None.

Habits, Not intemperate.

Nativity, Bohemia Austria Parents same.
Resident of State + Co. for over 16 years.

Physicians Committing, J.F. Phillips + G.A. Love.

Correspondents,

No. for Year, 348

Insane Relatives, 2 Cousins - Father a drunkard.

Cause Exciting, Unknown

Cause Predisposing, Previous attacks.

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, 4 weeks ago.

Duration, 4 weeks.

No. of Attack, Has had several.

No. of Admissions, 1st.

Age First Attack, about 30 yrs.

Time of Leaving, Aug. 30. 1897

Time in Hospital, 1 mo. 4 da.

Result, Discharged Feb. 9. 1898
Unimproved

EXAMINATION ON ADMISSION.

Exam. by R.M. + G. Phelps 7/17/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: --

Clear or Confused, Seems fairly clear at present.

Quick or Sluggish,

MEMORY:

Past Events, Seems fair

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Mostly correct.

REASONING POWER:

Ordinary Subjects, Somewhat impaired.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Seems somewhat restless + has an anxious expression. Talks Bohemian + understands but little English. So far as we are able to understand, seems sensible. Some impairment in nutrition.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Somewhat depressed.

DELUSIONS: —

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS: —

ILLUSIONS: —

CONVERSATION: —

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Josephine Peka.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. WEIGHT, 112 lbs NUTRITION, Fairly good

WOUNDS OR ABNORMALITIES, Skin very brown but normal condition.

TONGUE, Tremors, Coatings, White coat Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Normal Accommodation, Normal.

SIGHT, Seems good.

HEARING, "

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Normal Tongue,

Facial Muscles, " General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs - Some palpitation. Seems hypertrophied.

LUNGS, Expans. Chest symm. normal
R. Sounds "

TAKEN,

EXAM. URINE, July 20/97.
Color Pale yellow
Character Cloudy
Amt 24 hrs. XXII 3.
Sp. gr. 1006
Reaction Acid
Albumen Trace by Tanrets
Sugar None
Mic. Amor urates a few fat globules + uric acid crystals

GYNÆCOLOGICAL EXAM., 7/19/97 Uterus bound down toward left side - retroverted - immovable. Posterior portion of cervix very hard + resistive. Excavation of perineum. Slight haemorrhoids. Vomit

MENSTRUATION, Menopause past. hypertrophy of labia minora

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, No diseases can be determined. Has had periodical attacks for past 20 yrs. Always occurs about the menstrual period.

LENGTH OF INVASION, Very 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 Josephine Peka.

1897

This patient was brought here by Sheriffs Deputy Joseph Peka in fair physical condition, with the following history:- No history of consanguinity: First attack about 20 years ago & has had others at intervals ever since: First symptoms of present attack manifested about one month ago by delusions, incoherent talk & running away from home: Disease appears increasing. Is variable, with irregular rational intervals: Derangement manifested on almost every subject: Talks a great deal, but is incoherent & senseless: No disposition to injure others: No filthy or destructive habits: No previous peculiarities shown: No severe disease or injury to head: Has not been confined or restrained: Has received no treatment: On personal examination has all the appearances of mania.

July 16 On admission put upon 3rd W. (4th Ret Complexion dark: hair black: eyes brown: Skin normal: No marks or scars. A few small bruises on legs: Is dirty: Behavior quiet: Does not speak English.)

July 25 Summary Nurse's 14 Day Record: Patient has been very restless, wandering up & down the hall in an agitated manner ever since admission: cries very often, wringing her hands & worrying over delusive ideas: complains almost continually of a pain in the back of her neck: At times becomes quite excited and almost unmanageable: requires several nurses to manage her. July 30: Usually nervous & excited: complains of pain in head & back of neck: appetite good: bowels constipated: takes cathartics: Strychnia 3 times a day: tonic after meals: Gym. treatments have been given every other day: usually sleeps well: takes out door exercise: Tidy in habits:

Aug 4 Visited by husband: Still complains of headache a great deal & pain in back of neck: appetite fair: bowels usually constipated: Aug 27 Visited by husband who took her Home: Very little improved.

Discharged.

Personal and Medical History of

Personal and Medical History of Mary Ellestad

ROBERT, FISCHER & SCHMIDT, DAVENPORT, IOWA.

Whole No. 4823

Residence, Noble, Minn.

Date Admission, July 23rd 1897.

Admitted by Dr. P.M. Phelps Hour, 2:45 P.M.

How Sent, C.V. Farrington. J. of P. Dillmon Co.

Sex, Female.

Age, 28

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, School-Teacher.

Degree Education, Normal Graduate.

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Dillmon Co. Minn. Parents Norway. Became resident of State & Co. at Birth.

Physicians Committing, Jos. Phillips & G.A. Lon.

Correspondents, G.B. Ellestad, Lanesboro, Minn. Julia Ellestad, Mabel, Minn.

No. for Year, 356

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form,

Accompanying Bodily Disorder, Sleeplessness & Nervousness

Suicidal or Not, Not

Date of this Attack, Four weeks ago.

Duration, About 4 weeks.

No. of Attack, 1st.

No. of Admissions, 1st

Age First Attack, 28 yrs.

Time of Leaving, Sept. 28. 1898

Time in Hospital, 1 yr. 2 mo. 5 d.

Result, Discharged Feb. 8. 1899 Much Improved

EXAMINATION ON ADMISSION.

Exam. July 24 '97 by P.M. & H. Phelps

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Impaired

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Only partially correct.

REASONING POWER:

Ordinary Subjects, Much impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

Mind wanders from one thing to another. Very restless in behavior. Destructive & at times violent. Requires constant watching. General physical condition somewhat impaired.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Thinks she is hypnotized.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, ✓

Voluble or Reticent, ✓

Personal and Medical History of Mary Ellestad.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 2½ in. WEIGHT, 115 lbs. NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Coatings, Heavy yellow. Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Says good.

HEARING, "

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Marked. Tongue, None

Facial Muscles, General, Quite marked fine tremor.

REFLEXES, Patellar, Both 0-g

Other

ARTICULATION,

Slurred,

Hesitating, Hesitates in answering.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries normal

HEART, No Murmurs. Sometimes palpitating. Apex beat normal condition

LUNGS, Normal.

TAKEN,

EXAM. URINE, July 26/97

Color Yellow

Character Cloudy- ropy deposit

Amt. 24 hrs. XXXIV Z

Sp. gr. 1035

Reaction- Alkaline.

Albumen Trace by Tests

Sugar None.

Mic. Amor. urates- Large quantity pus & blood Corpuscles. a few blood clots- Bladder & Vaginal Epith.

GYNÆCOLOGICAL EXAM., 7/26/97 Hymen very close. Uterus retroverted & bound down toward Right side. External genitals normal

MENSTRUATION, Regular.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Short ONSET GRADUAL OR SUDDEN, Sudden

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

Mother or Mat. Relations, Unknown

Father or Pat. Relations, "

Brothers or Sisters,

Personal and Medical History of Mary Ellestad.

1897

This patient was brought here by Sheriffs Deputy E.K. Bhrand attended by Julia Ellestad, sister, in fair physical condition with the following history. No history of consanguinity ~~or~~ heredity or intemperance in parents or self: First symptoms of disease manifested four weeks ago by fear that something dreadful was about to happen: Disease appears increasing: Is variable with irregular rational intervals: Derangement now manifested principally on subjects of religion but is deranged on all subjects: Not disposed to injure others: Not filthy or destructive in habits: Has always been very sensitive, no other previous peculiarity mentioned: No severe disease or head injury. No confinement or restraint employed: Has received treatment for sleeplessness & general nervousness only, without any good results. On personal examination has all the symptoms & appearances of insanity.

July 23 On admission put upon B.T.U. (Gilt Rpt) Complexion dark: hair brown: eyes blue: Skin normal condition: Long scar on right leg: Eruption on back: a few small bruises on left leg: Is clean: Behavior excited, resisted being bathed (Has delusions.)

Aug. 5. Summary Nurse's 14 Day Record: Temperature taken 1st 4 Days normal: appetite very poor & irregular, behavior very nervous & restless & agitated: was up on the ward the second day, but struggled a good deal & had to be held most of the 3rd day: Out of bed at night: undresses herself if left alone. 5th day nervous & excited; fought several times: Has had to be catheterized for several days: Has to be fed by nurse: During 2nd week patient's condition even worse: Appetite very poor: untidy in habits: Slept very poorly: was agitated & delirious at times. Original record preserved.

Aug. 11 Summary Nurse's Notes by Dr. L.L. Phelps:- Nervous & excited most of the time: quite agitated: worries constantly over delusive ideas: requires feeding by nurse: bowels constipated: At times requires catheterizing: talks very incoherently: Aug 20 Very nervous & restless: refuses to eat: Fed with tube: physical health impaired: constipated: requires cathartics: Transf. to Infirmary: put to bed: Aug 30 Steadily in bed: fed by nurse: part of time fed with tube: cathartics given daily: Sponge baths given: Sept 1. On milk diet: T. P. R. about normal: Salt baths given: quiet most of the day: Sept 5 Beginning to take some gruels with milk: tonics given: up on ward: behavior quiet: able to sit up now all day each day: Sept 7 Early in morning escaped from nurses & tried to jump from window, but was caught by another patient: Transf. to 7B. Continued by Dr. Phelps.

Sept. 21 Most of this month has been fed daily by tube: Visited by friends today:

Oct. 31 Was fed by nurse: Still very dull & restless: Trans. to 11B. May 1898 Talks more rationally: Works some & is quieter in every way altho somewhat confused in manner. July 19. Trans. to A. Sept 28 Taken home on trial

Personal and Medical History of

Has been improving steadily, her manner a little peculiar, however, up to the time of going.

Discharged

Personal and Medical History of Josie Korson

EBERT, FIDLER & CHAMBERS, DAVENPORT, IOWA

Whole No. #827.
Residence, St. Paul, Minn.
Date Admission, July 27th 1897.
Admitted by Dr. R.M. Phelps Hour, 6.45 P.M.
How Sent, A. Willrich J. of P. Ramsey Co.
Sex, Female.
Age, 21 yrs.
Civil Condition, Single.
Children, -
Age Youngest Child, -
Occupation, Domestic (Father farmer)
Degree Education, Common Schools.
Profession Religion, Yes. Catholic.
Habits, Not intemperate.
Nativity, Minn. Parents Austria.
Physicians Committing, E.G. Eshelby + Arthur Denney.
Correspondents, Frank Korson (father)
Browerton, Minn.

No. for Year, 360.
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, Unknown.
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Yes. Propensity active.
Date of this Attack, Several weeks ago.
Duration, Several weeks.
No. of Attack, 1st
No. of Admissions, 1st here. Has been at City + Co Hosp. Stroud
Age First Attack, 21 yrs.
Time of Leaving, Sept. 8. 1897
Time in Hospital, 1 mo 12 d.
Result, Discharged Feb. 9. 1898 Improved.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. July 29 by D.L. Phelps

MENTAL ACTIVITY:
Clear or Confused, Quite clear.
Quick or Sluggish,
MEMORY:
Past Events, Very fair.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Correct.
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Patient feeble-minded, slow + dull. Talks in a simple childish manner. Says she tried to kill herself because a man to who had been calling upon her + paying her some attention told her he would have nothing more to do with her.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS:
Systematized or Not, None
Special Subjects,
Transitory or Not, None
HALLUCINATIONS: See
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,
Seems slow + dull.

Personal and Medical History of Josie Korson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 6 in. WEIGHT, 133 lbs. NUTRITION, Good.
WOUNDS OR ABNORMALITIES, Nose has been broken. Scar of old ulcer on outside of thigh.
Skin - Eruption on chest, back of shoulders + arms
TONGUE, Tremors, Coatings, slight whitish coat Promptness Movement,
PUPILS, Equality, Equal Size, Normal.
Response Light, Normal Accommodation, Normal.
SIGHT, Says good
HEARING, "
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, General,
REFLEXES, Patellar, Absent both legs.
Other
ARTICULATION,
Slurred,
Hesitating, Hesitates some.
FACIAL EXPRESSION,
Arteries normal.
SENSIBILITY,
HEART, No murmurs Sounds normal
LUNGS, Normal.

TAKEN,

EXAM. URINE, July 31/97
Color Yellowish red
Character - Flaky Deposit
Amt, 24 hrs. 1 L 3.
Sp. gr. 1028
Reaction - Acid.
Albumen Trace by Tanrets
Sugar. None.
Mic. Amor. urates. Oxal. lime a few uric acid crystals. Bladder + vaginal cells.

GYNÆCOLOGICAL EXAM., 7/9/97 Uterus retroverted + bound toward left side. Cervix lacerated. Extensive erosion of os. External genitals normal.
MENSTRUATION, Regular, began at 16 yrs. no pain.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor, ✗
SLEEP, Good,	Poor, ✓	Irregular, past month.
PULSE, ✗	Resp., 21	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, Has had headaches this spring + summer.
LENGTH OF INVASION, Short ONSET GRADUAL OR SUDDEN, Sudden.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Healthy
Father or Pat. Relations, Living + healthy
Brothers or Sisters, all healthy.

Personal and Medical History of Josie Karson

1897

This patient was brought here by Sheriffs Deputy R.F. Meisen attended by her sister in fair physical condition with the following history: No history of consanguinity, heredity or intemperance in parents or self. First symptoms manifested a few weeks ago when she became melancholy over a love affair: Disease appears stationary, not variable, no rational intervals: Derangement now manifested by profound melancholia & fear of violence: Not disposed to injure others: Attempted suicide by taking Carbo Quest: Not filthy or destructive in habits: No previous peculiarities shown: No severe diseases or injury to head: Confined at City & County hospital, St. Paul, for one week: Has received no treatment.

On personal examination is depressed, apathetic, talks but little & has delusions of violence toward her.

July 27 On admission put upon Bd W. Gth St. Rpt. Complexion dark: Hair light brown: Eyes brown: Skin normal: Slight scar on nose, nose has been broken: Is clean: Behavior quiet: Talks very little but sensibly.

Aug. 9. Summary Nurse's 14 Day Record: Temperature the first 4 days normal: Appetite good throughout: Behavior rather quiet & rational: 3rd day commenced to assist some with the work & was apparently quite agreeable: During 2nd week notes continue the same: Appetite good throughout, patient assisting with work, taking out door exercise, being agreeable in manner, sleeping well at night & presenting no physical ailment. Original record preserved

Aug. 24 Summary Nurse's Notes by Dr. S. L. Phelps: Appetite good: bowels irregular: cathartics & enemata given: takes out door exercise: assists with work: takes quite sensibly: tidy in habits: gym. treatments every other day:

Sept. 24 Appetite good: constipated: cathartics given: works some: takes gym. treatments very agreeable & pleasant: sleeps well: Sept. 27 enemata regularly.

Oct. 8 Visited by Sister who took her HOME: Behavior has been that of a quiet intelligent over since admission: Has always been pleasant in manner & assisting with work: Gen. health has been good.

Discharged.

Personal and Medical History of

Personal and Medical History of Julia Olm Hellerud

GIBERT, FOLAN & CHAMBERS, DAVENPORT, IOWA

Whole No. 4829
Residence, Northfield, Minn.
Date Admission, July 29th 1897.
Admitted by Dr. P.M. Phelps Hour, 3:15 P.M.
How Sent, R.A. Mott J. of P. Rice Co.
Sex, Female.
Age, - 71 -
Civil Condition, - married -
Children, - 5 -
Age Youngest Child, About 30 yrs.
Occupation, Housekeeper (Husband farmer)
Degree Education, Common.
Profession Religion, Lutheran.
Habits, Not intemperate.
Nativity, Norway Parents same.
Physicians Committing, Wm. Hunt & A.G. Schmidt.
Correspondents,

No. for Year, 364
Insane Relatives, One brother died insane.
Cause Exciting, Mental deterioration
Cause Predisposing, Heredity,
Form, Mania chronica.
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, Over 30 yrs. ago.
Duration, Over 30 years.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, About 40
Time of Leaving, December 8 - 1902
Time in Hospital, 5 Yrs 4 m 9 ds
Result, Died: Valvular Heart Disease (Insufficiency & Stenosis)

EXAMINATION ON ADMISSION.

Exam. by P.M. & A.G. Phelps. July 30

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: -
Clear or Confused, -
Quick or Sluggish, -
MEMORY:
Past Events, Impaired
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Much impaired.
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Very wild, noisy & restless. Resists everything that is done for her. Seems afraid she is going to be hurt in some way. Will not talk or answer questions at all sensibly. General physical condition fair.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, & noisy
Depressed,
DELUSIONS: Seems to have many. Re
Systematized or Not, Lists & is afraid.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, & noisy
Voluble or Reticent,

Personal and Medical History of Julia Olm Hellerud.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. 2 in. WEIGHT, 112 lbs. NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, none Skin dry. Varicose veins.
TONGUE, Tremors, Coatings, Coated. Promptness Movement,
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT, Impaired - Cataract over left eye
HEARING, Seems good.
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, — Tongue, —
Facial Muscles, — General, Very restless
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries - Atheroma
HEART, No murmurs. Regular
LUNGS, Normal.
GYNÆCOLOGICAL EXAM., 8/7/97 Uterus retroverted & bound toward left side by bands of adhesions. Os lacerated, some prolapse. Some laceration of perineum
MENSTRUATION, Menopause past
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug 3/97.
Color Yellowish red.
Character Clear with flaky deposit
Sp. gr. 1015
Reaction Acid
Albumen Trace by Nitric acid Good Not by Heat. Large quantity by Esbach's
Sugar None
Mic. Epith. cells; pavement & columnar cells. Amor urates Uric Acid Cryst. a few blood clots & blood corpuscles

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

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

Personal and Medical History of Julia Olson Hellrud

1897

This patient was brought here by Sheriffs deputy A.P. Dorin attended by her husband, in fair physical condition with the following history:- No knowledge concerning heredity:- First symptoms manifested over 30 years ago by signs of disturbed mental conditions, causes obscure & indefinite: Disease appears increasing, not variable: no rational intervals. Derangement now manifested simply by mental deterioration: Is liable to injure others because she does not know any better: Not suicidal: Habits filthy & destructive like an irresponsible child: No previous peculiarities noted, history obscure. No severe diseases or injury to head: Has received only home care: no treatment pursued. On personal examination has appearance & condition usually found in patients suffering from mental decay.

July 29 On admission put upon Ward 9 Kit. Kpt Complexion dark: eyes blue: hair brown skin hot & dry: Is clean: Left eye blind: Behavior very maniacal: Does not speak English)

Aug. 11 Summary Nurse's 14 Day Record: Patient rather aged with a history of chronic insanity: Seems to be melancholy, afraid & resistive: Appetite poor ~~good~~ during 1st week: Patient resisted some at times but later became more quiet 1st night sat up nearly all night & next day fought vigorously upon any attempt to do anything for her. Was placed on 6': Gradually quieted down during next two days & was for the most part fairly quiet: Appetite better the second week. Original Record Preserved.

Aug. 30 Summary Nurse's Notes by Dr. S.L. Phelps:- Appetite good: behavior quiet: bowels usually constipated: Takes cathartics: Tidy in habits and appearance: Sleeps well works a little on the ward: physical health good: wanders around in rather an inquisitive & dazed manner: seems to have many delusions- Continued by Dr. W.M. Phelps Aug 28 Patient's general health good. Is fairly quiet & assists some with ward work. Feb 19 Trans. to Annex. Has been occasionally resistive & rather untidy but fairly quiet on ward.

Aug 99 Has swollen glands on right arm. during intervening time has been quite quiet. Nov 16 Still at the Annex; about same in every way.

Jan 21 99 No change of any note since last note. Mch 1- Aug 8 1899. Cont. by Dr. Bobs. General health & appetite good. Sleeps well: Takes outdoor exercise: Clean in habits but careless: Mutters to herself: Usually stupid but at times active: Never converses but seems to understand much that is said to her. Aug 18 Wt. 120#

Sept 1- Feb 28 1900. (Dr Heyerdale) Sept 30. Left eye discolored: injury not severe. Nov 25 Neat in habits but careless in appearance: Troublesome - mutters to herself: Appetite good: General health good. goes riding. Dec 7. Visited by friends. Jan 15. Wt. 120#.

March 1- Nov 30 1900. (Dr Linton) Mutters & at times obstinate & resistive: Does not converse: Appetite good: Bowels regular: General health good: Takes outdoor exercise. (June 1- Visited by friends July 13 Vaccinated. Nov 28. 116#. Dec 1- Feb 28. Appetite fair

Personal and Medical History of

1901 bowels regular. Sleeps well, coughs some: Does no work: Goes riding & walking: Quiet in behavior: At times obstinate: does not converse. March Wt. 121# March 1- June 1- 1901 Expectorates a great deal.: otherwise condition unchanged. May 31 Wt. 123#

June to Sept. Does no work, takes out door exercise, does not converse. Sept. 1st Wt. 118#. Sept. to Dec During the winter refuses exercise, Nov. 29 visited by two sons, Nov. 30 Wt. 118½#.

From September 1- 1902 patient seemed to grow progressively weaker temperature varying from 99 to 103 had a cough and expectorated considerable sputum streaked with blood. No tubercular bacilli found, was kept in bed, ankles and leg edematous heart action very weak: is transferred to infirmary Nov 25 failed rapidly, both hands and feet becoming anasarcous and much congested. Died Dec 8-1902- 7:30 a.m.

Personal and Medical History of Paulina Peterson

BARLEY, PUGLAS & CHAMBERS, DAVENPORT, IOWA

Whole No. 4833

Residence, Faribault, Minn.

Date Admission, July 31st 1897.

Admitted by Dr. A.M. Phelps Hour, 3:15 P.M.

How Sent, R.A. Mott J. of P. Rice Co.

Sex, Female.

Age, 29.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Dressmaker.

Degree Education, Common

Profession Religion, Yes, Lutheran.

Habits, Not intemperate

Nativity, Mankato Minn. Parents Norway

Physicians Committing, M.L. Mayland D.M. Cool.

Correspondents,

No. for Year, 366

Insane Relatives, None.

Cause Exciting, Apparent cause overwork + lack of outdoor exercise

Cause Predisposing, —

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, About March 1st 97

Duration, Nearly 4 Months.

No. of Attack, 2nd

No. of Admissions, 1st

Age First Attack, 28

Time of Leaving, May 13. 1899

Time in Hospital, 1 yr 9 m. 13 d.

Result, Discharged Nov. 1. 1899 Much Improved.

EXAMINATION ON ADMISSION.

Exam. 8/3/97 by A.L. Phelps.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: —

Clear or Confused, Confused + sluggish.

Quick or Sluggish,

MEMORY:

Past Events, Seems impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull + rather restless.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Much impaired

Own Mental State, Says she is nervous.

Special Subjects, Impaired

GENERAL DESCRIPTIVE REMARKS: Has been living at home for past 3 years. Helped her mother some with housework but not able to do much. Was a dressmaker before she had La Grippe 4 yrs. ago, Since that time has been nervous + down hearted — nervous + at times cried. Has headaches sometimes. Could not sleep. Answers questions slowly.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, somewhat.

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent, Very slow in answering

Personal and Medical History of Paulina Peterson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, 170 lbs. NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Coatings, Heavily coated Promptness Movement,

PUPILS, Equality, Equal. Size, Dilated

Response Light, Accommodation, Normal.

SIGHT, Somewhat impaired: uses glasses at times.

HEARING, Seems good.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Fine tremor Tongue, Fine tremor

Facial Muscles, General, None

REFLEXES, Patellar, Both normal.

Other

ARTICULATION,

Slurred,

Hesitating, ✓

FACIAL EXPRESSION,

SENSIBILITY,

Arteries seem normal.

HEART, No Murmur. Sounds weak Regular.

LUNGS, Chest slow, normal Expans. + Breath sounds fair

EXAM. URINE, Aug 9/97

Color, Yellow.

Character, Cloudy

Quant. 24 hrs. XLVII ℥

Sp. gr. 1028

Reaction. Acid.

Albumen None

Sugar None

Mic. Large quant. amor. urates - Epith - Squamous, round + columnar - a few pus + blood corpuscles - few Acid crystals. Bladder epith.

TAKEN,

GYNÆCOLOGICAL EXAM., 8/9/97 Uterus retroverted: External genitals normal.

MENSTRUATION, Regular. Sometimes nervous during the time.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Had La Grippe 4 years ago. Has headaches at times.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Had La Grippe but no other sickness.

Father or Pat. Relations, Healthy

2 Brothers or ~~Sisters~~, Healthy

Personal and Medical History of Paulina Peterson.

1897

This patient was brought here by Sheriffs Deputy L.N. Peterson attended by Miss Livingston, in fair physical condition with the following history:- No history of consanguinity or heredity: First attack occurred in Spring of 1896 + lasted 5 or 6 weeks: First symptoms of present attack manifested about March 1st, was sleepless + failed to give connected + logical answers; imagined folks were talking about her: Disease appears increasing: is variable, no rational intervals but increases at monthly periods: Derangement manifested by melancholia, is dispondent + refuses to talk with mother or friends: Goods continually over expected evils. Not disposed to injure others: Not filthy or destructive in habits: No previous peculiarities noted: No history of intemperance in parents or self: No severe disease or injury to head. Has not been confined or restrained: Hygenic treatment + Bromide, Hyoscyamus, Cannacis Indicus, Hemp + Tonics + medicines to aid digestion given. No further particulars learned upon personal examination.

July 31 On admission put upon B'd W (G.H.W. Dpt. Complexion dark: Hair brown Eyes blue: Skin normal: No marks or scars noticed: Is clean: behavior quiet: Talks sensibly)

Aug 13 Summary Nurses 14 Day Record: Temperature 1st 4 days about 100: was rather inclined to refuse all food at first + was fed with tube several times during 1st week: Seemed rather stuporous + disinclined to do anything for herself in any way: was very stupid + dull together with a slight appearance of confusion: During second week was fed with tube several days, but began to eat later: Always sluggish about talking + appears as if unable to think with any speed or accuracy, or to keep her mind on any one subject. Original Record Preserved

Aug 29 Summary Nurses Notes by Dr. E.L. Phelps:- Very quiet: At times quite stupid: Does not talk excepting to answer a few questions when addressed: Appetite very poor: bowels constipated: enemata given: refuses medicines: rather tidy in habits + appearance: gen'l health good. Continued by Dr. R.M. Phelps. Aug 29 '99. Refuses medicine: Is quiet but rather obstinate: Feb 20 '98 Wt. 175# Has had to be fed by tube at times: Fairly intelligent but full of absurd delusions, + behavior is odd + unreasonable. Jan 6 '99 Patient during intervening time has been drifting along quietly on one of the best wards: usually well-behaved altho dull + writes very incoherent letters. Mch - May 13 '99 Cont. by Dr. Bebb. Patient quiet in behavior: Appetite quite good: Sleeps well: Refuses to go out doors: Spends most of time reading: Neat in habits: Talks quite sensibly but is very persistent May 5 Went home with brother.

Discharged.

Personal and Medical History of

Personal and Medical History of Annie Bultmann.

EGBERT, FISCHER & CHANDLER, DAVENPORT, IOWA

Whole No. 4834

Residence, Wheeling, Rice Co, Minn.

Date Admission, August 3rd 1897.

Admitted by Dr. R.M. Phelps Hour, 1 a.m.

How Sent, P.A. Mott Jof C. Rice Co.

Sex, Female

Age, about 23 years.

Civil Condition, married.

Children, one.

Age Youngest Child, 11 days old.

Occupation, Housewife (Husband laborer)

Degree Education, Common.

Profession Religion, Evangelical Lutheran.

Habits, Not intemperate.

Nativity, Minn. Parents Germany.

Physicians Committing, President of State at birth. Co? T.S. Warren. & M.L. Mayland.

Correspondents,

No. for Year, 1

Insane Relatives, None

Cause Exciting, Puerperal state.

Cause Predisposing, Previous attack

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, July 27th 1897

Duration, 7 days.

No. of Attack, 2nd (1st about 4 Mo. ago)

No. of Admissions, 1st

Age First Attack, 23.

Time of Leaving, Recg. 11th 1897

Time in Hospital, 12 days.

Result, Died - Acute Delirious Mania.

EXAMINATION ON ADMISSION.

Exam. 8/3/97 by R.M. Phelps.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, Much impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

Mind wanders from one thing to another. General health seems good.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS: Many & varied.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, very - restless & maniacal

Voluble or Reticent,

Personal and Medical History of Annie Bultmann.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

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

WOUNDS OR ABNORMALITIES, None. Skin normal.

TONGUE, Tremors, Coatings, heavily coated Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Normal Accommodation, Normal.

SIGHT, Seems good.

HEARING,

COORDINATION, Arms, Normal.

Legs, "

TREMORS, Hands, None Tongue, None.

Facial Muscles, General,

REFLEXES, Patellar, Both exaggerated. EXAM. URINE, Aug.

Other Not examined.

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries - Seem normal.

HEART, No Murmurs. Sounds mak. Apex beat Normal position - Regular.

LUNGS, Normal.

TAKEN,

GYNÆCOLOGICAL EXAM., Was sick in bed from time of admission. Not examined.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, 80 & mak	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, Has a baby 11 days old.

Brothers or Sisters,

Personal and Medical History of Annie Bultmann.

1897

This patient was brought here by Sheriffs Deputy D.W. Yates attended by husband, in fair physical condition, with the following history:- No history of consanguinity, heredity or intemperance in parents or self: First attack occurred about four months ago & lasted one week: First symptoms of present attack manifested July 27th 1897 by insomnia, delirium & incoherent speech: Disease appears increasing: Invariable with irregular rational intervals: Derangement now manifested by changed feelings toward her husband; hates him & calls him a murderer: Has threatened to injure others: Not suicidal: No filthy or destructive habits: No previous peculiarities manifested: No severe diseases or head injury: Has been watched constantly & has been given opiates & Sulfonal. On personal examination tongue quite coated: pulse 96.

Aug 5 On admission put upon B.W. Ofth Rpt. Complexion dark: eyes gray: hair light brown: No marks or scars: Eruption on her back: bruises on both arms: Is rather dirty: behavior noisy & very restless: Is incoherent & has delusions.)

Aug 14 Summary Nurses 14 Day Record. Patient admitted at 1. p.m: a very active restless patient: Ate nothing, refusing food from the start: noisy all night, slept none. Aug 6 Patient drank two glasses milk, but for the most part refused to eat all day: put in restraint at 5 p.m: was very noisy: did not sleep. Aug 7. Temperature 103.2 early in the morning: down to 101.2 in evening: was given a hypodermic & hot baths: Slept 3½ hours. Aug 8- Patient eating very little: Temperature 99.8 in the morning, 103.2 in the afternoon, down to 101.6 in the evening: Patient kept in restraint to conserve her strength: Hot baths given: Sponge bath later with cold applied to head: Aug 9. Slept very little: Temperature from 102.3 to 103. Ate a little more than the day before: was noisy & restless: Has observed quite well from the start the name "acute delirious mania". Patient was kept in restraint; baths given: Slept 6 hours. Aug 10. Temperature 101.6 in the morning, 103.2 in the afternoon: would not eat & was fed with tube: It was found very difficult however to keep food down when given with tube: was kept in restraint: Baths given frequently to keep down temperature. Aug 11. Fed with tube a couple of times. Temperature from 103 to 102.2: variable: Sponge baths given from time to time during day: Slept very little: Aug 12. Fed with tube: Temperature from 103.6 to 102.2. Bathed with alcohol. Transferred to Infirmary. Aug 13, Temperature 102.8 to 102.4 quite steadily during day: Fed with tube & took some egg nog: Slept some: Sponge baths given almost every hour: Back washed with alcohol & dusted with boracic acid: During the afternoon signs of failure commenced in that she was drowsy, showed some tendency toward stupor: Strychnine has been given during day

Personal and Medical History of Annie Bultmann

1897

Aug 14 Temperature remained from 103. To 102.6 during the day, patient dying at 3:15 p.m. from exhaustion: Patient might possibly have pulled through if nourishment could have been given, but at all attempts to feed with tube the vomiting seemed so great that the food was at once ejected: The excitement & delirium continued until the end & was only overcome by the weakness & stupor at the end.

Died.

Personal and Medical History of Rosa Rebel (or Rabe)

BERGET, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4835

Residence, Olmsted Co., Minn.

Date Admission, August 5th 1897.

Admitted by Dr. S. L. Phelps Hour, 11 A. M.

How Sent, J. A. Leonard J. of P. Olmsted Co.

Sex, Female

Age, 59.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Seamstress.

Degree Education, Common school.

Profession Religion, Catholic.

Habits, Not intemperate

Nativity, Germany - parents also born there. Became resident of State 40 yrs. ago.

Physicians Committing, W. W. Mayo & C. S. Granger.

Correspondents,

No. for Year, 2

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing, Previous attacks.

Form, Mania Chronic.

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, —

Duration, —

No. of Attack, Several.

No. of Admissions, 3rd

Age First Attack, about 52.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam by S. L. Phelps Aug 7 '97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Impaired

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State, "

Special Subjects, "

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS: Delusive ideas.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient rather melancholy & wanders away. Tries to follow anyone out of doors to get away. Seems to have many delusions. General physical condition fairly good.

Personal and Medical History of Rosa Rebel.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

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

WOUNDS OR ABNORMALITIES, Skin normal.

TONGUE, Tremors, Coatings, Slight coat Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Uses glasses.

HEARING, Seems good

COORDINATION, Arms, Normal.

Legs, "

TREMORS, Hands, No special Tongue, None

Facial Muscles, None General, "

REFLEXES, Patellar L. normal R. impaired

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries normal.

HEART, No murmurs - Sounds normal. Is regular.

LUNGS, Chest Gym. somewhat concave. B. Bases normal.

TAKEN,

EXAM. URINE, Aug 9/97

Color Reddish yellow

Character, Cloudy.

Amt. in hrs. XX z.

Sp. gr. 1027

Reaction. Acid

Albumen Trace by Tanrets

Sugar None.

Mic. Amor. urates. Uric acid crystals, oxal. of lime. Some pus. Bladder epith. mucus bands. A few blood corpuscles.

GYNÆCOLOGICAL EXAM., 9/10/97 Hymen intact. Uterus & external genitals normal.

MENSTRUATION, Menopause past

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Rose Rebel

1897

This patient was brought here by Shrimpton C.N. Stewart attended by Rev. Mother Superior + Sister, in good physical condition, with the following history:- No history of consanguinity known: Has had two previous attacks (1st continuous?) first 10 yrs. ago + had one year ago. Has been confined in this (Rochester) hospital twice - from Feb 11/95 to Mar 19/95 (Rec Vol. 28 p. 81 No. 3997) + from Mar. 25/96 to July 28/96 (Rec Vol 30 Fol. 133 No. 4357) First symptoms of present attack manifested by tendency to wander away + occasional violent spells: Disease appears increasing: Is variable with irregular rational intervals: Derangement now manifested by tendency to wander away + by delusions of persecution: Is disposed to injure others: Not suicidal, filthy or destructive: No information concerning previous peculiarities: No history of intemperance in parents or self: No severe disease or injury to head: Has been confined at + received hospital treatment as stated above. No further information obtained on personal examination.

Aug 5 On admission put upon A. W. (Gotu Rpt. Complexion dark: hair brown: eyes brown: Condition of skin normal: no marks or scars noticed: Is clean: Behavior quiet: Talks continually of going home: Has delusions)

Aug 18 Summary Nurse's 14 Day Record: Patient admitted here for the second time: Temperature normal: Appetite good: Unlike her preceding stay here she now eats well + has no objection to talking: Her one idea, however, is to get away + go home; watching the doors continually for this purpose: resists when held back: Upon the whole, however, excepting the change of subject + manner of behavior, her mental standing is about the same as at the preceding stay, when it was put down as a mild paranoia coincident with senile degeneration of circulatory character. Original record preserved.

Aug. 29 Summary Nurse's Notes by Dr. L. E. Phelps:- Very unreasonable in behavior. Attempts to escape almost every time door is opened: Thinks she is very unjustly kept here: Appetite poor: bowels regular: tidy in habits + appearance: seems to have many delusive ideas. Continued by Dr. Ada Phelps. Continued by Dr. Ada Phelps. Very unreasonable in her persistent attempts to escape. Does not talk of any delusive ideas + talks quite accurately on ordinary subjects, but is continually watching + struggling to get away. Feb 4 Wt. 127# Mch 14 98 Wt. 128# Cannot be taken out of doors because she struggles so persistently to get away. Aug 6 Wt. 126# Oct 10 Went out on trial. Dec. 8 98 Returned. In about same condition as when she left. Feb. 1 - Aug 31 99 Rpt. by Dr. Betts. General health + appetite good: Bowels regular: Out of bed very frequently during night: Is clean + neat + quiet in behavior except for constant attempt to escape whenever doors are opened. Is becoming more persistent + even violent in this. Scolds a great deal about being detained here. June 12 Refused to go to bed + resisted nurses, during struggle com-

Personal and Medical History of

plained of having arm + neck hurt. No injuries found. Frequently strikes nurses when they keep her from running to door, + Aug. 1 in one of these struggles hand was cut slightly. Occasionally assists a little with work but usually remains unoccupied. Necessary to keep her in seclusion much of time on account of her efforts to escape.

Sept. 1 - Feb 28 1900. (Dr. Heywdale) Neat in habits + appearance: Appetite good: Bowels regular: Sleeps fairly well: Matters to herself: Is constantly near door watching to escape when it is open: Talks + scolds a great deal: In seclusion frequently: Dec 8. Visited by friends. Dec 16 While trying to escape pushed back by nurse + fell. said she hurt her knee. No injury resulted. Dec 29. Visited by friends. Jan 18 148# Feb 11. Lower limbs swollen: In bed several days. Feb 27. Fought nurses when put in seclusion Feb 28. Limbs swollen. In bed during day. Mch 1 - Nov 30/1900 Neat: General health good: Eats + sleeps well: Expresses delusions that devil is under bed: Quite disagreeable at times: Scolds considerably: Continually tries to escape. Thinks she hears people calling to her. Mch 1 - 5 In bed - complained of feeling weak. Appetite rather poor. Mch 28 Struck nurse: Apr 30 Visited by two friends. Apr. 14 Visited by Sisters. Taken out of doors often. Resists very much when brought back to house. July 17. Attempted to escape - July 25 Pulled nurses hair July 31 Vaccinated. Sept 19 Wt. 150# Dec 1 - Feb 28 1901 General health good: Feb 9. Wms. to C3. Feb 28 Wt. 161#. Mar. to June 1901. No change in mental or physical condition. May 29 Wt. 162#. June to Sept. Patients general condition remains unchanged, Aug. 30 Wt. 161#. Sept to Dec. Oct. 17 visited by sisters from the convent, Oct. 24 was taken to the dentists accompanied by two nurses had impression taken for new set of teeth. Nov. 7 again taken to dentists office. Nov. 8 visited by two sisters, general health good, eats and sleeps well, takes out door exercise, bowels regular, has many delusions and expresses them freely, thinks that the devil is in her body and that she is persecuted by people around her, attempts to run away, scolds frequently, on the whole is quite agreeable, is unoccupied, occasionally strikes patients and nurses. Nov. 25 Wt 167.

Dec to Feb 1903 No change. Wt about 156#. Patient visited now and then by Sisters from the Convent. General health good

Personal and Medical History of Christina Allgauer

Whole No. H 837

Residence, St. Paul, Minn.

Date Admission, Aug. 9th 1897.

Admitted by Dr. Wm. Phelps Hour, 6th P.M.

How Sent, Hy. Gallick, Ct. Com. Ramsey Co.

Sex, Female.

Age, 52

Civil Condition, Widow

Children, Two.

Age Youngest Child, 22 yrs.

Occupation, Housewife.

Degree Education, Common School.

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Germany. - Parents also born there. Became resident of State 22 yrs. ago - of Co. 20 yrs. ago.

Physicians Committing, Talbot Jones & A. Downey.

Correspondents,

No. for Year, 4

Insane Relatives, None.

Cause Exciting, Heart disease & age.

Cause Predisposing,

Form,

Accompanying Bodily Disorder, Heart disease.

Suicidal or Not, Not.

Date of this Attack, Has been comingon for several years.

Duration, Several years

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, About 50?

Time of Leaving, Sept. 13, 1897

Time in Hospital, 1 mo. 4 d.

Result, Discharged Feb. 9. 1898 Improved

EXAMINATION ON ADMISSION.

Exam. by Dr. & Dr. Phelps 8/10/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Clear but deluded.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Fairly accurate but for delusions

Recent Events, Fair.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Incorrect on subject of delusions.

REASONING POWER:

Ordinary Subjects, Not very poor.

Own Mental State,

Special Subjects, Very poor.

GENERAL DESCRIPTIVE REMARKS: Patient appears more aged than she appears to be. It is an extreme circulatory derangement. The heart being very bad: She describes a shock occurring 2 years ago in which she became unconscious - This was probably a faint - a sort of heart failure. Has considerable dyspnoea & it is difficult for her to go up stairs. Has for past two years had considerable dropsy.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, - Slightly. Nervous.

DELUSIONS:

Systematized or Not, Fairly so. Thinks all neighbors

Special Subjects, are doing wrong & persecuting

Transitory or Not, her in various ways.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Christina Allgauer.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. WEIGHT, not Taken. NUTRITION, Very poor.

WOUNDS OR ABNORMALITIES, Chest peculiar. Skin somewhat discolored, dark, circulation very poor.

TONGUE, ~~Tremors~~, Fairly normal Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Accommodation,

SIGHT, Nearly blind in Right eye.

HEARING, Fairly good

COORDINATION, Arms, Fairly normal.

Legs,

TREMORS, Hands, Some - weakness probably Tongue, Normal.

Facial Muscles, General,

REFLEXES, Patellar, Normal.

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Murmurs, aortic regurg. + Mitral regurg. Sounds fair.

LUNGS, Chest type very poor. Chest very small, rather like that of a child

GYNÆCOLOGICAL EXAM., 8/10/97 Uterus retroverted & bound down: Cervix lacerated: hypertrophy of labia minora

MENSTRUATION, Menopause passed 2 yrs.

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug 12/97.

Color Amber

Character Clear with flaky deposit

Quant. 24 hrs. IX fl 3

Sp. gr. 1013

Reaction. Acid

Albumen Large quantity by all tests

Sugar None.

Microsc. Many overlapping epith. cells oval, lime crystals uric acid Crystals - blood corpuscles

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular, ✓
PULSE, 98	Resp., 36	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Drinks beer some. Has faint spells. Has had no attack except this one.

LENGTH OF INVASION, Several years ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, Died at 72. Had goitre also.

Father or Pat. Relations, Died of dropsy at 65

Brothers or Sisters, all fairly healthy. 2 sons.

Personal and Medical History of Christina Allgauer.

1897

This patient was brought here by Sheriff's deputy Wright attended by patient's son in fair physical condition, with the following history:- No history of consanguinity, heredity or intemperance in parents or self: For several years patient has been quarrelsome & has labored under delusions of prosecution: Disease appears stationary: Is variable & at certain times she appears quiet & rational upon some subjects. Derangement now manifested by delusion that people among her by calling names to worry her, she also believes that all the neighbors are immoral. Patient not disposed to injure others: not suicidal, filthy or destructive: Nothing known concerning previous peculiarities: No history of intemperance in parents or self: Has not been confined or restrained: Has received no treatment: On personal examination is very talkative on the subject of her delusions & is firm in the belief of her persecution.

Aug 9. On admission put upon A.T.W. (Y.M.C.A. Apt Complexion very dark: hair brown, partly gray, eyes brown. Condition of skin hot & dry. No marks noticed: Small scars on left knee & on nose. Has a large Goitre on left side of neck & small one on right - both feet swollen: Is clean: Says she is almost blind in right eye because of an injury received - Behavior quiet: Answers questions sensibly but seems to have delusions.

Aug 22 Summary Nurse's 14 Day Record:- Has very severe heart lesions: Throughout the two weeks took regular meals: Slept quite well most of time: Heart stimulants & general tonic given: bowels regular: Coughed some: took out-door exercise.

Aug 28 Summary Nurse's Notes by Dr. S. L. Phelps:- Quiet upon ward, but very nervous & uneasy: Has delusions: appetite fair: bowels usually constipated: Takes out door exercise: also takes tonic: Gen'l physical health much impaired: Has severe heart trouble: has a large goitre.

Sept. 12 Nurse's Notes:- Patient very nervous & uneasy: gen'l health very poor: appetite quite good: sleeps fairly well: takes out-door exercise: refused tonic: visited by son. Went Home.

Discharged.

Personal and Medical History of

Personal and Medical History of Eva Plum (or Mrs. Elsie Blom.)

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4838

Residence, St. Paul, Minn.

Date Admission, Aug. 9th 1897.

Admitted by Dr. A.M. Phelps Hour, 6.45 P.M.

How Sent, Hy. Gallick Ct. Con. Ramsey Co.

Sex, Female.

Age, 45

Civil Condition, -Married-

Children, One - dead.

Age Youngest Child, -

Occupation, Housewife (Husband laborer)

Degree Education, Common school.

Profession Religion, Lutheran -

Habits, Not intemperate

Nativity, Sweden (Parents also born there)

Became resident of State of Minn. in 1887.

Physicians Committing, F. Hahn. + B.F. Paxton.

Correspondents,

No. for Year, 5

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing,

Form, Mania Acute.

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, No information given

Date of this Attack, About Aug. 7th

Duration, 2 days -

No. of Attack, Unknown -

No. of Admissions,

Age First Attack,

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. by P.M. + Dr. Phelps - **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused -

Quick or Sluggish,

MEMORY:

Past Events, Impaired -

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull -

Correct or Illusive, Illusive -

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Answers but few questions + then not intelligently Very dull + somewhat melancholy - Physical condition seems quite good. Somewhat anaemic.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed, ✓

DELUSIONS: None determined

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Eva Plum.

Rochester ✣ State ✣ Hospital.

Name.....

℞ Eva Plum
909 Hudson Ave
Dayton Bluff
St Paul Minn

Dr.....

.....189.....

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, not Men. NUTRITION, Fair.

Eruption all over body - feet + legs badly scratched + bruised.

Coatings, heavily coated Gums very sore, breath bad. Promptness Movement,

Size, Normal -

Accommodation,

Tongue, Nons

General,

Hesitating, ✓ + slow

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs - Sounds fair Regular.

LUNGS, Apex. Normal. Expans. good.

TAKEN,

EXAM. URINE, Aug 13/97

Color Yellowish red

Character Cloudy

Amt. 24 hrs. XXII

Sp. gr. 1030

Reaction. Acid.

Albumen None

Sugar None

Mic- Amor urates Large quantity bladder + vaginal epith. Some blood. see below

GYNÆCOLOGICAL EXAM., 8/9/97 Uterus retroverted: Endometritis: Cystic degeneration of cervix: Cystocele beginning rectocele: Extensive laceration of perineum otherwise external genitals normal.

MENSTRUATION, Menopause past

OPHTHALMOSCOPIC EXAM.,

Examination of urine

HABITS, Dirty, Clean, Careless, Patient Aug 11/1897 Sp. G. Aug 11th 1897

BOWELS, Normal, Constipated, ✓ Irregular, Sp. g. 1018. Color yellow; cloudy -

APPETITE, Good, Medium, Poor, ✓ reaction acid

SLEEP, Good, Poor, ✓ Irregular, Least for 24 hours. Heat-0. Nitric acid-0.

PULSE, Resp., Temp., Albumen-0. - Sediment Epithelial cells-0.

CRANIAL MEASUREMENTS, Bismuth-0 - Moderate: mucous casts.

HISTORICAL, Pus. Several Casts. Epithelium, a few cells.

LENGTH OF INVASION, Unknown ONSET GRADUAL OR SUDDEN, Unknown

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

Mother or Mat. Relations,

Father or Pat. Relations, Unknown.

Brothers or Sisters,

Personal and Medical History of Eva Plume (or Mrs. Elsie Bl

EGBERT, FOLLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4838

Residence, St. Paul, Minn.

Date Admission, Aug. 9th 1897.

Admitted by Dr. P.M. Phelps Hour, 6.45 P.M.

How Sent, Hy. Gallick Ct. Con. Ramsey Co.

Sex, Female.

Age, 45

Civil Condition, Married.

Children, One - dead.

Age Youngest Child, -

Occupation, Housewife (Husband laborer)

Degree Education, Common school.

Profession Religion, Lutheran.

Habits, Not intemperate

Nativity, Sweden (Parents also born there)

Residence - resident of State 10 Yrs. in 1887.

Physicians Committing, P. Hahn. & B.F. Paxton.

Correspondents,

No. for Year, 5

Insane Relatives, None.

Cause Exciting, Mixtu

Cause Predisposing,

Form, Mania

Accompanying Bo

Suicidal or N

Date of this Attac

Duration, 2 da

No. of Attack, Uns

No. of Admissions,

Age First Attack,

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. by P.M. & L. Phelps - **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Impaired

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Answers but few questions & then not intelligently. Very dull & somewhat melancholy. Physical condition seems quite good. Somewhat anaemic.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not, None determined

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

al and Medical History of Eva Plume.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

GHT, 5 ft. 3 in. WEIGHT, 132 lbs. NUTRITION, Fair.

OUNDS OR ABNORMALITIES, Eruption all over body - feet & legs badly scratched & bruised.

TONGUE, Tremors, Coatings, heavily coated Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Good.

HEARING, Seems good.

COORDINATION, Arms, Normal

Legs,

TREMORS, Hands, None Tongue, None

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating, ✓ & slow

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs - Sounds fair. Regular.

LUNGS, Sym. normal. Expans. good.

TAKEN,

EXAM. URINE, Aug 13/97

Color Yellowish red

Character Cloudy

Amt. 24 hrs. XXII

Sp. gr. 1030

Reaction. Acid.

Albumen None

Sugar None

Mic- Amor urates Large quantity bladder & vaginal epith. some blood. see below

GYNÆCOLOGICAL EXAM., 8/13/97 Uterus retroverted: Endocervitis: Cystic degeneration of cervix: cystocele beginning rectocele: Extensive laceration of perineum otherwise external genitals normal.

MENSTRUATION, Menopause past

OPHTHALMOSCOPIC EXAM.,

Examination of urine

HABITS, Dirty, Clean, Careless, Passed Apl 11/1902 Sp. gr. Apl 11th 1902

BOWELS, Normal, Constipated, ✓ Irregular, Sp. gr. 1028. Color yellow; cloudy.

APPETITE, Good, Medium, Poor, ✓ reaction acid

SLEEP, Good, Poor, ✓ Irregular, Test for albumen. Heat & Nitric Acid. O.

PULSE, Resp., Temp., Tannic O. - Potassio Ferrocyanide & Acetic O. Bismuth O - Ammoniated: mucous bands. few pleural corp. Epithelium, a few cells.

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Unknown ONSET GRADUAL OR SUDDEN, Unknown

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

Mother or Mat. Relations,

Father or Pat. Relations, Unknown.

Brothers or Sisters,

Personal and Medical History of Ezra Plum.

1897

This patient was brought here by Sheriffs deputy P.G. Nuesin attended by Mrs Cummings in fair physical condition with the following history:- No history of consanguinity, heredity or intemperance in parents or self: First symptoms of disease manifested Aug. 7th, so far as known: Disease appears stationary: not variable: Has only been observed since early this morning (Aug. 7th) Derangement manifested by acute mania - on religious matters & by thinking that people wish to injure her: Not disposed to injure others: Is disposed to destructive habits: No information concerning previous peculiarities: No history of intemperance in parents or self: No severe disease or injury to head: Has not been confined or restrained: No information concerning treatment. On personal examination shows acute mania - fears of injury at hands of family & friends, - religious mania - delusions.

Aug 9 On admission put upon B.W. (A.H.A. Rpt. Complexion dark: Hair dark brown: Eyes gray: Condition of skin fat & dry: No marks, scars or eruptions - Both legs bruised: Is dirty: very restless & resists: Is incoherent.)

Aug. 22 Summary Nurse's 14 Day Records: Bowels very constipated: enema given: Slept fairly well: Appetite very poor: on liquid diet, part of time: Quite stupid - confused and incoherent in speech: Was had to be catheterized: tried to escape when door was opened: violent at times & confused in manner & speech.

Aug 25 Summary Nurse's Notes by Dr. S. L. Phelps:- Fought nurses: Aug 29 Appetite poor & bowels constipated: enema given: refuses medicine: incoherent in speech: does no work: violent at times: tries to get out when door is opened:

Sept. 1 Fought nurses: Gym. treatments have been given every other day. Continued by Dr. Phelps

Nov 29 Runs to 6th. Has been visited by husband. Has worked some has however been rather quarrelsome of late. Dec 6 Wt. 133#. May 21/98 Fought nurses & had to be secluded: Aside from these violent spells behavior has been fairly quiet June 7. Trans. to Annex. Feb 10 '99 General health good. Fairly quiet & well behaved of late. Stays at Annex & still rather dull & depressed Mch 1 - Aug 31 '99 Exam by Dr. Beebe. General health fair: Appetite good: Sleeps well: Is neat & quiet but very disagreeable & obstinate at times: Does not converse & has many delusions: Menses regular. July 8 Visited by sister & niece. Aug 18 - Wt. 155#. Sept 1 - Feb 28 '1900 Neat: Has delusions: Answers questions quite sensibly: Does not converse: Very stubborn: Eats & sleeps well: General health good. Takes outdoor exercise: Wt. 156 3/4#. Sits quietly about ward: Very cross to other patients. Mch 1 - Aug 31 '1900 Neat: Very disagreeable & stubborn: At times scolds: Has delusions: Takes outdoor exercise: General health good: Bowels constipated: Sleeps well: Takes outdoor exercise: Does no work. Friday 2 Vaccinated

Aug 31 - Feb 28 '1901. No change in behavior: General health good: Neat & Wt. 157#

Personal and Medical History of

Quite disturbed at times: sings but talks very little: Has delusions Wt. 156 1/2#

Mar 1 - June 1 - 1901 Does no work: menstruates: no change in mental or physical condition. May 30 Wt. 153#. June to Sept. Condition unchanged, Sept. 1st. Wt. 149#. Sept. to Dec. Seldom takes out door exercise, never attends chapel or amusements, does no work, does not converse. Nov. 30 Wt. 149 1/2 #.

Up to Feb. 1st, 1903. General health good: appetite good: bowels regular: sleeps well: does no work: as a rule does not take exercise: is quiet usually, but at times violent when disturbed: neat and clean in habits and appearance: Dec. 1st - Wt. 165 #.

Personal and Medical History of Barbara Baumgartner

ESSEX, FISCAR & CRAMER'S, DAVENPORT, IOWA

Whole No. 4839

Residence, Mower Co. Minn.

Date Admission, August 10th 1897.

Admitted by Dr. A.M. Phelps Hour, 10 40 A.M.

How Sent, D. L. Washburn Jof P. Mower Co.

Sex, Female.

Age, 70.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Has not been able to work.

Degree Education, Can read.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, Germany - (Parents Germany)
Became resident of State Co. March 1878

Physicians Committing, E.M. Washburn & F.E. Daigneau

Correspondents,

No. for Year, 6

Insane Relatives, None.

Cause Exciting, Congenital (supposed)

Cause Predisposing,

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Always weak-minded.

Duration, years.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, Weak minded always.

Time of Leaving, May 25. 1898

Time in Hospital, 9 mos. 15 d.

Result, Died - Old age.

EXAMINATION ON ADMISSION.

Exam. Aug. 11th by A.M. & A.L. Phelps - **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Much impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Gone.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Very demented from old age. Never bright. Mental powers about gone. Very noisy & vicious. Quite lame. General physical condition impaired.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, at times.

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Barbara Baumgartner.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION,

WOUNDS OR ABNORMALITIES, 2 fatty tumors on inside of left thigh - Cancer tumor on scalp.

TONGUE, Tremors, Coatings, normal Promptness Movement,

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT, Much impaired - almost blind - Arcus senilis + ulceration of cornea.

HEARING, Impaired.

COORDINATION, Arms, Impaired

Legs,

TREMORS, Hands, Very unsteady. Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, M murmurs.
Sounds fair

LUNGS, Expansion fair
Sounds "

TAKEN,

EXAM. URINE, Aug. 12/97.

Color Yellow.

Character Cloudy.

Quant. in hrs. XVI

Sp. gr. 1017

Reaction Acid

Albumen Trace by Tanrets.

Sugar Trace Ehrig + Bismuth

Mic. Some bacteria - Epith. cells of all varieties: Urate crystals Oxal. lime crystals.

GYNÆCOLOGICAL EXAM., 8/23/97 Uterus retroverted + bound down on left side: Uterus + appendages all atrophied. External genitals atrophied.

MENSTRUATION, Menopause passed

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Long - years ONSET GRADUAL OR SUDDEN, Gradual - for years

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Barbara Baumgartner.

1897

This patient was brought here by Sheriff's deputy E. Bassett attended by Mrs Bassett in an aged & feeble condition, with the following history:- No knowledge concerning consanguinity: This is first attack, patient has always been weak-minded & has gradually grown worse: Disease appears increasing: Not variable: Derangement now manifested on all subjects: Is disposed to injure others: Is filthy in habits: Has always had violent temper: No knowledge concerning intemperance in parents or self: Had typhoid fever when young: Has not been confined or restrained: Has received no treatment. Disease supposed to be congenital: On personal examination mumbles & mutterers incoherent & childish. Commitment recommended because she has perpetrated acts dangerous to others & is ill-treated & neglected by relatives

Aug 10 On admission put upon 3d W. (3rd U. Apt. Complexion dark: hair gray: eyes blue: Condition of skin normal: No marks or scars noticed: Has large lumps on left leg above knee: both arms bruised: Is dirty: Scalds some & resisted being undressed: Has tumor on head: Is tubercle)

Augs Summary Nurses 14 Day Record: Ate very little for regular meals: sponge bath given: Is very feeble: Slept well all night. Aug 15 Temp. up to 101: P. 80-R. 20. Ate little during first week: required feeding by spoon. Aug 14 T. 100: P. 100. R. 30: enema given: bowels moved: Sponge bath given: expectorates some: Very helpless: Is bed all the time: Appetite very poor. Temp. up occasionally to 100: Requires feeding by nurse & eats very little: Transf. to Infirmary Aug. 22. Continued by Dr. Wm. Phelps. Nov 30 Is still in bed: fed by nurse; Temp. normal. Is very senile, dull & demented: Feb 28 Fell out of bed & bruised her arm.

May 1898 Noted as failing slightly. May 25 Died this morning at 1:30. Has had a slight rise of temperature during latter part of March but since that time has been for the most part about normal. Has been noted, however, as losing strength

Died

Personal and Medical History of

Personal and Medical History of Mary Braudl.

EDGLEY, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4840

Residence, St. Paul, Minn.

Date Admission, Aug. 10th 1897.

Admitted by Dr. P. M. Phelps Hour, 6th PM.

How Sent, Ry. Gallick. Ct. Com. Ramsey Co.

Sex, Female

Age, 46

Civil Condition, Married

Children, 8

Age Youngest Child, 1 yr.

Occupation, Stonemason wife (Husband Stonemason)

Degree Education, None.

Profession Religion, R. Catholic.

Habits, Not intemperate

Nativity, Austria. (Parents Austria)
Became resident of State 40 yrs ago

Physicians Committing, Dr Hahn & Dr. Johnson

Correspondents,

No. for Year, 7

Insane Relatives, None.

Cause Exciting, "Religion"

Cause Predisposing, Unknown.

Form,

Accompanying Bodily Disorder, None mentioned,

Suicidal or Not, Not.

Date of this Attack, 8 days ago

Duration, 8 days

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 46 yrs.

Time of Leaving, Apr. 22 1898

Time in Hospital, 8 mo 12 da.

Result, Discharged Aug. 10 '98
Improved

EXAMINATION ON ADMISSION.

Exam. by Asst. Dr. Phelps 8/11/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events, Fair

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Partially correct.

REASONING POWER:

Ordinary Subjects, Probably impaired.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm, Appears normal but is

Indifferent, probably excitable.

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, None determined.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient a large healthy woman who says she has washed nearly every day for 6 years past. Says never has been sick. Can talk little English. She had a quarrel with husband on starting down here at Depot, & only guilty on his staying behind. Has expressed no delusions in her talk with me. Cannot learn very clearly about her history.

Personal and Medical History of Mary Braudl.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3½ in. WEIGHT, 175 lbs. NUTRITION, Good - Says not good as usual.

WOUNDS OR ABNORMALITIES, None. Skin good condition.

TONGUE, Tremors, Coatings, Promptness Movement, Fair

PUPILS, Equality, Equal. Size,

Response Light, Accommodation,

SIGHT, Says fairly good - Some squint.

HEARING, Good.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None of note Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Fairly good.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Normal.

HEART, Murmurs-Normal.

Sounds - normal - Regular -

LUNGS, Normal.

GYNÆCOLOGICAL EXAM., 8/9/97 Hypertrophy of uterus: Cervix lacerated: Erosion of os: endometritis: Metritis & Cystocele: Laceration of perineum: External genitals very dark.

MENSTRUATION, regular

OPHTHALMOSCOPIC EXAM.,

EXAM. URINE, Aug 13/97.

Color Brownish red.

Character Ropy deposit

Quant 24 hrs. XIII ½

Sp. gr. 1035

Reaction Slightly acid

Albumen None

Sugar A good test by Haines & Bis.

Mic. Amor. urates. Epith. cells, squamus, round & columnar, oval. limit. blood corpscles, fat globules, some pus.

TAKEN,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has varicose veins -

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Living 78 yrs.

Father or Pat. Relations, Died

Brothers or Sisters, Children 8 living 2 dead

Personal and Medical History of Mary Braudl

1897

This patient was brought here by Sheriffs Deputy P. J. Mirsen attended by Charles Gerber in fair physical condition with the following history:-
No history of consanguinity, heredity or intemperance in parents or self: First symptoms of attack manifested 8 days ago by religious mania: Disease appears increasing: not variable, no rational intervals: Derangement now manifested by religious delusions + imaginary persecutions: Not disposed to injure others: Not suicidal, filthy or destructive: No previous peculiarities shown: No severe disease or injury to head: Has not been confined or restrained: Has received no treatment.

Aug 10 On personal examination shows religious mania + delusions of persecution. On admission put upon Bd. W. (Gt. N. Apt. Complexion dark: Hair brown: eyes brown: Skin normal: No marks or scars noticed: Bruises on arms: Is dirty: Behavior quiet: Is cross-eyed: Does not speak English.)

Aug 15 Summary Nurses 14 Day Record:- First two days ate nothing: 3rd day took milk + coffee + after that took regular meals: Slept quite well every night: Temp. normal: bowels regular most of time - constipated at first usually quiet but at one time fought nurses when dressed: worked some on ward: went out walking.

Nurses Notes: Aug 25 Appetite good: sleeps well: habits clean: cares for self: works on ward + in dining room: Speaks of home quite often: bowels constipated: goes riding + walking. Continued by Dr. Alb. Phelps. Nov 30 Patient very quiet: does not change in her conduct: Sleeps quite well: works upon ward has, however, some delusion ideas. Feb 10 '98 Wt. 170# Apr. 22 Went home with relatives who wished to give her a trial altho recognizing the fact that she still had delusions.

Discharged.

Personal and Medical History of

Personal and Medical History of Clara Krause

HERBERT, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4841

Residence, Caledonia, Minn.

Date Admission, August 11th 1897.

Admitted by Dr. H. S. Herzog. Hour, 2.30 PM.

How Sent, Thomas Ryan & J. of P. Houston Co.

Sex, Female.

Age, 46

Civil Condition, Divorced.

Children, 3

Age Youngest Child, 19 yrs.

Occupation, Housekeeper (Husband butcher)

Degree Education, Well educated.

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Germany. Parents Germany.

Physicians Committing, Because President of State, 10 yrs. ago. R. J. Ferguson & Wm. Freeman.

Correspondents,

No. for Year, 8

Insane Relatives, None.

Cause Exciting, Trouble with husband.

Cause Predisposing,

Form, Mania Chronic.

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, About 4 yrs. ago.

Duration, 4 yrs.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 42

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam by L. L. Phelps Aug 12 '97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Somewhat confused tho'

Quick or Sluggish, quite quick.

MEMORY:

Past Events, Seems good.

Recent Events, Good.

Special Subjects, Good.

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Mostly correct.

REASONING POWER:

Ordinary Subjects, Somewhat impaired.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm, Normal.

Indifferent,

Exalted,

Depressed,

DELUSIONS: None determined.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Very pleasant in manner, talks freely about herself and upon other subjects. At times seems to be somewhat confused but on the whole is quite correct in her statements. Physically she is somewhat emaciated & pale. Complains of having a good deal of headache & neuralgia in right side of her face.

Personal and Medical History of Clara Krause.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 in. WEIGHT, 115 lbs. NUTRITION, Impaired.

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Slight. Coatings, Pale & somewhat flabby Promptness Movement,

PUPILS, Equality, — Size, —

Response Light, Normal. Accommodation, Normal.

SIGHT, Impaired.

HEARING, Impaired in right ear, good in left.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None. Tongue, Slight

Facial Muscles, None General, None.

REFLEXES, Patellar, Both somewhat

Other exaggerated.

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No Murmurs. Sounds fair. Apex beat strong transmitted to ax. Regular & quite strong. Sounds somewhat concord.

LUNGS, Expans. fairly good. Sounds normal.

TAKEN,

EXAM. URINE, Aug 13/97

Color Pale yellow.

Character. Cloudy

Quant. 24 hrs. LXVII 3j

Sp. gr. 1014

Reaction Neutral.

Albumen None

Sugar. None

Microscop. The field in places almost covered with squamous Epith. & Amor. urates - Pus. a little blood.

GYNÆCOLOGICAL EXAM., 8/19/97 Uterus normal position: hypertrophy of uterus & cervix: cystic degeneration of cervix: bleeds on touch: laceration of ext. Sound runs back & rotates, more toward right side.

MENSTRUATION, Menopause past. Some laceration of perineum.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Head injured 2 yrs. ago by falling into a wire fence. Has frequent headaches & dizzy spells at times.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Died Cholera

Father or Pat. Relations, Died Nervous fever.

Brothers or Sisters, None 1 son.

Personal and Medical History of Clara Kaiser

1897

This patient was brought here by Sheriffs Deputy O.N. Blessud attended by Mrs. A Blessud, in fair physical condition, with the following history: No history of consanguinity, heredity or intemperance in parents or self. First symptoms of attack manifested about 4 years ago with loud talking: Was examined Nov. 22 '96 & given over to care of her son. Disease appears increasing: is variable with irregular, rational intervals: Derangement now manifested on subject of stealing & carrying off of her boy.
Not disposed to injure others: not suicidal or destructive but is filthy in habits: Patient has been irritable & peculiar for many years.
No history of intemperance in parents or self: Says her head has been injured several times, once by falling out of a buggy & also by a blow from her husband: Has not been confined or restrained & has received no treatment.
On personal examination it is found that patient is in the habit of walking the streets early & late carrying a hand satchel, is dressed neatly, talks freely resenting the testimony of witness: Has a handkerchief tied over right temple to relieve pain there, she says.

Aug 11. On admission put upon B.W. (G.H.U.Rpt. Complexion dark: hair dark partly gray: eyes brown: Skin normal. No marks or scars noticed: Is dirty: behavior quiet. Talks sensibly)

Aug 24 Summary Nurses 14 Day Record: Ate regular meals: quiet & agreeable: T. P. R. normal. Complained a good deal of head ache, tooth ache & neuralgia: bowels usually constipated: requires cathartics: Also took tonic after meals: usually slept well.
Nurse's Notes: Aug 22: Patient very noisy at times: appetite: complained of headache a good deal: bowels constipated: takes tonic & cathartics: Has a great many delusions: sleeps well: tidy in habits & appearance: G.y.n. treatments given Continued by Dr. Mrs. Phelps. Oct 26 Trans. to Annex: Has been at times noisy & untidy. Nov 30 Still scolding: At times fights. Feb 17 '98 Wt. 115 Still noisy Aug 6 Wt. 116# Sept. 16 Trans. to 6: Feb 25 '99 Wt. 114#. No especial change in behavior scolds very much at times when in any way put out of her room or the ordinary routine of her habits.

Mch 1 Aug 31 '99 Cont. by Dr. Bibb. General health good: Appetite good: Takes outdoor exercise: Neat in habits: Has delusions: Is extremely noisy at times: resists being bathed: Remains in room most of time. July 26 Trans. to annex Aug 18 Wt. 113#.

Sept 1 Feb 28 '900. (Dr. Heyerdale) Burned left hand slightly on radiator. Oct 25. Visited by lady friend. Nov 29. Neat. extremely noisy most of time: Talks to herself in german: Eats & sleeps well: Takes outdoor exercise

Dec 5. Again burned herself Jan 1st. Wt. 110# Burns healed nicely.

Mch 1 Nov 30 1900. (Dr. Linton) Neat in habits: very noisy: At times scolds & is very disagreeable: Has delusions: General health & appetite good. Bowels regular: Sleeps well: Mch 7 Struck in face with chair, bruising left eye. Apr 5 Visited by friends July 20 Vaccinated: Does no work & is quite obstinate Nov 24. Wt. 109½ # Dec 1- Feb 28 '901- No change during period: General health good Mch 1 Wt. 114#.

Mar. 1 - June 1 - 1901. does no work, no change in either mental or physical condition. May 30 Wt 110#

June to Sept. Does no work, takes out door exercise. Sept. 1st. Wt. 105#.

Sept. to Dec. Condition practically same during quarter Nov. 30 Wt. 100#.

Ys to Feb. 1, 1903. General health good: appetite good: sleeps well: bowels regular: does no work but takes exercise: extremely noisy part of the time: violent at times: habits and appearance neat: does not speak English. Dec. 1st. Wt. 96#.

Personal and Medical History of

Personal and Medical History of Olivia Lawson

HERBERT, PUDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4842

Residence, St. Paul, Minn.

Date Admission, August 12th 1897.

Admitted by Dr. L. H. D. Eby, Hour, 6:45 P.M.

How Sent, Hy. Gallick Ct. Com. Ramsey Co.

Sex, Female.

Age, 55

Civil Condition, Married.

Children, one

Age Youngest Child, 25

Occupation, Cook.

Degree Education, Can read & write.

Profession Religion, Swedish Lutheran.

Habits, Not intemperate.

Nativity, Sweden, (Parents also born there) Became resident of State & Co. in 1870.

Physicians Committing, J. F. Baker & Haldor Enoe.

Correspondents,

No. for Year, 9

Insane Relatives, Unknown.

Cause Exciting, Not stated

Cause Predisposing, Not stated

Form, Mania Chronic.

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, About July 26 1897.

Duration, 17 days.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 55

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam by P.M. & D.L. Phelps Aug 13/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Impaired.

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Talks in an incoherent way. Mind wanders from one subject to another. Talks a good deal about Insurance Cos. Mind seems feeble from age. Physical condition fairly good.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, & demented.

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Has many Concerning

Special Subjects, Property & insurance Cos.

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

8/13/97 Mpls.

CLAIMED THE HOUSES.

Olive Larson Has a Peculiar Mania.

Mrs. Olive Larson was committed to the insane hospital at Rochester yesterday by Court Commissioner Gallick. Mrs. Larson is the woman that was found in a vacant house in the midway district several days ago. She imagines that she has a large amount of property and has taken possession of several vacant houses in the midway district, stating that they belonged to her. She also had a habit of cutting large bunches of weeds, for which, she told the physicians yesterday, she got large sums of money.

Medical History of Olivia Lawson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 in. WEIGHT, 118 lbs. NUTRITION, Fairly good.

WOUNDS OR ABNORMALITIES, None. Skin normal.

TONGUE, ~~Tremors~~, Normal Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Normal. Accommodation,

SIGHT, Impaired - Uses glasses.

HEARING, Seems good.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Slight. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Both normal.

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs: Sounds Normal: Regular

LUNGS, Breath sounds somewhat roughened in left upper anterior, Chest form. normal.

GYNÆCOLOGICAL EXAM., 8/19/97 Uterus retroverted & bound by adhesions toward left side: Os + perineum lacerated: some cystocele.

MENSTRUATION, Menopause past 5 yrs.

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug 14/97

Color Reddish yellow

Character Clear

Amt. 24 hrs. XLI Z.

Sp. gr. 1024

Reaction. Acid

Albumen None

Sugar "

Mic. Much fat. Epith cells oxal. lime - amor. urates few uric acid crystals, a few blood corpuscles.

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has had Typhoid fever & Small pox. Had headaches when young.

LENGTH OF INVASION, Gi ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations, dead

Father or Pat. Relations, dead

Brothers or ~~Sisters~~, healthy 1 son

Personal and Medical History of Olivia Lawson
(or Olivia Larson or Larsen)

1897

This patient was brought here by Sheriff's deputy P J Meisson attended by Mrs Sylvester in fair physical condition, with the following history:- No history of consanguinity: First symptoms of attack manifested about July 26 97 Disease appears increasing: So variable: Derangement now manifested by belief that she is worth a vast amount of money (Takes possession of empty houses & claims them as her own: Not disposed to injure others: Not filthy or destructive in habits: No information concerning previous peculiarities, or intemperance in parents or self. No injury to head or severe disease: Has not been confined or restrained: Has received no treatment.
On personal examination does not know where she is: Does not appear worried because she is undergoing this examination.
On admission put upon. B^n W. (G.H.R.pt Complexion dark: hair brown: eyes blue: Condition of skin normal: no marks or scars noticed: Both arms bruised: So clean: Behavior quiet: Has delusions.)

Aug. 31 Summary Nurses 14 Day Record:- Temp. normal: Took regular meals: Quiet at first: later inclined to be some what violent & quarrelsome: Slept well at first but later on some nights slept very little: Has delusions: Second week Appetite rather poor: Tidy in habits & appearance: took out door exercise: did no work: talked incoherently. Aug 31 Fought nurses
Nurse's Notes: Tidy in habits & appearance: At times violent: Appetite: bowels regular: takes out door exercise: has delusion: Continued by Dr. R.M. Phelps.

Sept 13 97. Trans. to Annex: works some: at times inclined to be violent. Feb 98 Wt. 135#
Feb 17 99 Has drifted along ever since last note at annex: usually quiet altho incoherent & rather dull. At present is working in the sewing room.

March 1- Aug 31 99 - Cont by Dr Bibb. Genral health good- eats & sleeps well: Takes outdoor exercise: Clean but careless: Quite obstinate & disagreeable & at times violent: Talks very little & incoherently but can answer questions sensibly. So quarrelsome.

Sept 1- Nov 28 1900. Dr. Kryendale) Eats & sleeps well. Takes outdoor exercise: Violent at times: Oct 5 Struck Belle Pattie: no injury. Works in dining room.
Jan 1st Wt. 155# March 1- (Nov 30 1900 Dr. Linton) Nat: Very vulgar & disagreeable & at times quite violent. Has delusions & talks incoherently. Appetite good: Bowels regular: Sleeps well: Takes outdoor exercise: works in dining room part of time July 20 Vaccinated Nov 24 Wt. 153 1/4# Dec 1- Dec 28 1901. Appetite good: Bowels regular: Takes out door exercise: Attends chapel & amusements occasionally Works in dining room: Very stubborn & disagreeable: & at times violent. Mch 4. Wt. 153#

March 1- June 1 - 1901
No change in mental or physical condition: helps with work on ward
May 29 Wt. 154#

Personal and Medical History of

1901

June to Sept. Assists with ward work, takes out door exercise, Sept. 2 Wt. 152#.
Sept. to Dec. Condition about the same during quarter, attends amusements, still inclined to be violent at times, Nov. 23 Wt. 157#.
Up to Feb. 1, 1903. General health good: appetite good: sleeps well: bowels regular: attends amusements: exercises: assists with the work: is at times very disagreeable and violent: sometimes attacks the nurses and quarrels with the other patients: rather incoherent in speech: Nov. 29th. Wt. 154#.

Personal and Medical History of Ida Kittleson

Whole No. 4844

Residence, St Paul, Minn.

Date Admission, August 13th 1897

Admitted by Dr. R. M. Phelps Hour, 6.45 PM.

How Sent, Hy. Gallick Ct. Com. Ramsey Co.

Sex, Female.

Age, - 18 -

Civil Condition, Single.

Children, -

Age Youngest Child,

Occupation, Domestic (Father Stonecutter)

Degree Education, Common school.

Profession Religion, Yes catholic

Habits, Not intemperate.

Nativity, Switzerland (Parents also born there)

Physicians Committing, Arthur Brenney & A Schuppe

Correspondents,

No. for Year, 11

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing,

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Yes - attempted by jumping from window.

Date of this Attack, About 3 weeks ago

Duration, 3 weeks.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 18 yrs.

Time of Leaving, July 5: 1898

Time in Hospital, 10 m. 22d.

Result, Discharged Jan. 5 '99 Unimproved

EXAMINATION ON ADMISSION.

Exam. by A. Phelps 8/14/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Seems clear.

Quick or Sluggish,

MEMORY:

Past Events, Good

Recent Events, Says of late is forgetful.

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Impaired.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Talks willingly & quite sensibly on most subjects. Says she has had headaches for years & also some nervous movements of her head but was able to work & study up to Jan. 97 when she says this nervous sickness came on her. Has general choreaic movements in her whole body. Thinks they tried to kill her at the City Hospital, St. Paul.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, & at times excitable.

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Ida Kittle.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not Taken WEIGHT, Not Taken NUTRITION, Good.

WOUNDS OR ABNORMALITIES, — Skin - Eruption on face otherwise about normal.

TONGUE, Tremors, Slight. Coatings, Yellow coat. Promptness Movement,

PUPILS, Equality, Equal Size, Normal

Response Light, Normal Accommodation,

SIGHT, Says gets dizzy when she tries to read.

HEARING, Good

COORDINATION, Arms, Much impaired. Choreaic movements in arms, hands, legs & head.

Legs,

TREMORS, Hands, Choreaic movements Tongue, Fine & large tremors.

Facial Muscles, General, Choreaic movements.

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Fairly good.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No Murmurs. Sounds rather accentuated & irritable. Apex beat Normal Situation - Irregular

LUNGS, Normal.

GYNÆCOLOGICAL EXAM., 9/9/97 Uterus retroverted: External genitals normal.

MENSTRUATION, Regular, but very painful.

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug 16

Color Light Yellow

Character Cloudy with flaky deposit

Amt. 24 hrs. XXII ℥

Sp. gr. 1018

Reaction Slightly acid.

Albumen Good test by heat - Nitric acid

Sugar Trace by Fehling.

Mic. Large amt. fat globules & pus corpuscles - Epith cells - round & squamus - Oxal. lime crystals.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, at Home	Medium,	Poor,
SLEEP, Good, up to last few wks	Poor,	Irregular, now.
PULSE, 80 - full.	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Says never had any bad sickness except nervous sickness. - Has had headaches & vertigo for years. Has had nervous movements of head for years.

LENGTH OF INVASION, Much more since Jan. '97. ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Says never any nervous trouble in her family.

Mother or Mat. Relations, Died when patient was 2 yrs. old. Relations Healthy.

Father or Pat. Relations, Healthy

Brothers or Sisters, Healthy.

Personal and Medical History of Ida Kittle

1897

This patient was brought here by Sheriffs deputy P. J. Mireen attended by father + Miss Bowman, in fair physical (?helpless) condition, with the following history: No history of consanguinity, lunacy or intemperance in parents or self: First symptoms manifested about 3 weeks ago when she became unconscious + afterward maniacal: Disease appears stationary: is variable with irregular rational intervals: Derangement now manifested by maniacal conduct: Delusions of persecution + chorea: Not disposed to injure others: Suicide attempted by jumping from window: No disposition to filthy or destructive habits: Was very stubborn before accession of disease: Has received no head injury, had chorea this Spring. Has been restrained in bed at City Hospital, St. Paul + has been given sedatives + rest.

On personal examination is restless noisy + violent in her outbursts, believing that people are trying to kill her.

On admission put upon 3rd W. (Gt. N. Dpt. Complexion fair: hair light: eyes blue: eruption on face + body: both arms slightly bruised: is clean: Behavior hysterical, would not walk, keeps up a continual jerking of head + arms when anyone is in sight.

Aug. 29 Summary Nurses 14 Day Record:- Appetite poor first day, but from that time on patient ate regular meals: bowels usually regular: constipated at end of two weeks: Very hysterical in behavior: did not feel homesick at first but did so later: Temp. normal: medicine given after meals: Slept quite well: Assisted some with work. Aug 24 Attempted to run away while out walking: fought nurses: was brought in + put in restraint sheet: Very noisy during evening: Continued by Dr. Rem. Phys.

Aug 29 Is rather uncertain in behavior: at times falls on the floor, speaks of having spells or convulsions: Is at times violent. Sept 6 Trans. to 6th. Sept 22 Very restless + unruly on ward: put in restraint. Oct 9 Received bruise on eye from Ida Nelson. Oct 16 Again in restraint. Oct 25 Trans. to 6s.

Feb 8 98 Has been at times put in her room on account of being noisy + restless. Is very troublesome in behavior which seems quite distinctly hysterical: She is intelligent + realizes what she does: Thinks she cannot help it.

March 9 98 Trans. to 6th. Apr 18 Trans. to B1. Apr. 30 Trans. to 6th, July 5 Went home on trial.

Discharged

Personal and Medical History of

Personal and Medical History of Katharine Farrar

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4845

Residence, Olmsted Co. Minn.

Date Admission, Aug. 16th 1897.

Admitted by Dr. A. F. Kilbourn Hour, 3 PM.

How Sent, J. A. Leonard Sup't Olmsted Co.

Sex, Female.

Age, - 56 -

Civil Condition, Married

Children, 4

Age Youngest Child, 20 yrs.

Occupation, Housewife (Husband farmer)

Degree Education, Common school.

Profession Religion, Baptist.

Habits, Not intemperate

Nativity, New York (Parents also born there)

Because resident of State 37 yrs ago - Of County 30 yrs ago.

Physicians Committing, A. W. Stinchfield & C. F. Granger.

Correspondents,

No. for Year, 1V

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing, "

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, 2 or 3 yrs. ago.

Duration, 2 or 3 years.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, about 53.

Time of Leaving, Oct. 9. 1897

Time in Hospital, 1 mo- 24 d.

Result, Discharged Feb. 23. 1897 Under Peterson Law.

EXAMINATION ON ADMISSION.

Exam by P. M. & H. Phelps Aug 17 97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, Fairly quick

MEMORY:

Past Events, Good

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Fair.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects, Impaired

GENERAL DESCRIPTIVE REMARKS: Seems rather feeble minded, nervous & excitable. General physical condition impaired. Bowels constipated. Anaemic & quite emaciated. Says she has had uterine trouble for years that has caused her to have many reflex symptoms.

EMOTIONAL STATE:

Normal, Calm, Excitable & nervous.

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 Katharine Farrar

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. WEIGHT, 110 lbs. NUTRITION, Impaired - Color bad.

WOUNDS OR ABNORMALITIES, Some bruises Skin normal.

TONGUE, Tremors, Coatings, Yellowish Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Impaired - wears glasses - Very slight arcus senilis.

HEARING, Left ear - Impaired.

COORDINATION, Arms, Normal.

Legs,

TREMORS, Hands, None Tongue, None

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Sounds a little weak & regular

LUNGS, Chest sym. - normal. Expansion fair Sounds seem normal.

TAKEN,

EXAM. URINE, Aug 19/97

Color Yellow

Character Cloudy.

Quant. 24 hrs. XX ℥

Sp. gr. 1015

Reaction - Acid.

Albumen Trace by Tanrets

Sugar - None.

Mic - Large quant. amor. & Sodium urates. a few pus & blood corpuscles. Epith. cells, squamus & round - Uric acid Crystals

GYNÆCOLOGICAL EXAM., 9/19/97 Uterus retroverted: Cervix hypertrophied & bleeds on touch: whole organ extremely sensitive; perineum lacerated: inflammation of urethra.

MENSTRUATION, Menopause past 8 yrs.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has had measles - Some headache & vertigo

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Living 85 Aunt insane

Father or Pat. Relations, Died accident

Brothers or Sisters, 7 in all. 4 Children oldest 35 - divorced - In St Charles - Son 26 - living Farrar Chatfield, Minn.

Personal and Medical History of Katharine Farrar.

1897

This patient was brought here by Sheriff C. N. Stewart & attended by Mrs. Stewart. in good physical health, with the following history:- No history of consanguinity, heredity or intemperance in parents or self: First symptoms of attack manifested two or three years ago by delusions: Disease appears to be increasing: Not variable, no rational intervals: Derangement now manifested by delusions: Imagines her character has been ruined: Is disposed to injure others: Not suicidal, filthy or destructive: No previous peculiarities shown: No history of intemperance in parents or self: No recent disease or head injury: Has not been confined or restrained: has received no treatment: On personal examination shows delusions. On admission put upon B. & W. (G.H.U. Rpt Complexion dark: hair brown: eyes blue: Condition of skin good: Left Knee & both arms bruised: Is clean: behavior quiet: talks sensibly.

Aug 19 Summary Nurse's 14 Day Record:- Aug. 14: Ate nothing: bowels moved: complains of pain in side: Wet cold: sand bags applied: Aug. 20 Temp. normal: Has taken regular meals: complains of pain in back & right side: Slept quite well: Aug. 22 complains of Headache & pain in back: takes tonic after meals: Aug. 27 Bowels regular: Quiet & agreeable: Temp. normal: Sleeps well: Has had Gyn. treatments: Aug. 29 Visited by Husband: Very anxious to go home.

Sept 11 Summary Nurses Notes by Dr. B. L. Phelps:- Transf. to Inf. Operation done: Hysterectomy & removal of ovaries & tubes. Took ether well: Reaction good: Put to bed: Strychnia given ~~hy~~ & hypodermically for tonic.

Sept. 28 Able to sit up 4 hrs. in chair: Has had no Sad Symptoms whatever: Sept. 29 Sat up most of day: Has made a good & uneventful recovery. Is anxious now to go home: Sept 30: up on ward most of day. Appetite good: bowels usually constipated: cathartics given

Oct. 9 Went Home much improved mentally & physically.

Discharged.

Personal and Medical History of

Personal and Medical History of Abaigail C. Goodrich

Transferred from St. Peter.

EGBERT, FIDLAR & CHANDLER, DAVENPORT, IOWA

Whole No. 4848

Residence, Marshall, Minn. Transferred from St. Peter. (Original admission Dec. 13/1894)

Date Admission, August 19, 1897. (Change of residence.)

Admitted by Dr. R. M. Culps Hour, 10:30 A.M.

How Sent, O.E. Maxson & A.P. Lyon Co.

Sex, Female.

Age, 50 (53 now.)

Civil Condition, married.

Children, 7- (six living)

Age Youngest Child, -

Occupation, Housewife

Degree Education, -

Profession Religion, Church member

Habits, Temperate & Moral.

Nativity, New York.

Physicians Committing,

Correspondents, W.S. Goodrich (Husband) Marshall, Minn.

No. for Year, 15

Insane Relatives, Grandmother & maternal grandfather.

Cause Exciting, Recent marriage. Menopause.

Cause Predisposing, Previous attack - Heredity.

Form, Melancholia Atonica

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Yes- Propensity active.

Date of this Attack, About Sept. 1894.

Duration, Since Sept 1894.

No. of Attack, 2nd

No. of Admissions, 1st here. (Trans. fr. St Peter.)

Age First Attack, about 28 years old.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Impaired.

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull, Very dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State, "

Special Subjects, "

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS: Has delusive ideas.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient sits in a stooped position with head down most of the time, appearing quite demented. Usually hesitates a good deal in answering questions tho at times talks quite sensibly. Realizes more than she appears to. General physical condition is impaired: Emaciated & anaemic.

Personal and Medical History of Abaigail C. Goodrich

Abaigail C. Goodrich.

Was admitted Dec. 13, 1894, at the age of 50 yrs. She was born in New York, was married and had 7 children.

This attack commenced about 12 weeks before her admission. She had had an attack lasting 3 years 30 years before.

Family History.

Parents not living. Cause of death of father, comsumption; of mother, dropsy and childbirth. Age at death of father 41; of mother 27. One aunt died of consumption. Grandmother was insane and maternal grandfather.

Personal History.

She had measles and typhoid fever in childhood. Menstruation commenced at the age of 12 or 13. In later years it was somewhat irregular and sometimes painful. She was married at the age of 16, and her first child was born 15 mos. later. Her labors were short and not severe. Her last child was born in 1881. The health of the children was good. Physically and mentally she resembled her father; was always quiet and non-communicative.

The present attack manifested itself by restlessness and hallucinations. She thought she had killed her children and must suffer for it; was not homicidal or dangerous to others; but suicidal, filthy and careless in her habits, ate poorly; had had treatment with negative

D.

Impaired

I. URINE, Aug 30/97

Yellow.

Clear.

XLI 3

1008

Acid

None

None.

ratio, large amt. uric

sal. hind. a few

lls.

General hyperaemia

ocasis of pain in pelvic

as on pressure.

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,

Civ. Condition,

Childre

Age Youn,

Occupation,

Degree Education

Profession Religion,

Habits, Temper

Nativity, New York

Physicians Committing,

Correspondents, Wm. Goodrich

EX. ON ADMISSION.

CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Impaired.

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull, Very dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Patient sits in a stooped position with head down most of the time, appearing quite demented. Usually hesitates a good deal in answering questions tho at times talks quite sensibly. Realizes more than she appears to. General physical condition is impaired: Emaciated & anaemic.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS: Has delusive ideas.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Abaigail C. Goodrich

results; cause of attack given, recent marriage, change of residence, menopause.

At the time of admission she was poorly nourished, weighed 80 lbs., her flesh was flabby, dry, scaly, her vitality much reduced, her body temperature 99. There was in indistinct murmur heard at the ensiform cartilage, time ?; the lungs seemed healthy; there was a rough systolic murmur heard over the abdominal aorta; the urine contained traces of albumen; her eyelids drooped, her mouth was asymmetrical, the tongue deviated slightly upon protrusion and there was much course tremor present; of the limbs there was very little tremor present. Of the superficial reflexes, the puppillary were present but slight; and those of the forearm present and active.

She was untidy, did not attend to her toilet, walked slowly and unsteadily, was dull and sad in appearance, her perceptivity was fair; and rate of mental process somewhat slow. Her memory was good. She slept poorly and was much depressed. Thought she was going to be hung here.

Her physical condition was never good, her appetite usually was fair though she often had to be fed by the nurses. She was usually constipated and slept poorly. She was depressed at all times, very indifferent about her appearance and surroundings, filthy in her habits, either dull and inactive or restless; would seldom speak, but when she would answer questions usually spoke in a whisper. She has made many

D.

Impaired

I. URINE, Aug 30/97
Yellow.
Clear.
XLI
1008
Acid
None
None.
rates, large amt. uric
ral. hind- a few
ells.

General hyperaemia
clains of pain in pelvic
on pressure.

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,

Civ
Childr
Age Youn
Occupation,
Degree Educatio
Profession Religion,
Habits, Temper
Nativity, New-York
Physicians Committing,
Correspondents, W.S. Goodrich

EX MISSION.
STICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Impaired.
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Very dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State, "
Special Subjects, "
GENERAL DESCRIPTIVE REMARKS: Patient sits in a stooped position with head down most of the time, appearing quite demented. Usually hesitates a good deal in answering questions tho at times talks quite sensibly. Relapses more than she appears to. General physical condition is impaired: Emaciated & anaemic.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS: Has delusive ideas.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

...al and Medical History of Abaigail C. Goodrich

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

Impaired

attempts to commit suicide by choking or hanging or burning herself.

Aug. 18, '97, a pelvic examination was made. She had a slight leucorrhea; the hymen was destroyed; her uterus was very small, anteverted and movable; there was a small transverse tear of the cervix, a small erosion on lower lip; the left side; a slight laceration of the perineum. The ovaries and tubes could not be palpated. There was general tenderness and the vaginal mucous membrane was hyperaemic and bled easily.

The vaginal discharge contained staphylococci & granular epithelium.

I. URINE, Aug 30/97
Yellow.
Clear.
XLI
1008
Acid
None
None.
urates, large amt. uric
ural, lines a few
ells.

General hyperaemia
plaints of pain in pelvis
ss on pressure.

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,

Deg.

Profession

Habits,

Nativity, New

Physicians Committing,

Correspondents, Wm Goodw

E[illegible]N.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Impaired.

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull, Very dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Patient sits in a stooped position with head down most of the time, appearing quite demented. Usually hesitates a good deal in answering questions tho at times talks quite sensibly. Realizes more than she appears to. General physical condition is impaired: Emaciated & anaemic.

TATE:

alm,

erent, ✓

Exalted,

Depressed,

DELUSIONS: Has delusive ideas.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

[illegible]onal and Medical History of Abaigail C. Goodrich

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

IGHT, 4 ft. 11 in WEIGHT, 83½ lbs. NUTRITION, Impaired

OUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Coatings, None. Promptness Movement,

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT, Impaired.

HEARING, Seems good.

COORDINATION, Arms, Normal.

Legs,

TREMORS, Hands, No marked tremor Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating, ✓ Stumbles her words.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries normal.

HEART, no murmurs: Sounds good.

Size normal: Regular.

LUNGS, Apex Asymmetry, normal Chest concave. Expan. poor. Sounds fair. Hyperresonance Exc both lungs.

GYNÆCOLOGICAL EXAM., 8/25/97 Uterus normal position - Cervix lacerated - General hyperæmia of cervix, endocervicitis - Laceration of perineum - slight haemorrhoids. Complains of pain in pelvic region at times. Some tenderness on pressure.

MENSTRUATION, Menopause past

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug 30/97

Color Yellow.

Character Clear.

Amt. 24 hrs. XLI ℥

Sp. gr. 1008

Reaction. Acid

Albumen None

Sugar None.

Mic. Amor. urates, large amt. uric acid crystals. Oxal. lime- a few Bladder epith. cells.

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Abbigail E. Goodrich

1897. This patient was brought here from the St. Peter State Hospital, by Miss Mrs Dillie Peterson. a copy of the original warrant, also copy of "Certificate of Jury also synopsis of history (see preceding page) came with her. The copy of original history read as follows: Grandmother insane: Cause of present attack recent marriage, change of residence, trouble &c: Form of attack depressed & chronic: First symptoms of attack manifested about 12 weeks ago (Dec. 13/94) by restlessness & later, hallucinations: First attack occurred 30 years ago, lasted 3 years: Insanity manifested by thinking that she has killed her children & must be punished for it: Not disposed to injure others: Has attempted suicide by drowning & by setting fire to herself. So filthy & destructive in habits: No severe disease or injury to head: Has not been confined or restrained: Has received treatment with negative results.

Aug 19 On admission put upon B'd W (Gen'l Apt Complexion dark: hair gray: eyes blue: Skin normal: So clean: behavior quiet: has delusions)

Sept 1 Summary Nurse's 14 Day Record:- Temp. normal: Appetite good: bowels regular at first: Habits untidy: Slept well: Aug 25 Had diarrhoea: Boiled milk given for dinner & supper: medicine given: Visited by husband: has delusions: Sept 1 Talks very little except to answer questions: eye sore & red: medicine applied: Slept well.

Nurse's Notes:- Augs: Quite stupid: untidy: bowels regular: appetite fair: takes out door exercise continued by Dr McPhee. Oct 14 Visited by husband. Has been receiving gynaecological treatments. Has been quite dull & depressed, so very quiet. Feb 28'98 87/97 Is receiving massage. Apr. 18'98 Visited by husband. July 26'98 Visited by husband: Does not talk much: Still depressed: sits in a quiet way by herself: will say nothing; at times makes some suicidal attempts. Nov 1'98 - Aug 31'99 Cont. by Dr Bell

1899 Physical health fair: Appetite poor: bowels constipated: Sleeps well: Takes out door exercise: Receives gyn. treatments: Is very melancholy & actively suicidal. Has attempted to choke herself & burn herself on Heater. Is very quiet. Feb 25 Wt. 106#. Rarely speaks to anyone: seems quite dull & stupid much of time but understands what is going on & occasionally laughs if anything amusing occurs. Sometimes resists when taken to dining room. Apr 14 Visited by husband. June 16 Attempted suicide when out walking. Has many delusions: Is untidy & careless: Aug 29 Wt. 100#.

Sept 1 - Feb 28'1900 - Dr. Heyndale) Appetite good: Sleeps well: Takes out door exercise. Is very quiet: expresses delusions: Is actively suicidal, Jan 17 Wt 100#. Feb 10. Trans. to B'd W. Went to fire place & emptied a handful of coals on lap. No injury resulted. March 1 - Nov. 30'1900 Untidy in appearance but clean in habits: Very quiet & melancholy: Seldom converses is at times quite poor. Often speaks of committing suicide & at times attempts to run away. Has also attempted to take her life. Appetite fair: bowels regular: Sleeps well:

Personal and Medical History of

Takes out door exercise: Has delusions: July 16 Vaccinated. Sits in bay all day with knees drawn up on bench. & head on knees. Nov 16 Wt. 100#. Dec 1 - Feb 28'1901 General health good: Has many delusions & at times destructive: Answers questions but does not care to read or converse: always disturbed when fire is made on hearth Wt. 91½#. Mar. 1 June 1 - 1901 No change in mental or physical condition: does no work. May 29 Wt. 99#

June to Sept. No change, Sept. 2 Wt. 94#. Sept. to Dec. No change during quarter Nov. 30 Wt. 99#.

Dec to Feb 1, 1903. Appetite good: bowels regular: sleeps well: takes exercise: does no work: is very quiet usually: does not voluntarily converse: but answers questions sensibly when so disposed. Nov. 25th Wt. 91#.

Personal and Medical History of Jane Rich

Whole No. 4852
Residence, St. Paul. Minn.
Date Admission, August 23rd 1897
Admitted by Dr. le R. Eby Hour, 6.45 PM
How Sent, H. Gallick Ct House. Ramsey Co.
Sex, - Female -
Age, - 40 -
Civil Condition, Single.
Children, -
Age Youngest Child, -
Occupation, Nurse
Degree Education, Common school.
Profession Religion, Baptist
Habits, Not Intemperate.
Nativity, New York - (Father Ireland - Mother England) Became resident of State & Co. in Sept. 1896.
Physicians Committing, Le Baron & Haldor Swift
Correspondents, Sister - Mrs Mary Mossong Cor. Hudson & Bates St. St Paul, Minn.

No. for Year, 19.
Insane Relatives, None
Cause Exciting, House struck by lightning caused 1st attack
Cause Predisposing, Several.
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not.
Date of this Attack, Aug 22nd 1897.
Duration, 1 day.
No. of Attack, Has had several.
No. of Admissions, 1st time. (Has been at Grand Rapids & Kalamazoo, Mich.)
Age First Attack, —
Time of Leaving, Jan. 23. 1899
Time in Hospital, 1 yr. 5 mo.
Result, Discharged 1/23/99 Recovered

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused & Sluggish
Quick or Sluggish,
MEMORY:
Past Events, Impaired
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Much Impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Seems very drowsy & dull. Says she has been in several hospitals. Mind wanders from one subject to another. Very listless & dull.

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

Personal and Medical History of Jane Rich

JANE RICH.

Her sister, Mrs. Mossong, writes that although she is her sister, she has only seen her three times since she was a child. She knows that she has been sick a good deal, but has not known the cause or any of the details. Miss Rich has been in Michigan, and her sister does not know of any friends to whom to write and find out about her. Her sister did not know until she came to St. Paul, about a year ago that she was ever out of her mind.

good.

Legs,
TREMORS, Hands, None. Tongue, None.
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating, Hesitating.
FACIAL EXPRESSION,

SENSIBILITY,
Arteries normal.
HEART, No murmurs. Sounds normal Regular
LUNGS, Chest sym - normal. Expansion good. Coughs & expectorates some.

TAKEN,

EXAM. URINE, Aug 30/97
Color Yellow
Character Cloudy
Amt. 24 hrs. XVIII 3/4
Sp. gr. 1010
Reaction Acid.
Albumen Trace by heat, Nitracid & Tannic
Sugar None.
Mic. Amor. urates - Large amt pus & Corpuscles. Some oxal. lime, a few uric. acid crystals.
Epith. cells Squamous & round.

GYNÆCOLOGICAL EXAM., 8/25/97 Uterus retroverted & immovable - Very extreme tenderness of whole body of uterus - Foul discharge. Urethra red & very sensitive. Pain on urination. Erosion of os.
MENSTRUATION, Suspended since Oct. '96
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular, ✓
PULSE, 90	Resp., 16	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, dead.
Brothers or Sisters,

Personal and Medical History of Jane C.

Whole No. 4852
Residence, St. Paul, Minn.
Date Admission, August 23rd 1897
Admitted by Dr. Le R. Eby Hour, 6.45 PM
How Sent, H. Gallick Ast Cor. Ramsey Co.
Sex, - Female -
Age, - 40 -
Civil Condition, Single.
Children, -
Age Youngest Child, -
Occupation, Nurse
Degree Education, Common school.
Profession Religion, Baptist
Habits, Not Intemperate.
Nativity, New York - (Father Ireland - Mother England)
Became resident of State & C. in Dept. 1896.
Physicians Committing, Le Barron & Haldor Suive
Correspondents, Sister - Mrs. Mary Moscong Cor. Hudson & Ratcliff St. Paul Minn

No. for Year, 19.
Insane Relatives, None
Cause Exciting, House struck by
Cause Predisposing, Several.
Form,
Accompanying Bodily Disorder, None mentio
Suicidal or Not, Not.
Date of this Attack, Aug 22' 1897.
Duration, 1 day.
No. of Attack, Has had several.
No. of Admissions, 1st time - (Has been at Grand Rapids & Kalamazoo, Mich.)
Age First Attack, —
Time of Leaving, Jan. 23. 1899
Time in Hospital, 1 yrs. 5 mo.
Result, Discharged 1/23/99 Recovered

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused +
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Impaired
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Much Impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Seems very drowsy + dull. Talks to herself a good deal. Says she has been in several hospitals. Mind wanders from one subject to another. Very listless + dull.

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

Personal and Medical History of Jane Rich.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HT, 5 ft. 7 in. WEIGHT, 114½ lbs. NUTRITION, Fairly good.
UNDS OR ABNORMALITIES, None. Skin normal condition.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Normal. Accommodation, Normal.
SIGHT, Sometimes uses glasses.
HEARING, Normal.
COORDINATION, Arms, Normal
Legs,
TREMORS, Hands, None. Tongue, None.
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating, Hesitating.
FACIAL EXPRESSION,
SENSIBILITY,
Arteries normal.
HEART, No murmurs. Sounds normal Regular
LUNGS, Chest sym - normal. Expansion good. Coughs + expectorates some.
GYNÆCOLOGICAL EXAM., 8/25/97 Uterus retroverted & immovable - Very extreme tenderness of whole body of uterus - Foul discharge, urethra red & very sensitive. Pain on urination. Erosion of os.
MENSTRUATION, Suspended since Oct. '96
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug 30/97
Color Yellow
Character Cloudy
Amt. 24 hrs. XXIII 7/7
Sp. gr. 1010
Reaction Acid.
Albumen Trace by heat, Nitric acid + Esbach
Sugar None.
Mic. Amor. urates - Large amt pus & Corpuscles. Some oxal. lime, a few uric. acid crystals - Epith. cells squamous + round.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular, ✓
PULSE, 90	Resp., 16	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, dead.
Brothers or Sisters,

Personal and Medical History of Jane Rich.

1897.

This patient was brought here by J. R. Kabaneu attended by Mrs. Moscong, in fair physical condition, with the following history: No history of consanguinity, heredity or intemperance in parents or self: Not first attack: Has had several within last ten years; duration unknown: Has been in hospitals at Grand Rapids + Kalamazoo: First symptoms of present attack manifested by insomnia, restlessness + queer actions: Appeared all right Sunday Aug. 29th. Disease appears increasing: Derangement manifested as follows:- went to post office, removed part of clothing + said that she was going to stay until she had received her mail: Not disposed to injure others: Not filthy or destructive in habits: No previous peculiarities manifested No history of intemperance in parents or self: No severe disease or injury to head: Was confined in jail for a few hours: Has received no treatment First attack caused by house being struck by lightning.

On personal examination answers questions quite readily, removes clothing, is incoherent, cries frequently, has apparently no memory, says she is tired. On admission put upon Bd W (Gth N. Apt. Complexion fair: hair gray: eyes gray: condition of skin normal: No marks noticed: Small scar on chest: Is clean: behavior quiet: Has delusions)

Sept 5 Summary Nurse's 14 Day Record: Appetite good: bowels regular first week: take cathartics required: much confused mentally on admission: slept quite well: coughs + expectorates some: Temp normal: assisted with work: very quiet + agreeable. Sept 27 transf to A: talked sensibly: Sept 29 complained of headache: occasionally quite talkative: July 30 Expressed no delusions: Gym treatment every other day: Sept 5 Very quiet + agreeable: works on ward: takes outdoor exercise: Complains of pain in back at times: takes tonics + cathartics: takes regular treatments 3 times per week. Continued by Dr. Wm. Phelps.

Sept 15 At present talking quite sensibly + behaving quite well. Sept 27 Again rather silly walks up + down ward: pulls clothes off Sept Fought nurses + was held part of forenoon: Trans. to Bd Oct 9 Trans. to B: Again quiet + agreeable. May 30 98 Noted at times as being very nervous, but has been quite same ever since attack of Sept. 30th Nov 26 Wt. 110 lbs Sept 3 98 Operated upon for floating kidney + for retroflexion of uterus. Oct 7 Patient has been quite fussy while in bed: So inclined to ~~be~~ complain + demand a good deal. Has, however, gotten along quite well in every way: Jan 29 99 Went home on trial. Since operation patient has been quite well behaved + same in every way, but is rather weak + pallid + not in very good health.

Discharged

Personal and Medical History of

Personal and Medical History of Josie Dunbar

Whole No. 4857	No. for Year, 21
Residence, St. Paul, Minn.	Insane Relatives, Don't know.
Date Admission, August 25th 1897.	Cause Exciting, Don't know
Admitted by Dr. R. M. Phelps Hour, 6th P.M.	Cause Predisposing,
How Sent, Hy Gallick, Lt. Lou. Ramsey Co.	Form, Mania Acuta Hysterical
Sex, Female	Accompanying Bodily Disorder, None mentioned.
Age, 30	Suicidal or Not, Not.
Civil Condition, married	Date of this Attack, One week ago.
Children, None.	Duration, One week.
Age Youngest Child, —	No. of Attack, 1st
Occupation, Housewife (Husband Optician)	No. of Admissions, 1st
Degree Education, Common school.	Age First Attack, 30
Profession Religion, None.	Time of Leaving,
Habits, Not intemperate.	Time in Hospital,
Nativity, Iowa. (Parents nativity unknown)	Result,
Physicians Committing, Became resident of state 2 Co. 3 yrs ago. Park, Ritchie & Aco. Dunning.	
Correspondents, Amos Dunbar. Cor Rice & Wabasha Sts. St. Paul Minn.	

EXAMINATION ON ADMISSION.

Exam. by R.M. & A. Phelps

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:	EMOTIONAL STATE:
Clear or Confused, Confused	Normal, Calm,
Quick or Sluggish,	Indifferent,
MEMORY:	Exalted, Exalted
Past Events, Impaired.	Depressed,
Recent Events,	DELUSIONS:
Special Subjects,	Systematized or Not,
PERCEPTIVITY:	Special Subjects,
Alert or Dull,	Transitory or Not,
Correct or Illusive,	HALLUCINATIONS: of sight - Sees things flying
REASONING POWER:	ILLUSIONS: around the room.
Ordinary Subjects, Impaired	CONVERSATION:
Own Mental State,	Coherent or Incoherent,
Special Subjects,	Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient inclined to be silly & unreliable in statements tho she appears quite intelligent. Seems to have had a Hysterical form of Mania. Husband calling later says for year past has had this jerking manner a good deal though he did not think of it as insane at all.

Personal and Medical History of Josie Dunbar

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4 in. WEIGHT, 117 lbs. Usually 126 NUTRITION, Good

WOUNDS OR ABNORMALITIES, Skin normal condition

TONGUE, Tremors, Coatings, Slight brown coat Promptness Movement,

PUPILS, Equality, Equal - & Size, Normal

Response Light, Normal Accommodation, Normal.

SIGHT, Impaired - Uses glasses.

HEARING, Good.

COORDINATION, Arms, Normal

Legs,

TREMORS, Hands, None Tongue, None

Facial Muscles, General,

REFLEXES, Patellar, Both normal.

Other

ARTICULATION,

Slurred, Normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Normal.

HEART, No murmurs.

Sounds Normal. Regular

LUNGS, Chest sym. normal. Expan. & Sounds - normal.

TAKEN,

EXAM. URINE, Aug 30/97

Color Light Yellow

Character Cloudy with flaky deposit

Amt 24 hrs. XL VIII Z

Sp. gr. 1010

Reaction. Alkaline.

Albumen Trace by Tannets

Sugar None.

Mic. Large quantity Amor urates, a few pus corpuscles. Bladder & vaginal Epith. cells. Triple phosphates

GYNÆCOLOGICAL EXAM., 9/1/97 Uterus anteflexed & immovable. Some adhesions on left side. External Genitals normal

MENSTRUATION, Regular - normal

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, 76	Resp., 20	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Says she drinks some. No sickness but measles.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Living.

Father or Pat. Relations, Living

Brothers or Sisters,

Personal and Medical History of Josie Dunbar.

1899.

This patient was brought here by Sam'l Marks, Sheriffs deputy, attended by Mr. Dolan & Ellen Strong, in fair physical condition, with the following history:- No knowledge concerning consanguinity, heredity or intemperance in parents or self: This is first attack & first symptoms were manifested one week ago by violence & obscenity: Disease appears increasing: Not variable, with no rational intervals: Derangement now manifested by delusions & incoherence: Shows disposition to injure others when angry: Not suicidal, filthy or destructive: No knowledge concerning previous peculiarities: No severe diseases or injury to head: Was confined for one week in County Jail: Has received no treatment. Cause of disease unknown.

Aug. 25 On personal examination is irritable, incoherent, violent temper: No history obtainable from her.

On admission put upon B'd W. (3d N Apt. Complexion fair: Hair light brown: eyes blue: Condition of skin normal: No marks or scars noted: Both arms bruised: Is rather dirty: Behavior hysterical: Talks coherently but seems to have some delusions)

Sept. 7 Summary Nurses Notes by Dr. P. V. Phelps. 14 day Record:- Appetite good throughout the two weeks: Talked incoherently: Slept well: Temp normal: bowels usually regular: Cathartics required occasionally: Tonic given after meals: took out door exercise: Very impudent & disagreeable: At times uses very vulgar Language: Sept. 1 Fought nurses: Sept. 5 Transf. to 6th. Sept. 6 Quiet: tidy in habits: Sept. 7 Very stubborn.

Nurses Notes- Aug. 25: Incoherent at times: violent: bowels regular: Appetite good: takes out door exercise: Neat: takes tonic. Continued by Dr Rm. Phelps.

Nov. 27 Appetite fair: General health good: Talks in a silly, careless, rambling way. She shows no very marked delusions: Feb. 27 '99 Wt. 111 lbs. General health fairly good. Jan 10 '99 Patients general health is quite good: Is still rather obstinate

1899 but is not now especially troublesome: Is quite untidy.

Mch 1- Aug 31 '99. Cont by Dr Bebb. General health fair: Appetite good: Sleeps well: Takes out door exercise: Is neat & clean: Very sarcastic & sometimes excited when asked to go out doors. understands everything said to her & sometimes answers quite sensibly but is usually rather silly: usually sits unoccupied day after day but reads a little. June 5 Had convulsion at 5 A.M. Complained of headache & backache- remained in bed 2 days. Aug 18 Wt. 103 lbs.

Sept 1- Feb 28 1900 (Dr. Weyrdale) Very disagreable, vulgar & profane: Eats & sleeps well: Takes out door exercise: Occasionally has convulsions. Jan 26 Had a convulsion. Jan 31. Wt. 112 lbs.

Mch 1- Nov 30 1900 (Dr Linton) Neat. Very disagreable: usually quiet but obstinate: Appetite is good: Bowels regular: Sleeps well. Takes out door exercise. Does no work: Apr. 18 In seclusion 4 hrs. July 20 Vaccinated. Nov. 30. Wt. 116½ lbs. Dec 1- Feb 28 1901. No change. Does no work. Is obstinate, disagreable & profane.

Personal and Medical History of Josie Dunbar

May 1- June 1- 1901 does no work: no change in mental or physical condition. May 30 Wt. 140½ lbs. June to Sept. Does no work, takes out door exercise, Sept. 1st. Wt. 103 lbs. Sept. to Dec No change during quarter, Nov. 30 Wt. 103 lbs.

Up to Feb. 1, 1903. General health good: appetite good: sleeps well: bowels regular: does no work. Takes no exercise; neat and clean at times disagreable and obstinate: answers questions intelligently. Dec. 1st, Wt 112½ lbs

Personal and Medical History of Charlotte F. Sanders

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4857

Residence, Pilot Mound, Minn.

Date Admission, August 30th 1897.

Admitted by Dr. R. M. Phelps. Hour, 6.45 P.M.

How Sent, E.V. Farrington J. of P. Fillmore Co.

Sex, - Female -

Age, - 57 -

Civil Condition, - Married -

Children, - 4 -

Age Youngest Child, - 24 yrs.

Occupation, Housewife - (Husband farmer)

Degree Education, Academic.

Profession Religion, Methodist.

Habits, Not intemperate.

Nativity, Ohio (Father N.Y. Mother Ohio.)

Physicians Committing, President of State Vic. since 1864 George A Lon + Henry Jones.

Correspondents,

No. for Year, 24.

Insane Relatives, None.

Cause Exciting, Overwork + worry.

Cause Predisposing, Previous attack.

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, Two months ago.

Duration, Two months.

No. of Attack, Has had many.

No. of Admissions, 2nd

Age First Attack, 31 yrs.

Time of Leaving, Dec. 28. 1898

Time in Hospital, 7 mos.

Result, Discharged Aug. 10'98 Much Improved

EXAMINATION ON ADMISSION.

Exam. by G.M. & A.L. Phelps 9/1/97. — MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Clear

Quick or Sluggish, Quite quick

Wanders from one subject to another

MEMORY:

Past Events, Much good said

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Somewhat impaired

Own Mental State, Impaired

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Very nervous + excitable - Says her husband said he had been obliged to live with an insane woman 40 yrs. which is a hint that this present condition is a chronic one - No delusions found + she denies the present existence of hallucinations

EMOTIONAL STATE:

Normal, Calm, Rather exalted + nervous.

Indifferent,

Exalted,

Depressed,

DELUSIONS: Seems to have some

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Charlotte F. Sanders.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Somewhat pale.

WOUNDS OR ABNORMALITIES, None. Skin Normal condition.

TONGUE, Tremors, A little pale. Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size, Normal.

Response Light, Accommodation,

SIGHT, Impaired

HEARING, Seems good.

COORDINATION, Arms, Normal.

Legs, Walks a little weak.

TREMORS, Hands, No special tremor but Tongue,

Facial Muscles, nervous movements General,

REFLEXES, Patellar, Both about +. Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries - Some atheroma

HEART, No murmurs

Sounds Weak. Regular

LUNGS, Chest concave. Expans. good.

TAKEN,

EXAM. URINE, Sept. 1/97

Color Pale yellow.

Character Cloudy.

Amt. 24 hrs. XXVIII — 3

Sp. gr. 1011

Reaction - Neutral.

Albumen None

Sugar None.

Mic. Amor. urates a few red blood corpuscles, fat, uric acid crystals.

GYNÆCOLOGICAL EXAM., 9/1/97 Uterus retroverted: Endometritis: Erosion of os: Laceration of cervix: Extreme tenderness of whole urethra + meatus. Laceration of perineum.

MENSTRUATION, Menopause past.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular, ✓
PULSE, 80	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 Charlotte F. Sanders.

1897

This patient was brought here by her son, as sheriff's deputy, in fair physical condition, with the following history:- No history of consanguinity, lunacy or intemperance in parents or self: First attack occurred at age of 31 + there were many during the following twenty years: Patient was brought to this (Rochester) hospital, Apr. 3rd 1891 + left here Aug 28'91. (for further particulars see Vol. 16 Fol. 49 No. 2651) First symptoms of present attack manifested about two months ago by nervous troubles, sleeplessness, headaches etc. Disease appears increasing: is variable with irregular rational intervals: Derangement now manifested by all sorts of delusions on all subjects: Hears voices, sees lights + imagines the family abuse her: Not disposed to injure others: Not suicidal, filthy or destructive: No previous peculiarities shown: No severe diseases but had sunstroke 28 years ago:
Received treatment + was confined at hospital, as above stated.
On personal examination no further particulars noted.
On admission put upon B.W. (24 N. Rpt. Complexion dark: Hair partly gray: Eyes gray: Condition of skin normal: No marks or scars: Both knees bruised: Is clean: Behavior quiet, but very nervous: Talks sensibly)
Summary Nurse's 1st Day Record:- Appetite good: bowels usually regular: cathartics given 1st day: tonic given after meals: quiet + agreeable, though rather nervous: took out door exercise: Gyn. treatments given: very talkative.
Nurse's Notes. Aug 3: Very quiet + agreeable: appetite fair: bowels regular: complains of pain in back: takes out door exercise: sleeps well: Gyn. treatment given: Tonic after meals: also medicine every two hours: neat + tidy: does a little work
Continued by Dr. P.M. Phelps. Nov 25 Patient is fairly well behaved: Is receiving gynaecological treatments: Is rather mildly incoherent in manner + somewhat silly. Feb 28 Patient went home: Has been for the past month or two quite well behaved not very anxious to go home: was rather afraid of having to work too hard or of not getting along with the family.

Discharged.

Personal and Medical History of

Personal and Medical History of Elizabeth Krohn.

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4858

Residence, South St. Paul, Minn.

Date Admission, August 21st 1897.

Admitted by Dr. P. M. Phelps Hour, 6.45 P.M.

How Sent, Thos. P. Morans J. of P. Dakota Co.

Sex, Female

Age, 56.

Civil Condition, married

Children, Seven

Age Youngest Child, 24 yrs.

Occupation, - Housewife -

Degree Education, Can read & write.

Profession Religion, Methodist.

Habits, Not intemperate.

Nativity, Germany (Parents Germany) Became Resident of State & Co. in 1867

Physicians Committing, J. C. Fitch & H. Van Buck

Correspondents, Louis Krohn 149 E. Isabella St. St. Paul. Dr. O.H. Beal - 20 Wabasha St. St. Paul Minn

No. for Year, 25

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing, Unknown

Form,

Accompanying Bodily Disorder, None mentioned -

Suicidal or Not, Not

Date of this Attack, August 6th 1897.

Duration, 25 days.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 66 yrs.

Time of Leaving, Oct. 5. 1897.

Time in Hospital, 1 mos. 5 d.

Result, Discharged Feb. 9. 1898 Much Improved.

EXAMINATION ON ADMISSION.

Exam by P.M. & L. Phelps 9/4/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: ~~Quick to wander from one subject to another~~

Clear or Confused, Confused

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Much Impaired

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, Somewhat Impaired

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Patient had paralysis in March which from account seems to have been a hemiplegia of slow onset & affecting one leg only. From the slow onset, it was possibly not any distinct or large haemorrhage but the impairment or plugging of some small artery near leg centre. She seems to have made quite complete recovery from Paralysis & it is denied that there was mental trouble then.

EMOTIONAL STATE:

Normal, Calm, Agitated Melancholia.

Indifferent,

Exalted,

Depressed,

DELUSIONS: Seems to have many

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Elizabeth Krohn.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken. NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, Many bruises over her body - Goitre - Umbilical hernia. Separation of rectus fem. sin.

TONGUE, Tremors, Fair furnish rdry. Coatings, Slight coat. Promptness Movement,

PUPILS, Equality, Equal. Size, Slightly dilated.

Response Light, Normal. Accommodation,

SIGHT, Cannot tell - Probably fair.

HEARING, Seems to hear well.

COORDINATION, Arms, Has had paralysis but appears strong & active now.

Legs,

TREMORS, Hands, None but keeps hands moving constantly Tongue,

Facial Muscles, General,

REFLEXES, Patellar, ?

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Atheromatous.

HEART, No murmurs.

Sounds normal

LUNGS, Chest Sym. - normal B. Sounds normal -

TAKEN,

EXAM. URINE, Sept 3/97

Color Brownish red

Character Pinkish - Copy deposit.

Amt. 24 hrs. XXXVII - 3

Sp. gr. 1027.

Reaction Acid.

Albumen Trace by Tanrets

Sugar A good test by Haines & Bismuth

Mic. Large amt. amor. urates - Pus corpuscles - Oxal - lime Bladder & vaginal cells.

GYNÆCOLOGICAL EXAM., 9/4/97 Uterus in normal position but enlarged to about size of a five months pregnancy - Seems to contain a tumor Os widely dilated. Glands on thumb. Tumor can be palpated within the os. Some tenderness in the mass by manual palpation - Laceration of perineum - Slight haemorrhoids - External genitals somewhat atrophied & dark - Complains of difficult micturition

MENSTRUATION, Menopause past.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, 60 Weak	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, No history obtainable from her -

Father or Pat. Relations,

Brothers or Sisters,

1897

This patient was brought here by Sheriffs Deputy G.H. Highley attended by her husband: in fair physical condition, except for age; with the following history:- No history of consanguinity, heredity or intemperance in parents or self: This is first attack; first symptoms manifested August 6th 1897, came on suddenly: Disease appears increasing: Not variable, no rational intervals: Came on abruptly & continues with increasing severity: Derangement manifested on no particular subject but she is constantly incoherent: Not disposed to injure others: not suicidal, filthy or destructive: No previous peculiarities noted: In March last had paralysis of left leg, after three weeks treatment recovered. Has not been confined or restrained. Has received only temporary treatment.

On personal examination no further particulars noted.

Aug 9. On admission put upon 3d Ev. Gen. Rpt. Complexion dark: Hair brown partly gray: Eyes gray: Condition of skin normal: No marks or scars: Has a small goitre: Bruises on legs & arms: Has an umbilical hernia: Is very dirty, very maniacal & violent & incoherent)

Sept. 13 Summary Nurse's 14 Day Record: Appetite very poor first few days but later took regular meals: Pulse normal: bowels usually regular: occasionally requires cathartics: did not sleep well: first night restless, & slightly noisy, talking to self: talked incoherently: Sept 3 Up & dressed: Sept 4 Quiet & more neat in habits: Sept 7 untidy in habits: Sept 8 Refuses to go out of doors: Sept 12 Refused medicine: Visited by her son: Seemed quite sensible: Slept well:

Sept. 14 Summary Nurse's Notes by Dr. L.L. Phelps: Appetite good: bowels regular: Very agreeable & quiet: takes out door exercise: reads a good deal: Sleeps well: Transf. to A': Oct 3 Had a convulsion: Transf. to Inf. Oct. 4 Very dull & quite comatose: seemed to take very little notice of anything about her: Relatives were notified: Oct 5 Husband & son came: patient very much better: Went Home.

Discharged.

Personal and Medical History of Britha Ness (or Nases)

FORSEY, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4861

Residence, Wauamings, Minn.

Date Admission, September 3rd 1897.

Admitted by Dr. P.M. Phelps Hour, 6th P.M.

How Sent, Axel Haller & J. P. Goodline & Co.

Sex, Female.

Age, 56 (says 61)

Civil Condition, Married

Children, - 7 - (Says 8)

Age Youngest Child, - 13 yrs. -

Occupation, - Farmer -

Degree Education, - Common school -

Profession Religion, - Lutheran -

Habits, Not intemperate.

Nativity, Norway - Parents Norway.

Physicians Committing, B. Jacking & Marcus Strane.

Correspondents, A. J. Ness. (Husband)
Spring Creek, Minn.

No. for Year, 28

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form,

Accompanying Bodily Disorder, Goitre Mentioned.

Suicidal or Not, Not. (Has asked her husband to shoot her.)

Date of this Attack, September 1896.

Duration, 1 year.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 55

Time of Leaving, June 15. 1898

Time in Hospital, 9 mos. 12 da.

Result, Died Pyeletis.

EXAMINATION ON ADMISSION.

Exam. by Drs P.M. & St. Phelps 9/6/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Very stubborn often resists. Sometimes violent. Very noisy & incoherent at times. Answers few questions. General health seems fair.

EMOTIONAL STATE:

Normal, Calm, At times exalted then

Indifferent, becomes quiet & depressed.

Exalted,

Depressed,

DELUSIONS: Has many delusions

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Bertha Ness.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1½ in. WEIGHT, 141 lbs NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None. Skin Normal condition.

TONGUE, Tremors, Coatings, Promptness Movement, Good.

PUPILS, Equality, Equal Size, Normal.

Response Light, – Accommodation, –

SIGHT, Uses glasses

HEARING, Seems to hear well

COORDINATION, Arms, Normal.

Legs, "

TREMORS, Hands, None. Tongue, None.

Facial Muscles, General,

REFLEXES, Patellar, ? -

Other

ARTICULATION, Normal -

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries Rather tense

HEART, No murmurs.

Strength Sounds normal.

LUNGS, Normal.

TAKEN,

EXAM. URINE, 9/7/97

Color Reddish yellow

Character Ropy deposit

Amt. 24 hrs. XVI ℥

Sp. gr. 1020

Reaction. Acid

Albumen Trace by heat & Tanrets

Sugar None

Mic. Amor. urates - Large amt. pus corpuscles. Bladder & vaginal Epith. cells. Oxal. lime - Fat globules - Uric acid crystals.

GYNÆCOLOGICAL EXAM., 9/15/97 Uterus Normal position. Hypertrophy. Erosion of os. External genitals excoriated & red. Perineum lacerated - Profuse discharge.

MENSTRUATION, Menopause past.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, 90 full	Resp., 18	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 Britha Ness

1897

This patient was brought here by P.J. Lundquist attended by Lena Lundquist in fair physical condition, with the following history:- No history of consanguinity or heredity, or intemperance in parents or self: First symptoms appeared in Sept. 96 when she became quarrelsome & talked to herself incessantly: Disease appears increasing: Is variable but no entirely rational intervals: Derangement manifested by fear of bodily injury from tramps: Not disposed to injure others: Not filthy or destructive in habits: Was melancholy previous to accession of disease: No severe disease or injury to head: Has been tied for a month: Has received no treatment. On personal examination has a high forehead: Talks very incoherently

Sept 9 On admission put upon Br. W.C.T.U. Ward. Complexion dark: Hair brown partly gray: Eyes brown: Condition of skin normal: No marks scars or bruises noted: Has vermin & is very dirty: Is extremely noisy & violent: Does not speak English.)

Sept 10 Summary Nurse's 14 Day Record:- Temp. normal: ate regular meals except 2nd day, when ate no breakfast & only a little dinner & supper: bowels regular: Inclined to be violent: Slept fairly well after 1st night: somewhat inclined to be violent: very noisy at times: incoherent in talk: very disagreeable: refuses food: refuses to go out of doors: Gym. treatment given: no work:

Oct. 5 Summary Nurse's Notes by Dr. C.A. Bebb Oct 5 Complains of stomach trouble:

Nov. 27/98 No special change: weight 150 lbs.: May 5 Complains of limbs aching: remained in bed: seemed quite weak: slight rise of temperature: refuses nourishment: expectorates some: June 2: Transferred to Inf. June 6 T. 103 2/5 to 105: P. 80 to 110: R. 130 to 135: patient lying with knees drawn up: in pain: moaning considerably: abdomen bloated: coughs some: expectoration dark in color: very nauseated: emesis: very constipated: June 7 to 13: T. 98 2/5 to 99 3/5: P. 78 to 86: R. 19: raving at times: urine very dark & cloudy: refused nourishment, therefore fed with tube several days: June 13 to 15: T. 97 4/5 to 99 3/5: P. 76 to 118: Resp. 14 to 28: seems very weak & appears to have pain in bowels: restless & moaning: nauseated: emesis: took nourishment willingly from this time on: Stimulants given: Examination of urine June 14: albumen & pus found: patient suffering: face very pale: from this time uraemic symptoms more quite marked: tendency to vomit: Dyspnoea present: occasional twitching of muscles: remained in a drowsy & comatose condition from this time until she died, June 15th at 6:15 p.m.

Autopsy held: Points of interest as follows: accumulation of fluid throughout abdominal cavity: nut-meg liver: sclerosis much more marked in kidneys: both kidneys enlarged: left very much congested: right considerably larger & full of pus cavities: Dilatation of sigmoid flexure: bowels otherwise appeared normal in structure: no obstruction apparent: Thorax not examined

Died.

Personal and Medical History of

June 15 Mrs. Ness came here and saw his wife before she died and wished us to bury her here (A.F.K.)

Personal and Medical History of Ellen Greenwood.

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4863

Residence, St. Paul, Minn.

Date Admission, September 4th 1897.

Admitted by H.H. Herzog Hour, 6.45 PM.

How Sent, Hy. Gallick Ct. Conv. Ramsey Co.

Sex, Female.

Age, -80-

Civil Condition, Widowed.

Children, 9.

Age Youngest Child, -35 yrs-

Occupation, Housewife (Husband was a Carpenter)

Degree Education, Common school.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Canada - (Parents also born there) Became resident of State & Co in 1880.

Physicians Committing, J.A. Hauten & D.F. Barton MD.

Correspondents, Ed Greenwood (Son) Dakota Av. St. Paul, Minn.

No. for Year, 30.

Insane Relatives, None.

Cause Exciting, Senility.

Cause Predisposing,

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, 5 yrs ago - following La Grippe.

Duration, 5 yrs.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 75

Time of Leaving, Jan. 30. 1899

Time in Hospital, 1 yr. 4 mo 26 d.

Result, Died.

EXAMINATION ON ADMISSION.

Exam. by D.L. Phelps 9/6/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Much impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Very illusive.

REASONING POWER:

Ordinary Subjects, Gone

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Is unaware herself in a senseless way. Very demented. Very feeble in mind. Realizes very little.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS: Seems to have many

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Very incoherent: Talks constantly & General senile atrophy of all tissues.

Personal and Medical History of Ellen Greenwood.

EXAMINATION ON ADMISSION. CONTINUED.

ELLEN GREENWOOD.

E.R. Greenwood writes: Mrs. Greenwood was always a nervous woman, had the grippe about five years ago, and kept growing worse. The last two years has not recognized any of her friends. This is all the information of value given.

HEARING, Impaired

COORDINATION, Arms, Impaired

Legs, "

TREMORS, Hands, Constant Tremor.

Facial Muscles,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, ✓ Tongue very thick - Talks easy

Hesitating, Partially paralyzed.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Strength. Sounds very mak

Pulse weak & irregular

LUNGS, Chest concave. Expansion poor. Very much stooped & round shouldered. Tubular breathing anteriorly. Mucous rales over both posteriorly.

GYNÆCOLOGICAL EXAM.,

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

Tongue,

General, Yes - Head in constant motion.

EXAM. URINE, Sept. 7-97

Color Yellowish red

Character Cloudy with flaky deposit

Quant. in hrs. XX ½

Sp. gr. 1020.

Reaction Acid.

Albumen A good test by Esbachs.

Sugar None.

Mic. Exam. Urates. Large quant. of pus corpuscles - Oxal. of lime - Vaginal & Bladder Epithe - cells.

TAKEN,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, 86 - Weak & irregular	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 Ellen Greenwood.

GIBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4863

Residence, St. Paul, Minn.

Date Admission, September 4th 1897.

Admitted by H.H. Herzog Hour, 6.45 Pm.

How Sent, Hy. Gallick Ct. Conv. Ramsey Co.

Sex, Female.

Age, -80-

Civil Condition, Widowed.

Children, 9.

Age Youngest Child, -35 yrs-

Occupation, Housewife (Husband was a Carpenter)

Degree Education, Common school.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Canada - (Parents also born there)
Became resident of State or Co in 1880.

Physicians Committing, J. A. Hanten & R. F. Paxton M.D.

Correspondents, Ed Greenwood (Son) Dakota Ave. St. Paul, Minn.

No. for Year, 30.

Insane Relatives, None.

Cause Exciting, Senility.

Cause Predisposing,

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, 5 yrs ago - following La Grippe.

Duration, 5 yrs.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 75

Time of Leaving, Jan. 30. 1899

Time in Hospital, 1 yr. 4 m. 26 d.

Result, Died.

EXAMINATION ON ADMISSION.

Exam. by D. L. Phelps 9/6/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Much impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Very illusive.

REASONING POWER:

Ordinary Subjects, Gone

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Is unaware herself in a senseless way. Very demented. Very feeble in mind. Realizes very little.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS: Seems to have many

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Very incoherent: Talks constantly & General senile atrophy of all tissues.

Personal and Medical History of Ellen Greenwood.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Hft. WEIGHT, 85 lbs NUTRITION, Impaired.

WOUNDS OR ABNORMALITIES, Umbilical hernia Skin normal condition

TONGUE, Tremors, Coatings, slight. Promptness Movement, Retracts to midright

PUPILS, Equality, Unequal. Size, Left dilated.

Response Light, Impaired Accommodation, Impaired

SIGHT, Impaired - Cataract over left pupil - Senile senilis.

HEARING, Impaired

COORDINATION, Arms, Impaired

Legs, "

TREMORS, Hands, Constant tremor. Tongue,

Facial Muscles, General, Yes - Head in constant motion.

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Tongue very thick - Talks easily

Hesitating, partially paralyzed.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Strength Sounds very weak
Pulse weak & irregular
Chest concave. Expansion poor.

LUNGS, Very much stooped & round shouldered
Inspiration breathing anteriorly. Moist rales over both posteriorly.

TAKEN,

EXAM. URINE, Sept. 7/97

Color Yellowish red

Character Cloudy with flaky deposit

Amt. in 24 hrs. XX ℥

Sp. gr. 1020.

Reaction Acid.

Albumen A good test by Tsuits.

Sugar None.

Mic. Exam. Urates. Large amt. of pus corpuscles. Oxal. of lime - Vaginal & Bladder Epith. Cells.

GYNÆCOLOGICAL EXAM.,

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, 86 - Weak & irregular	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 Ellen Greenwood.

1897.

This patient was brought here by Sheriffs Deputy Saml. Marx attended by Mrs Annie Goodrich in poor physical condition, with the following history: No knowledge concerning history of Consanguinity. No history of heredity or intemperance in parents or self: First symptoms of attack manifested 5 yrs. ago following an attack of LaGrippe: Disease appears increasing. Not variable: No rational intervals: Derangement manifested by thinking that she is being persecuted: Does not recognize her own children + relations: Not disposed to injure others: Not suicidal, filthy or destructive: Has always been very religious: No severe diseases or injury to head: Has been confined at home - locked in room a few hours at a time: Has received a course of mild sedatives; no other treatment.

On personal examination talks constantly + there is constant motion of extremities.

Sept 4 On admission put upon B⁴ W (Gt N. Rt. Complexion dark: Hair grey: Eyes brown: Condition of skin normal. No marks or scars noted: both knees bruised. Behavior very nervous + restless: Does not speak English.)

Sept. 18 Summary Thus: 14 Day Record: Appetite good: bowels regular: Temp. Pulse + Resp. normal: Slept well: quiet in behavior: Habits clean: Sept 10 Had slight convulsion during night, recorded by night watch: also had slight convulsion Sept 6. Quiet + takes out door exercise Continued by Dr. Wm. Phelps.

Oct. 7 Patient noted as having a slight fit this forenoon: Oct. 5 Had another slight Convulsive attack, fell on floor + bruised her forehead. Nov 17 Has had several slight convulsive attacks Jan'y 98 Wt. 94# Has had a good many of the slight spasmodic attacks. July 18 Trans. to Infirmary: Seems to be failing

Nov 30 Has had frequent attacks of the kind mentioned above: So at present on B'. Has to be fed. The greater part of the time is rather noisy:

Jan 26 99. Seems to be failing: Trans. to Infirmary. Jan 30 99 Died at 3:30 P.M. Failed steadily with no very marked symptoms. Died from weakness

Died

Personal and Medical History of

Personal and Medical History of Laura Gilmore

EBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4864.
Residence, St. Paul, Minn
Date Admission, Sept. 7th. 1897
Admitted by A. J. Kilbourne Hour, 6 45 p.m.
How Sent, Henry Gallick. Ct. Com. Ramsey Co.
Sex, Female
Age, 43
Civil Condition, married
Children, none
Age Youngest Child,
Occupation, House-wife (Husband Druggist)
Degree Education, Common School
Profession Religion, Methodist
Habits, Not Intemperate
Nativity, Wisconsin (Parents Penn.) Patient became resident of state + county in 1845
Physicians Committing, J. Christianson + C. E. Seggs.
Correspondents,

No. for Year, 31
Insane Relatives, None
Cause Exciting, Unknown
Cause Predisposing, Unknown
Form, Chronic Melancholia
Accompanying Bodily Disorder, none
Suicidal or Not, Not Suicidal
Date of this Attack, -
Duration,
No. of Attack, Not 1st.
No. of Admissions, 1st time (Providence Retreat Buffalo)
Age First Attack, 41.
Time of Leaving, March 15. 1900.
Time in Hospital, 2 yr. 6 m. 8 d.
Result, Died. Chronic Nephritis.

EXAMINATION ON ADMISSION.

Exam. by P.M. + A.L. Phelps 9/9/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Seems confused.
Quick or Sluggish,
MEMORY:
Past Events, Cannot determine
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS: Probably has delusions
Systematized or Not, but more determined.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Melancholy answers
Coherent or Incoherent, very few questions.
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Very reticent, melancholy. Talks very little. Answers but few questions. General health seems impaired: Rather thin + emaciated.

Personal and Medical History of Laura Gilmore.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Impaired a little Anaemic
WOUNDS OR ABNORMALITIES, None. Skin somewhat dry.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Accommodation,
SIGHT,
HEARING, Impaired
COORDINATION, Arms, Normal.
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, ✓
Other
ARTICULATION,
Slurred, Normal
Hesitating,
FACIAL EXPRESSION,

SENSIBILITY,
Arteries Slightly Atheromatous.
HEART, No Murmurs.
Sounds fairly good. Regular
LUNGS, Bronchial breathing upper part of left lung.
TAKEN,

EXAM. URINE, 9/1/97
Color Yellowish red.
Character Cloudy.
Amt. 24 hrs. XVIII oz
Reaction Acid
Albumen By all tests
Sugar None.
Mic. Large amt. pus + blood Corpuscles. Fat globules. Epith. cells. Uric acid crystals. a few casts

GYNÆCOLOGICAL EXAM., Extensive laceration of perineum. Lateral laceration of cervix. Uterus retroflexed.
MENSTRUATION, History cannot be obtained.
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, Gradual 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 Laura Gilmore

1897

This patient was brought here by Sheriffs Deputy Mieson attended by W.G. Gilmore (patients husband) in fair physical condition, with the following history: No history of heredity or intemperance in parents or self: no knowledge concerning history of consanguinity: First attack occured two years ago when patient was confined in Providence Retreat, Buffalo. Disease appears in creasing variable, with irregular rational intervals: Derangement manifested by hallucinations of hearing & vision: Patient has shown no disposition to injure others: Is not suicidal, not filthy or destructive: Has always been hysterical: no severe disease or injury to head: Has been confined for 7 months. Received Post Cure. On personal examination no further particulars noted.

Sept 7. On admission put upon 13' W. (G. H. R. Pts) Hair brown, eyes blue, condition of skin normal: breath: behavior quiet: Refused to talk.

Sept 8. Summary Nurse's 14 Day Record: Appetite not very good: part of time required feeding with spoon: bowels constipated: requires catheterizing also: has many delusions: Quiet on admission & stupid: Sept. 10 Became quite disturbed: undressed herself if not watched: slept only five hours: Sept 12 was quite violent in night: would not stay in bed: threatened to kill room mate: was put in seclusion: Sept. 13 Pauls T. B.: untidy in appearance: did not sleep well: used profane language: disturbed by many delusions: bowels constipated: refused tonic: eats when fed with a spoon. appetite not very good.

Sept 23 Second examination urine. Color reddish yellow, character cloudy with ropy deposit, Specific gravity 1022. Reaction acid - Albumen. Trace only by Tanrets - Sugar absent. Mic. examination of sediment - Excess amor. urates - a few bladder & vaginal cells - pus, & fat globules. Continued by Dr. W.M. Phelps. Nov 8 '97 Temp. to 6th. Has been struggling & fighting & quite thoroughly demented ever since coming here, but has been fairly quiet until recently Dec 25 Visited by husband.

Feb 28 Wt. 95. Apr 19 Has been in restraint some. Is rather actively troublesome & tries to injure herself. July 4 Visited by husband Aug 23 Visited by husband: Oct 19 Visited by friend: Nov 17 Do. Nov 25 Feet have been somewhat swollen of late: In general condition & behavior, however, there has been no change.

Feb 28 98. No change. Mch 1 - Aug 31 99 Cont. by Dr. Bebb. Physical condition much impaired. Appetite poor, is fed from tray by nurse. Sleeps well: Frequently has diarrhoea & is very restless & quite noisy: Strikes & pounds body & usually has bruises on face, also frequently strikes other patients without provocation. Habits filthy, is extremely destructive. May 23 Choked while at dinner, fell & bruised nose & eye

July 6 Again choked while eating. Takes out door exercise June 9 & 17 Visited by husband

Sept 1 - Feb 28 1900. (Dr. Heyerdale) Very restless & destructive: Strikes herself is very untidy. Noisy at times day & night. Appetite fairly good.

Personal and Medical History of

Fed by nurse: Rarely takes out door exercise: Nov. 9 Very restless: put in restraint to prevent injuring himself. Nov. 14 Large bed sore on back. Taken out of restraint. Nov. 30 Still has bed sore: dressed daily.

Dec. 8. Very restless & troublesome: Struck by Clara Roberts: nose bled.

Dec 14. Struck on head by Clara Roberts. Trans. to 3rd. Feb 26. Patient choked on piece of meat. almost asphyxiated. Feb 28. Gradually failing feet swollen: eruption on limbs. Bed sore still remains.

Mch 1 - Mch 15 1900 (Dr. Heyerdale) Mch 11. Gradually failed: bed sore dressed several times daily: Odor very bad - Transferred to Infirmary.

Mch 15 Died at 10:50 PM. of Tuberculosis of the lungs.

Died.

Bro. Note: Mar. 13-1901

Mr. Gilmore visited his wife today having been notified that she was in a critical condition. On being questioned states that this attack was first noticed four or five months before she come to this hospital. She complained constantly of headache on the top of her head and of increasing nervousness. States that he knows of no heredity in her family, it may be farther back. The cause of her trouble has been that of paresis, and upon questioning him we find that the commencement of her troubles she thought she was Queen of England., had loss of memory. States that she had been married twice that she had been a widow several years when he married her. States as far as he knew first husband was a good man. No history of syphilitic infection & no positive evidence that there was any.

Personal and Medical History of Annie Barnes.

EGBERT, FOLEY & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4867

Residence, St. Paul, Minn

Date Admission, Sept. 10th. 1897

Admitted by A. F. Kilbourne Hour, 6 45 p.m.

How Sent, Henry Gallick, Ct. Com. Ramsey Co.

Sex, Female

Age, About 40

Civil Condition, Single

Children, none

Age Youngest Child, —

Occupation, House-work

Degree Education, not Educated

Profession Religion, not a church member

Habits, Intemperate

Nativity, Norway - (Patients parents also). Resident of State & County 10 years.

Physicians Committing, J. M. Finnell & John F. Baden

Correspondents,

No. for Year, 34

Insane Relatives, not known

Cause Exciting, not known

Cause Predisposing, not known

Form, Mania acuta

Accompanying Bodily Disorder, none

Suicidal or Not,

Date of this Attack, Sept. 8. 1897

Duration,

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, About 40

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by A. L. Phelps Sept 16 '97

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Seems good.

Recent Events, Good.

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive as regards herself.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects, Impaired

GENERAL DESCRIPTIVE REMARKS: Talks very willingly & freely. Thinks she is imposed upon by people that want to kill her. Says she is all right & not crazy. While talking gets quite excited at times. General health seems good aside from uterine trouble.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS: Thinks people are going to kill her.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Annie Barnes.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. WEIGHT, 145 lbs. NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None. Skin - normal condition

TONGUE, Tremors, pale - Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Normal Accommodation, Normal.

SIGHT, Near sighted.

HEARING, Normal.

COORDINATION, Arms, Normal

Legs,

TREMORS, Hands, Some. Tongue,

Facial Muscles, None. General, None.

REFLEXES, Patellar, Both 8

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY, ~~No Disturbance~~

~~Sounds a little Weak.~~

HEART, No murmurs. Sounds a little Weak -

Chest Symm. Normal. Very full chest.

LUNGS, Expansion good. Sounds normal

TAKEN,

EXAM. URINE, Sept. 13/97

Color Brownish red

Character. Cloudy with flaky deposit

Amt. 24 hrs. XXII ℥

Sp. gr. 1027.

Reaction. Acid

Albumen By all tests

Sugar None.

Mic. Epith. cells - oxal. lime crystals - pus corpuscles - fat globules - amor. urates - uric acid crystals.

GYNÆCOLOGICAL EXAM., 9/15/97 Uterus retroverted - Some adhesions on left side - Some erosion of os. Endometritis - External genitals red & excoriated.

MENSTRUATION, Regular. Some pain at times.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular, ✓

PULSE, 100. Weak & somewhat irregular Resp., Normal - Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Drinks some whiskey at times: Has scar of an operation on back.

LENGTH OF INVASION, Short ONSET GRADUAL OR SUDDEN, Sudden

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

Mother or Mat. Relations, Very delicate always - Dead -

Father or Pat. Relations, Healthy

Brothers or Sisters, 5 all living

Personal and Medical History of Annie Bernes

1897

This patient was brought by Sheriff's Deputy Missen attended by Mrs. Franklind in fair physical condition with the following history: No knowledge of history of consanguinity or heredity: First symptoms occured Sept. 8. 1897. Disease appears to be stationary with irregular rational intervals. Derangement now manifested by ideas of persecution. Believing food to be poisoned & by hallucinations & delusions: Has shown disposition to injure others: Is not suicidal, not filthy or destructive: no history of previous peculiarities: Patient Intemperate: Has been confined in County jail 2 days: Has received no treatment: Nothing known as to severe diseases or injury to head:

On personal examination- Has hallucinations & delusions, thinks someone is trying to poison her: Removes clothing.

Sept. 10 On Admission put upon B[r] (Q.H.T. Rx) Complexion dark: Hair brown: Eyes gray: condition of skin normal: Scar on right side of back, left arm bruised: clean: very talkative & extremely noisy at times: Has delusions)

Sept. 23 Summary Nurse's 14 Day Record: Appetite poor on admission but improved: Very restless at night: usually noisy when awake: very disagreeable: inclined to be abusive to other patients & at times violent: talks incoherently: bowels regular: seldom sleeps more than five hours: Temp. 99. on Sept. 12. Does no work. Continued by Dr. Wm. Phelps. Patient rather untidy in appearance sleeps poorly. Is rather noisy & destructive. Nov 28 Patient fainted at breakfast time: was nauseated. Feb 98 Wt. 153½ lbs. May 2 Patient fell on floor, was unconscious for a short time. Nov 7 Working in laundry. Dec 23 Health seems as good as usual. Is working in laundry & is becoming quite fleshy & her facial appearance suggests heart weakness

Jan 1- Aug 31. 99 Cont by Dr Bros. Physical health fairly good. Is neat & usually quiet & agreeable when not mentally disturbed. Has delusions: Works in laundry. Mch 31 to May 99 Complained of feeling sick & taken home from laundry. Pain in abdomen & emesis: pulse rapid. Temp. slightly elevated. Aug 18 Wt. 118 lbs.

Sept 1- Feb 28 1900 (Dr Heyerdale) Works in laundry: Does not talk: Appetite good: Health good & Takes outdoor exercise: Neat in appearance & habits: Menstruates regularly. Jan 2 Wt 159 lbs

Mch 1- Nov 30 1900 Neat, quiet & agreeable: Answers questions: Talks quite sensibly but does not converse unless addressed. Appetite good: Sleeps well: Goes riding. July 23 Vaccinated. Nov 24 - Wt. 149 lbs. Still works in laundry. Dec 1- Feb 28 1901 Appetite very good: Sleeps well: General health good. Takes outdoor exercise: Assists with laundry work. Quiet & agreeable: Does not converse Mch 4 Wt 143.

Mar 1- June 1- 1901 Assists in laundry: no change in mental or physical condition. May 31. Wt. 139½ #. June to Sept. Assists with work in the laundry takes exercise, Sept. 1st. Wt. 149 #. Sept. to Dec. Weight not taken

Personal and Medical History of Annie Bernes

1901

in November, no change during quarter.

Up to Feb. 1, 1903. Appetite good: bowels regular: sleeps well: exercises: attends no amusements: assists in the laundry no untidy in appearance: somewhat unclean in habits. Dec. 1st. Wt. 146 #

Personal and Medical History of Mary Lofgren

GOSSETT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4869

Residence, St Paul, Minn

Date Admission, Sept. 11. 1897.

Admitted by A J Kilbourne Hour, 6⁴⁵ p.m.

How Sent, Henry Gallick Bff Com. Ramsey Co.

Sex, Female

Age, 39

Civil Condition, married

Children, Two

Age Youngest Child, 4 years

Occupation, Housewife (Husband Grocery Clerk)

Degree Education, Common School

Profession Religion, Baptist

Habits, Not Intemperate

Nativity, Denmark. (Mother Denmark Father Germany) (Has resided in State + County since 1873)

Physicians Committing, John B. Burnhall + Alof Lokkeberg

Correspondents,

No. for Year, 36

Insane Relatives, none

Cause Exciting, unknown

Cause Predisposing, unknown

Form, Mania Chronica

Accompanying Bodily Disorder,

Suicidal or Not, Not Suicidal

Date of this Attack, 1894

Duration,

No. of Attack, Not 1st.

No. of Admissions, 2nd.

Age First Attack, 26 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. by D L Phillips 9/15/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Fair.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Talks very freely. Is infatuated with the same man as when here before. Has given up husband + children to follow him.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not,

Special Subjects, About a man who lives near

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Notice of hearing petition for appointment of John Lofgren as guardian for Mary Lofgren, insane - recd - Nov. 97

Filed with commitment papers.

ary Lofgren.

. Lofgren was very
After a while she
enced to think
tached, and com-
menced following him. Commenced to work in a factory, leaving her home.
Complained of the girls in the factory making fun of her and acted very
strange. Then went to live with her parents. Was abusive and trouble-
some to them, and finally had to be recommitted.

INE, Sept 15

Character	Light Flaky sediment
Amt. in 24 hrs.	XXV
Sp. gr.	1025
Reaction	Slightly acid
Albumen	None
Sugar	None
Microscop.	—

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No Murmurs. Sounds Normal. Apex beat full + displaced downward + toward Left.

LUNGS, Expans good - Sounds Normal

TAKEN,

GYNÆCOLOGICAL EXAM., 9/15/97 Uterus retroverted: Cervix Lacerated: Slight Laceration of Perineum.

MENSTRUATION, Regular

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good,	Medium, ✓	Poor,
SLEEP, Good,	Poor, ✓ Restless + Wakeful.	Irregular,
PULSE, 74 full + regular	Resp., 16	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Mary Lofgr

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4869

Residence, St Paul, Minn

Date Admission, Sept. 11. 1897.

Admitted by A J Kilbourne Hour, 6 45 p m.

How Sent, Henry Gallick Cst Com. Ramsey Co.

Sex, Female

Age, 39

Civil Condition, married

Children, Two

Age Youngest Child, 4 years

Occupation, Housewife (Husband Grocery Clerk)

Degree Education, Common School

Profession Religion, Baptist

Habits, Not Intemperate

Nativity, Denmark. (Mother Denmark Father Germany) Has resided in State + County since 1872

Physicians Committing, John B. Burnhall + Olof Sahlberg

Correspondents,

No. for Year, 36

Insane Relatives, none

Cause Exciting, unknown

Cause Predisposing, unknown

Form, Mania Chronica

Accompanying Bodily Disorder,

Suicidal or Not, Not Suicidal

Date of this Attack, 1894

Duration,

No. of Attack, Not 1st

No. of Admissions, 2nd.

Age First Attack, 26 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by A L Childs 9/15/97

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Fair.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Talks very freely. Same man as when here before. Has given up husband & children to follow him.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not,

Special Subjects, About a man who lives near

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

ersonal and Medical History of Mary Lofgren.

MARY LOFGREN.

Mr. E. P. Strom writes:- On first going home Mrs. Lofgren was very excited, so much so that they had to tie her in bed. After a while she quieted down and kept house for a while, until she commenced to think that one particular man was the one to whom she was attached, and commenced following him. Commenced to work in a factory, leaving her home. Complained of the girls in the factory making fun of her and acted very strange. Then went to live with her parents. Was abusive and troublesome to them, and finally had to be recommitted.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

...od.

...INE, Sept 15

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No Murmurs. Sounds Normal. Apex beat full + displaced downward + forward slight.

LUNGS, Expans good - Sounds Normal

TAKEN,

Character Light flaky sediment

Amt. in 5 hrs. XXV

Sp. gr. 1025

Reaction Slightly acid

Albumen None

Sugar None

Microscop. —

GYNÆCOLOGICAL EXAM., 9/15/97 Uterus retroverted: Cervix lacerated: Slight laceration of perineum.

MENSTRUATION, Regular

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good,	Medium, ✓	Poor,
SLEEP, Good,	Poor, ✓ Restless + wakeful.	Irregular,
PULSE, 74 full + regular	Resp., 16	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of W...

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4869
Residence, St Paul, Minn
Date Admission, Sept. 11. 1897.
Admitted by A J Kilbourne Hour, 6⁴⁵ p.m.
How Sent, Henry Gallick Bd Com. Ramsey Co.
Sex, Female
Age, 29
Civil Condition, married
Children, Two
Age Youngest Child, 4 years
Occupation, Housework (Husband Grocery Clerk)
Degree Education, Common School
Profession Religion, Baptist
Habits, Not Intemperate
Nativity, Denmark. (Mother Denmark Father Germany) (Has resided in State + County since 1872)
Physicians Committing, John B. Burnhall + Olof Sahlberg
Correspondents,

No. I...
Insane I...
Cause Exc...
Cause Predisp...
Form, Insan...
Accompanying Boo...
Suicidal or Not,
Date of this Attack,
Duration,
No. of Attack, Not 1
No. of Admissions, 2nd.
Age First Attack, 26 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by D L Phillips 9/15/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish,
MEMORY:
Past Events, Fair.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Talks very freely. Is infatuated with the same man as when I saw before. Has given up Husband + Children to follow him.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS:
Systematized or Not,
Special Subjects, About a man who lives near
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

...rsonal and Medical History of Mary Loftgren.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 6 in. WEIGHT, 132 lbs. NUTRITION, Good.
WOUNDS OR ABNORMALITIES, None
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Normal. Accommodation, Normal.
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms, Normal.
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Both Normal.
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds Normal. Apex beat full + displaced downward + toward left.
LUNGS, Expans good - Sounds Normal

TAKEN,

EXAM. URINE, Sept 15
Color Yellow.
Character Light flaky sediment
Amt. in hrs. XIV
Sp. gr. 1025
Reaction Slightly acid
Albumen None
Sugar None
Microscop. —

GYNÆCOLOGICAL EXAM., 9/15/97 Uterus retroverted: Cervix lacerated: Slight laceration of perineum.
MENSTRUATION, Regular
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good,	Medium, ✓	Poor,
SLEEP, Good,	Poor, ✓ Restless + wakeful	Irregular,
PULSE, 74 full + regular	Resp., 16	Temp.,

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

Personal and Medical History of Mary Lofgren

1894

This patient was brought here by Sheriff's Deputy Marcin, attended by Miss Bariveau, in good physical condition, with the following history: No history of consanguinity, heredity or intemperance in parents or self. First attack occurred in 1894 when patient was in this (Rochester) Hospital from Nov 1st '94 to July 7th '95 (for further particulars see Vol. 26 Fol. 367 No. 3895) First symptoms of present attack occurred in 1894, patient lost all love for home life & became infatuated with another man. Disease appears stationary, not variable & with no rational intervals. Derangement now manifested by patient being insanely in love with another man; cares for nothing but his company; Has shown no disposition to injure others; is not suicidal; not filthy or destructive; no history of previous peculiarities; no severe disease or head injury; Has been confined in Hospital as above; received treatment but made no improvement.
On personal examination: general appearance good but becomes intensely excited at the sight of the man she is in love with.

Sept 11. On Admission put upon B[d] G H N Apt Complexion dark; Hair brown; eyes brown; Condition of skin, normal, no remarks, scars or bruises noticed; Clean, behavior quiet; Has delusions)

Sept 24 Summary Nurse's Notes by Dr L. L. Phelps (14 Day Record):- Appetite good; took regular meals each day; bowels regular. Temp. normal; slept well; second day up & dressed & about the ward; quiet & agreeable; given tours after meals; talked quite sensibly aside from her delusive ideas; read a good deal.

Sept 28 Urine analysis. 1 Clinical. Color yellow - Character clear with ropy deposit. S.G. 1012 - Reaction acid. Albumen trace only by Tsuretz - Sugar absent. & Microscopical - excess amor. urates. excess blood & pus corpuscles - a few epith cells & uric acid crystals. Continued by Dr. W. Phelps. Nov 29 Refuses medicine. Is quite obstinate & very uncertain in behavior. Broke one of the glass transoms without cause. Jan 31 '98 Trans. to Annex. Very silly in behavior. Feb 14 '98 Tried to escape by jumping from the window; Trans. to D[r] Aug 6 Wt. 140[#]. Sept 16 Still rather silly. Trans. to C[3]. Feb 29 '99 Much quieter in behavior of late, but still silly. Mch 1 - Aug 31 '99 Cont. by Dr Bell. General health good. Seldom takes outdoor exercise. Is rather silly at times. Talks to herself & expresses many delusions. Menst. regular. Is at times exceedingly disagreeable at others assists on ward & attends amusements. On april 26 threw herself on floor expressing desire to die. Has been much infatuated with Mrs Miller & annoyed her so much that patient was transferred to C[3]. May 16 & 17 escaped when door was open, returned. June 29. Again attempted to escape. July 3 Visited by friend. Is a little more cheerful & talkative than she was a few months ago. Sept 1 - Feb 28 '1900 (Dr Heyerdahl) Expresses many delusions. Very disagreeable also rather silly. Talks to herself. Rarely takes outdoor exercise. Dec. 29 Struck Mrs. Lind. No injury.

Personal and Medical History of Mary Lofgren.

Menstruates regularly. Jan 15 Wt. 143[#]. Mch 1 - Nov 30 1900 Habits neat, but occasionally careless in appearance; Expresses many delusions; Sometimes violent in behavior; Reads much of time; Very stubborn & resistive; Sometimes refuses meals; Appetite good; bowels regular. Takes outdoor exercise; menstruates regularly; Mch 25 Became violent in dining room & attempted to throw dishes. Apr. 28 Fought nurses. July 21 Vaccinated - July 26 Fought nurses. Has delusions - thinks a shoemaker in St Paul hypnotizes her. Reads a great deal. Nov 16 Wt. 143[#].

Dec 1 - Feb 28 1901 - General health good; will not answer questions; Keeps by herself most of time; Does not attend amusements. Wt 135[#].

Mar 1 - June 1 - 1901 Does no work; menstruates regularly. May 30 Wt. 137[#]

June to Sept. June 23. menstruating, takes out door exercise, does no work, attends no amusements, June 25 when taken out on the lawn in the afternoon escaped was not returned until Wednesday, June 26 at 9:00 A.M, trans. to 1 West. Sept. 2 Wt. 143[#]. Sept. to Dec No change Nov. 30 Wt. 146[#].

1 Yr to Feb. 1, 1903. Appetite good; sleeps well; bowels regular; menstruates regularly; exercises; attends chapel; assists with the work; also makes rugs; is usually agreeable; somewhat delusional; answers questions readily; is not now so violent as formerly. Very much improved mentally. Nov. 29 Wt. 136#

Personal and Medical History of Mary Pullis

Whole No. 4871
Residence, St. Paul, Minn
Date Admission, Sept. 14th. 1897
Admitted by R. W. Phelps Hour, 6 45 p.m
How Sent, Henry Gaelick. Ct. Com. Ramsey Co.
Sex, Female
Age, 28
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Domestic
Degree Education, Reads & writes German
Profession Religion, Roman Catholic
Habits, Patient likes alcohol.
Nativity, Germany (parents also)
Has resided in State & County eight years.
Physicians Committing,
Correspondents, Uncle - Mr Grimm

No. for Year, 38
Insane Relatives, not known.
Cause Exciting, unknown
Cause Predisposing, unknown
Form, Mania Chronic -
Accompanying Bodily Disorder,
Suicidal or Not, not suicidal
Date of this Attack, One year ago
Duration,
No. of Attack, 1 st
No. of Admissions, 1 st
Age First Attack, 27.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam by R. W. Phelps Sept 15 '97 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused -
Quick or Sluggish,
MEMORY:
Past Events, Seems impaired.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive.
REASONING POWER:
Ordinary Subjects, Impaired.
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Talks willingly. Seems quite confused at times. Talks quite sensibly about some things: General health is good.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Somewhat exalted.
Depressed,
DELUSIONS: Many & varied.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Mary Pullis

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1 in. WEIGHT, 119 lbs. NUTRITION, Good.
WOUNDS OR ABNORMALITIES, None. Condition of skin Normal.
TONGUE, Tremors, Coatings, White coat. Promptness Movement,
PUPILS, Equality, Left slightly dilated. Size,
Response Light, Accommodation,
SIGHT, Good.
HEARING, Normal.
COORDINATION, Arms, Normal.
Legs, Normal.
TREMORS, Hands, None. Tongue, None
Facial Muscles, Some twitching in muscles of right Eye. General,
REFLEXES, Patellar, Normal.
Other
ARTICULATION, Normal
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries Normal.
HEART, No Murmurs. Sounds normal.
LUNGS, Chest open. normal. Expansion good. R. Sounds rather shallow.

TAKEN,

Sept 17. EXAM. URINE,
Color Brownish red.
Character Cloudy.
Amt. 24 hrs. XXXVI
Sp. gr. 10 30
Reaction Acid.
Albumen none --
Sugar absent.
Microscop. amorphous: excess oxalate lime crystals - Excess bladder & vag. Epith. cells & uric acid crystals.

GYNÆCOLOGICAL EXAM., External genitals normal - uterus normal position, hymen lax. offensive chocolate colored discharge.
MENSTRUATION, Says regular & free from pain - but statements not reliable.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE, Rate 76 - Regular	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Died after childbirth 8 yrs. ago.
Father or Pat. Relations, Farmer Well
Brothers or Sisters, 3 bros. 2 sisters

Personal and Medical History of Mary Pullis

1877

This patient was brought here by Sheriff's Deputy P. J. Nissen, attended by Miss Augustine, in fair physical condition with the following history: No knowledge of history of consanguinity or heredity: This is first attack: First symptoms manifested one year since when patient became eccentric: Disease appears to be increasing: not variable & with no rational intervals: Derangement now manifested by religious hallucinations: Has shown no disposition & injure others: Is not suicidal: not filthy or destructive: no previous peculiarities: Patient likes alcohol: No severe disease or head injury: Has not been confined or restrained: Has received no treatment: On personal examination: Talks incessantly & incoherently, especially relating to the Holy Ghost.

Sept. 14 On Admission put upon B.2. (G.H.N.Rpt:- Complexion dark: Hair brown: eyes blue: condition of skin normal: no marks, scars bruises &c. noticed. Clean: Behavior quiet: Does not speak much English.)

Sept. 27 Summary Nurse's Notes (14 Day Record):- Temp normal: took regular meals each day: tonic after meals: Slept well: bowels regular: Sept 17 Up & dressed on ward: assisted with dining room work: Quite talkative: laughs & smiles a good deal: rather incoherent & has delusions. takes out door exercise Continued by Dr. W.M. Phelps. Nov 14'99 Patient agreable in behavior: Works some in the congregate dining room: Is rather deluded & incoherent & silly. Talks & laughs to herself.

Dec 14'98 Intervening notes show no change of importance.

Jan 1-99- Aug 3'99 Cont. by Dr Bibb: General health fairly good: Sleeps well: Refuses to take outdoor exercise: Assists in employes dining room: Is neat in habits: Talks & scolds almost incessantly to herself & is very incoherent & is occasionally violent & usually boisterous without cause: Is quite irritable at times.

Sept 1- Feb 28 1900. (Dr. Heyerdale) Nov 29. Disagreeable: Occasionally strikes nurses: Appetite good: Health good: Takes out door exercise Very talkative. Dec. 28 Attempted to strike nurse when bathed. Jan 1 Wt. 114 #. March 1- Nov 30 1900 Neat: Bowels regular: Assists with ward work: Takes out door exercise: Usually agreable: May 15 Sometimes quite disagreeable & scolds. June 15 Attacked nurses. July 21 Vaccinated. Nov. 21 114½ #. Dec 1- Feb 28 1901. General health good: Feb 21. Wt. 108 #.

Mar. to June 1901 No change in mental or physical condition, May 28 Wt. 111 #.

June to Sept. Patient's general condition shows no change Aug. 29 #107.

Sept to Dec. Neat in habits and appearance, appetite good, bowels regular, refuses out of door exercise, assists with ward work, at times becomes very much disturbed and excited mentally, Nov. 30 Wt. 107.

Personal and Medical History of Mary Pullis.

Up to Feb. 1, 1903. Appetite good: sleeps well as a rule: bowels regular: takes exercise: does no work: rather untidy in appearance: is very incoherent in speech: never converses rationally: refuses laughs and talks to herself a great deal: is at times violent. Wt. Dec. 1st. 104 #.

Personal and Medical History of Matilda Lachinski.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4874
Residence, St. Paul, Minn.
Date Admission, September 17 1897.
Admitted by Dr. D. L. Phelps Hour, 7:20 P.M.
How Sent, by Gallick Ext. Com. Ramsey Co.
Sex, - Female -
Age, - 22 yrs. -
Civil Condition, - Single -
Children, - None -
Age Youngest Child, —
Occupation, "Working girl" (Father Laborer)
Degree Education, Common school.
Profession Religion, Catholic.
Habits, Not intemperate.
Nativity, Russia. Parents also born there. Became resident of State 10 yrs. ago.
Physicians Committing, Talbot Jones. 2nd. A. Nicuggo.
Correspondents,

No. for Year, 41.
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, "
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, mm
Duration, —
No. of Attack, 2nd (First occurred 6 yrs. ago. lasted 5 mo.
No. of Admissions, 1st
Age First Attack, 18.
Time of Leaving, February 5' 1898
Time in Hospital, 6 mos. 2/3 da
Result, Discharged Aug. 10. 1898
Improved.

EXAMINATION ON ADMISSION.

Exam. by Dr. Phelps 9/19/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused -
Quick or Sluggish, Very sluggish.
MEMORY:
Past Events, Probably impaired.
Recent Events, Recalls slowly but seems fairly correct.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Partly correct.
REASONING POWER:
Ordinary Subjects, Much impaired.
Own Mental State,
Special Subjects,

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

GENERAL DESCRIPTIVE REMARKS: Mind acts very slowly. Answers in a very deliberate manner. Seems to recall with great difficulty. Quite sluggish. General physical condition impaired. Anaemic & rather thin.

Personal and Medical History of Matilda Lachinski.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1½ in. WEIGHT, 120 lbs. NUTRITION, Impaired - Anaemic.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size, Normal
Response Light, Normal Accommodation, Normal.
SIGHT, Seems good.
HEARING, Says good.
COORDINATION, Arms, Normal.
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, General,
REFLEXES, Patellar, Very much
~~Other~~ Impaired in both.
ARTICULATION,
Slurred, Very slow to answer.
Hesitating, Hesitates.
FACIAL EXPRESSION,
SENSIBILITY,
Arteries normal.
HEART, No murmurs. Heart sounds transmitted over whole chest
LUNGS,
GYNÆCOLOGICAL EXAM.,
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

Sept 20/97 EXAM. URINE,
Color Reddish yellow
Character Cloudy
Amt. 24 hrs. XXV oz.
Sp. gr. 1020
Reaction acid.
Albumen absent
Sugar "
Microscop. Excess Amor. urates. a few Rodium urate, some pus & excess of oxalate of lime crystals

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, ✓ Constipated, Irregular,
APPETITE, Good, Medium, Poor, ✓
SLEEP, Good, ✓ Poor, Irregular,
PULSE, 90. irregular Resp., 30 - Rather shallow. Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL, Says she was sick when a child. Was in City Hospital St Paul, 8 yrs. ago. Has had a tired feeling for yrs.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, living, but sickly - Has cramps a good deal.
Father or Pat. Relations, living, healthy
2 Brothers or 3 Sisters, 2 brothers healthy. One sister older is sickly - Says she has asthma.

Personal and Medical History of Matilda Lachinski.

1897

This patient was brought here by Sheriff Deputy P. J. Mison attended by Miss Finn, in fair physical condition, with the following history:- No history of consanguinity, heredity or intemperance in parents or self. First attack occurred six years ago & lasted five months. First symptoms manifested by religious delusions. Patient not disposed to injure others: not suicidal. So filthy & destructive in habits. Manifested previous peculiarities, no information given as to nature of them. No severe diseases or injury to head. Has not been confined or restrained. Has received no treatment. On personal examination exhibits religious delusions.

Sept. 17/97 On admission put upon B. W. (G.H.U. Apt. Complexion dark: hair brown: eyes gray. Condition of skin normal. No marks, scars or eruptions noticed. Small bruise on left knee. Is clean. Behavior quiet. Talks sensibly but is absent minded.

Sept 20 Summary Nurse's 14 Day Record:- Temp. Pulse & Resp. normal on admission Sept. 19 Pulse rather slow. Temp below normal. Ate rather poorly. Took no solid food. Sept. 20 Temp. P. & Resp. about normal. Slept fairly well. up & dressed. Sept. 21: cathartics given. bowels did not move. Quite noisy, praying aloud. Sept. 25 Cathartics given. bowels moved. pulse mischievous. Sept. 24 Noisy at times. requires feeding by nurse. Sept. 25 = Inclined to be violent. bowels moved. Sept. 26 Very silly in actions. Slept quite well. Sept. 27 Appetite improving but refuses to feed herself. Sept. 28 Quite erratic. sings a good deal & prays part of time aloud. At times stubborn: at other times silly. will occasionally feed herself. Continued by Dr. P. M. Phelps. Nov 2 Trans. to A2. Has been rather troublesome in behavior but fairly neat in appearance. Works some in the sewing room. Feb 5 98 Went home on trial when visited by sister. Still had many delusive ideas but fairly good disposition & behavior.

Discharged.

Personal and Medical History of

Personal and Medical History of Celestia C. Warner.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4878	No. for Year, 45
Residence, Milton, Dodge Co. Wisc.	Insane Relatives, Yes - (no further information given)
Date Admission, September 22' 99	Cause Exciting, "Religion"
Admitted by Dr H.H. Herzog Hour, 1 P.M.	Cause Predisposing, -
How Sent, Saint Cloon & Sup't Dodge Co.	Form,
Sex, Female.	Accompanying Bodily Disorder, None mentioned.
Age, - 54 -	Suicidal or Not, Not.
Civil Condition, - married -	Date of this Attack, 10 yrs ago.
Children, - 2 -	Duration, 10 yrs (?)
Age Youngest Child, 24	No. of Attack, 1st
Occupation, - Housewife -	No. of Admissions, 1st
Degree Education, Common school.	Age First Attack, 44
Profession Religion, Congregationalist.	Time of Leaving, Apr. 9. 1900
Habits, Not intemperate.	Time in Hospital, 6 m. 18 d.
Nativity, N. Y. (Father Ireland, Mother Pa.)	Result, Discharged Aug. 10. 1898 Improved
Physicians Committing, J.H. Vancleve, O.O. Wright.	
Correspondents, C.C. Warner, (Husband) Mantorville, Minn.	

EXAMINATION ON ADMISSION.

Exam by Rev. + Al. Phelps.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:	EMOTIONAL STATE:
Clear or Confused, Confused	Normal, Calm,
Quick or Sluggish, Sluggish	Indifferent, Rather.
MEMORY:	Exalted,
Past Events, Seems impaired.	Depressed,
Recent Events,	DELUSIONS: Has many -
Special Subjects,	Systematized or Not,
PERCEPTIVITY:	Special Subjects, Mostly on religion
Alert or Dull,	Transitory or Not,
Correct or Illusive, Illusive	HALLUCINATIONS:
REASONING POWER:	ILLUSIONS:
Ordinary Subjects, Much impaired	CONVERSATION:
Own Mental State,	Coherent or Incoherent,
Special Subjects,	Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient lies in bed. Talks quite freely tho occasionally is quite vague in answers. Says was brought here because she would not keep moving from one of the children to the other. Says she finally went to "Farm" + said she would not move again + they had her brought down here. Is quite careless + indifferent. Altho she mentioned no delusions she expressed some vague ideas such as that her headaches were "mortal putting on mortality"

Personal and Medical History of [illegible] Warner.

REGARDING MRS. CELESTIA WARNER.

(From conversation with her husband and daughter. Oct. 30th, 1897.)

It is about ten or twelve years since she commenced being different from what she had been. About eight years ago she became quite violent, that is, was not herself at all, and that lasted for two or three years. It had been coming on gradually,- hard to tell just when. First thing different from what she had been which was noticed by her family was that she commenced feeling jealous. At the time she became violent (Seven or eight years ago) her husband was away from home and her daughters were afraid of her. Of late years this has run into religion. She thinks that she is the second Christ and whatever she is told to do she has to do, and that idea has been growing on her for the past few years. For several years she thought her family were attempting to poison her and take her life in that way, but she finally gave up that idea and took this religious turn of mind. The reason she was committed here was that her friends feared that she would feel called upon to take someone's life, or would injure her daughters. She had always felt that anything her daughters did was about right, especially the younger one. She had lived part of the time at home and part of the time with each of her two daughters, just as she chose, for the past two years. The last letter which she wrote home from here was different from former ones. Much more sensible. Said she would stay here if they wished her to do so, if not, she would ask to leave. Spoke of electric lights, etc. Her moods change however. Then she wanted her daughter to come and see her; today she might not care to see her: Her mother had been insane, and was always hard to get along with. Her friends wished to emphasize the religious ideas which had been growing upon her so and state that this was the only reason for bringing her here. For past three or four years has seemed to be troubled with poor circulation. Always seemed to be cold, Required wraps and covering even in summer. Her husband and daughters have tried to do all they could for her, but at times she seemed to get tired of them. Dr. Van Cleve advised a changed. She had always been humored in everything at home. Her friends thought the entirelydifferent treatment she would receive here might be beneficial. At home was governed entirely by her moods. Did not seem to improve under such treatment. She realized perfectly where she was going when brought here. Has a wonderful memory; will remember a single act or word for years. C n also commit anything readily and remember it. Her friends thought at one time several years ago that they should have to bring her her, but managed to keep her at home instead.

good.

fair.

flaky deposit

+ urates

- Excess

uric acid crystals - bladder + vaginal Epith. cells

LUNGS, Vesicular Breathing	TAKEN,	
GYNÆCOLOGICAL EXAM.,		
MENSTRUATION,		
OPHTHALMOSCOPIC EXAM.,		
HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓ at present.	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, Fairly -	Poor,	Irregular,
PULSE, Full	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, 10 yrs. ago had an attack of violent headache + some mental symptoms. Has had sick + spell [illegible] every winter.

LENGTH OF INVASION, Probably long. ONSET GRADUAL OR SUDDEN, Probably gradual.

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

Mother or Mat. Relations, Died of old age.

Father or Pat. Relations, Died of apoplexy in '83.

2 Brothers or 3 Sisters, all healthy 2 children

Personal and Medical History

Whole No. 487
Residence, Multo
Date Admission, Dec
Admitted by Dr Hatfield
How Sent, Asst Olson
Sex, Female.
Age, - 54 -
Civil Condition, - married -
Children, - 2 -
Age Youngest Child, 24
Occupation, - Housewife -
Degree Education, Common school.
Profession Religion, Congregationalist.
Habits, Not intemperate.
Nativity, N. Y. (Father Ireland, Mother Vt.)
Physicians Committing, Dr. Vawdrey. O.O. Wright.
Correspondents, O.F. Warner, (Husband) Mantorville, Minn.

...00
...d.
...d Aug. 10. 1898.
...proved

EXAMINATION ON ADMISSION.

Exam. by Rev. + Mr. Phelps. **MENTAL CHARACTERISTICS.**

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Rather.
Exalted,
Depressed,
DELUSIONS: Has many -
Systematized or Not,
Special Subjects, Mostly on religion
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient lies in bed Talks quite freely, tho occasionally is quite vague in answers. Says was brought here because she would not keep moving from one of the children to the other. Says she finally went to "Farm" + said she would not move again + they had her brought down here. Is quite careless + indifferent. Altho she mentioned no delusions she expressed some vague ideas such as that her headaches were "mortal putting on mortality"

...onal and Medical History of Celestia L. Warner.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, — WEIGHT, — NUTRITION, Seems good.
WOUNDS OR ABNORMALITIES, None. Condition of skin normal.
TONGUE, Tremors, Coatings, Heavily coated. Promptness Movement,
PUPILS, Equality, Equal. Size,
Response Light, Accommodation,
SIGHT, Uses glasses.
HEARING,
COORDINATION, Arms, In bed - Seemingly good.
Legs, do
TREMORS, Hands, Tongue, Slight
Facial Muscles, None. General,
REFLEXES, Patellar, Both S. + Q.
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Regular.
LUNGS, Vesicular Breathing
GYNÆCOLOGICAL EXAM.,
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

Sept 24/97 EXAM. URINE,
Color Yellow.
Character. Cloudy with flaky deposit
Amt. in hrs XIX 3j.
Sp. gr. 1013
Reaction Neutral
Albumen Absent
Sugar
Microscop. Excess amor. urates a few pus corpuscles - Excess uric acid crystals - bladder + vaginal epith. cells

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, ✓ at present. Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, Fairly - Poor, Irregular,
PULSE, Full Resp., Temp.,
CRANIAL MEASUREMENTS,

HISTORICAL, 10 yrs. ago had an attack of violent headache + some mental symptoms - Has had sick spells ...parly every month.
LENGTH OF INVASION, Probably long. ONSET GRADUAL OR SUDDEN, Probably gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies.
Mother or Mat. Relations, Died of old age.
Father or Pat. Relations, Died of apoplexy in 83.
2 Brothers or 3 Sisters, all healthy 2 children

Personal and Medical History of Celestia L. Warner.

1897

This patient was brought here by Sheriff Jos. Tucker attended by Miss W.E. Crampton in good physical condition, with the following history:- No history of consanguinity. First symptoms manifested 10 years ago by intense headaches: Disease appears increasing: Is variable with rational intervals: Derangement manifested by jealousy & on subject of religion: Has threatened to injure others: Not suicidal, filthy or destructive: Previous peculiarities "jealousy & religion: No history of intemperance on parents or self: Has been subject to intense headaches. On personal examination will answer no questions.

Sept 22 On admission put upon B^r W. (2^d Fl. Rt. Complexion dark: hair & eyes brown: Condition of skin normal: No marks, scars or bruises noted: Is rather dirty: Behavior quiet but resisted being bathed: Has delusions.)

Oct. 5 Summary Nurse's 14 Day Record:- Temp. Pulse & Resp. normal: Appetite poor on admission: would take no solid food: improved gradually: bowels constipated: Cathartics given: regular during remainder of two weeks. Gyn. treatments given: seemed quite sensible, quiet & agreeable, though at times quite stubborn: neat & clean. refused to take out door exercise: Slept well after 1st few nights. Continued by Dr. R.M. Phelps.

Oct 21 Trans. to A^r. Visited by her daughter. Refuses to go out doors but is more quiet & melancholy in all her ideas & ways. Nov. 22 Quiet in behavior but talks more willingly. Apr 9 Went home on trial with relatives. Has been losing much flesh of late

Discharged.

Personal and Medical History of

Personal and Medical History of Mary Auger. (Augr.)

HERBERT, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4879

Residence, White Bear, Minn.

Date Admission, Sept. 27th 1897.

Admitted by Dr. R. M. Phelps. Hour, 6th P.M.

How Sent, Hy. Gallick Ct. Com. Ramsey Co.

Sex, Female

Age, - 41 -

Civil Condition, - married -

Children, none.

Age Youngest Child, -

Occupation, - Housewife -

Degree Education, - None -

Profession Religion, - Catholic -

Habits, Not intemperate.

Nativity, Minn. (Parents Canada)

Physicians Committing, O. Martel + A. Sweeney

Correspondents,

No. for Year, 46.

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form, ag. melancholia.

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, 41 -

Time of Leaving, Mar. 13. 1898

Time in Hospital, 5 mo. 17 d.

Result, Died. General Paresis.

EXAMINATION ON ADMISSION.

Exam by R.M. + M. Phelps. 9/28/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Probably impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Much impaired

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, + agitated.

DELUSIONS: Seems to have many.

Systematized or Not,

Special Subjects,

Transitory or Not;

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Talks only French + cannot understand any English. Cries most of time. Very depressed + agitated. Seems to have many delusions. Violent at times. Can obtain no history from patient. General health somewhat impaired. Circulation very poor. Bowels constipated.

Personal and Medical History of Mary Auger

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, 107 lbs. NUTRITION, Fair

WOUNDS OR ABNORMALITIES, None. Skin normal condition.

TONGUE, Tremors, Coatings, Coated + dry. Promptness Movement,

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT, Seems good.

HEARING, "

COORDINATION, Arms, Normal.

Legs, Somewhat unsteady at times.

TREMORS, Hands, None. Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries atheromatous.

HEART, Sounds quite weak.

LUNGS, Bronchi normal. Chest Expn. Normal.

TAKEN,

Sept 28/97 EXAM. URINE,

Color Reddish yellow

Character Cloudy

Amt. 24 hrs. XVIII ℥j

Sp. Gr. 1016

Reaction Acid

Albumen absent

Sugar "

Microscop. scarce pus cells, blood cells, oxalate of lime crystals, a few uric acid crystals, Epith. cells all varieties.

GYNÆCOLOGICAL EXAM.,

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, ✓ Irregular,

APPETITE, Good, ✓ Medium, Poor,

SLEEP, Good, ✓ Poor, Irregular,

PULSE, 102 - Rather weak Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Has done washing + worked my hard.

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

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Mary Auger.

1897

This patient was brought here by Sheriffs deputy Frank Lonnier attended by Emilie Lonnier in fair physical condition with the following history.- No history of consanguinity. Heredity or intemperance in parents or self. No previous peculiarities noted. No severe disease or injury to head. Was at City & Co Hospital St. Paul for two weeks. On personal examination is quiet, melancholy, refuses to talk. Prays a great deal & is confused & lost in her own house.

On admission put upon Dr W. (Hosp Rpt Complexion dark: Hair black: eyes brown: Condition of skin normal: No marks: scars or bruises noticed. Is clean: quiet. Does not speak English.)

Oct 7 Summary Nurse's 14 Day Record. Temp. Pulse & Resp. normal: Appetite usual good: bowels fairly regular: enema required occasionally: Did not sleep well during first week noisy & restless when awake: Sept 26 Fought several times: Sept 28 Quite violent: Trans. to C's. Oct 3 Quiet during day: slept quite well: Oct 7 Appetite fair: At times quite nervous & noisy during day, but usually sleeps well at night Continued by Dr. R.M. Phelps.

Nov 28 At times rather noisy. So easily excited: General health seems good. Speaks only French. Feb 26 '98 Noted as being rather nervous at times & at times noisy & easily excited. Wt. 130.# Mch 7 Patient has been noted as failing rapidly for the past two or three weeks. Appetite poor: inclined to be disturbed. Trans. to Infirmary today. Mch 13 '98 Patient died at 5 a.m. today. She had rather slight rise of temperature during the past week. So noisy & excited. Appearance has been that of general paresis toward the last.

Died.

Personal and Medical History of

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,

GYNÆCOLOGICAL EXAM.,

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of

Personal and Medical History of: