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

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Version 3
August 20, 2018

BOOK

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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 Charles Brigham.

EBERT, FIELAN & CHAMBERS, DAVENPORT, IOWA

Whole No. 4503

Residence, Dundas, Minn.

Date Admission, August 25' 1896

Admitted by Dr. R.M. Phelps Hour,

How Sent, R.A. Mott, Co P. Rice Co.

Sex, - Male -

Age, - 46 -

Civil Condition, Married.

Children, - 5 -

Age Youngest Child, —

Occupation, Painter.

Degree Education, Common

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, Mass. (Parents also Mass.)

Physicians Committing, J.R. Phillips + R.A. Smith

Correspondents, —

No. for Year, 36

Insane Relatives, Reputed to have been several - 2 aunts + 1 Cousin disclosed by wife

Cause Exciting, Domestic trouble acting

Cause Predisposing, on hereditary disposition

Form, Melancholia acute

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, About 10 days ago.

Duration, About 40 days.

No. of Attack, 1yrs.

No. of Admissions, 1st

Age First Attack, - 46 -

Time of Leaving, Nov. 30. 1896

Time in Hospital, 3 mo. 5 da.

Result, Discharged 11/30/96 Recovered

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Charles Brigham.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION,

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT,

HEARING,

COORDINATION, Arms,

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Charles Brigham.

1896

This patient was brought here by Sheriffs deputy A.D. Weston with the following history:- Patient is in fair physical condition: No history of consanguinity: Just symptoms of this (1st) attack manifested about 10 days ago by excited religious mania & business delusions. Disease appears stationary; continuous with abiding delusions on religion & business. Patient has shown no apparent disposition to injure others, is not suicidal, filthy or destructive: No peculiarities previously shown: No history of intemperance in self or family: No severe disease or head injury: The supposed cause of disease domestic trouble; patient has received no systematic treatment - On personal examination the following facts were learned:- Patient had a favorite daughter 14 years old who eloped with a boy to whom he was opposed & finally married - this is supposed exciting cause.

Sept 7 Nurses Notes (Summary) Patient came on ward at 4 P.M. Aug 25 Given bath to clean: Physical condition good. Is very talkative but apparently rational. Sleeps 7 hrs. per night. Writes a great many letters & appears to have considerable business on his mind: Works on ward: reads & plays games & is seldom idle. Says he is very glad that he was sent here for he needs rest. Some rise of temperature. Has been given 3 shower baths of 95°. Physical & mental condition apparently improved: Appetite good: Bowels regular: Behavior good: Habits neat & clean Makes no complaints.

Sept 9 Patient very quiet & well behaved: Habits neat & clean: Answers are rational Laughs & jokes seemingly having a good time: Physical condition good. Appetite good: Bowels regular: Sleeps well: Wt. 141 lbs. Pulse 90.

Oct 1 No change since last note. Talks rationally but is a little childish in actions. Wt. 162. Pulse 84 Oct 6 Trans. to A'.

Oct 13 Patient in bed, complains of his back; also has a bad cold. Appetite fair Bowels slightly constipated: Is quite restless. Nov 4 Physical condition apparently good - Mental condition somewhat improved. Talks rationally on all subjects. Bowels regular: Appetite good: Wt. 160 Pulse 76.

Nov 16 Later marked tremors of hands & facial muscles - says is more nervous of having trouble with other patients: Shows no marked delusions except a vague religious tone of talk: Is anxious to get home & to make a good impression (Status per. nurses)

Nov. 30 Went Home

Discharged

Personal and Medical History of

Personal and Medical History of John Reed.

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4510
Residence, St Paul Minn
Date Admission, Aug 29 - 1896
Admitted by Dr. Eby Hour, 6 40 p.m.
How Sent, J. P. Wilbuck Ramsey Co.
Sex, Male
Age, 39
Civil Condition, Married
Children, none
Age Youngest Child, —
Occupation, Theatrical
Degree Education, common school
Profession Religion, none
Habits, Intemperate
Nativity, New York (parents born Ireland)
Physicians Committing, R.S. Robb & Geo. J. Hanley
Correspondents, —

No. for Year, 43
Insane Relatives, none
Cause Exciting, "drink alcohol"
Cause Predisposing, unknown
Form, dementia alcoholic
Accompanying Bodily Disorder, none mentioned.
Suicidal or Not, not
Date of this Attack, 10 years ago,
Duration, 10 years.
No. of Attack, 1st 2nd? 2-3 years ago delirium tremens
No. of Admissions, 1st
Age First Attack, 29
Time of Leaving, 11th December 1901
Time in Hospital, 5 yrs 3 mos 12 ds
Result, Transferred to Hastings Asylum

Ex'd by Dr Herzog Aug 30/96

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, somewhat confused
Quick or Sluggish, fairly quick
MEMORY:
Past Events, impaired slightly
Recent Events, impaired considerably.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, at times illusive
REASONING POWER:
Ordinary Subjects, impaired slightly
Own Mental State, does not admit
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, somewhat.
DELUSIONS:
Systematized or Not, somewhat systematized
Special Subjects, of persecution
Transitory or Not, seem fixed
HALLUCINATIONS: probably.
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, slightly incoherent
Voluble or Reticent, reticent, (suspicious)

GENERAL DESCRIPTIVE REMARKS: Patient seems to have been at one time of fair mental grade although he has had various occupations, variety performer, billiard room keeper, bar tender, ran small confectionery store. Has been a hard drinker for 20 years, continuous. says had syphilis 4-5 years ago. history vague. Present condition approaches an alcoholic dementia. loss of memory &c. Is extremely suspicious, became frightened during examination saying "I know what you are trying to do, You are trying to take (something unintelligible) away from me." Has paranoiac ideas. Hints vaguely at a conspiracy to deprive him of his freedom

Personal and Medical History of John Reed.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in. WEIGHT, 136 lbs. NUTRITION, fairly good somewhat pale. puffy under lids
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, slight Coatings, heavy yellow coat Promptness Movement, prompt.
PUPILS, Equality, yes Size, normal
Response Light, Excessive Accommodation, excessive
SIGHT, slightly impaired
HEARING, good
COORDINATION, Arms, slight impairment, usual tests
Legs, do. do.
TREMORS, Hands, slight Tongue, slight.
Facial Muscles, no General, no
REFLEXES, Patellar, 10 - equal
Other
ARTICULATION,
Slurred, good
Hesitating,
FACIAL EXPRESSION, face smooth, somewhat expressionless
SENSIBILITY,
HEART, No murmurs, regular somewhat weak & rapid
LUNGS, appear good

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, yes	Careless,
BOWELS, Normal,	Constipated, slightly	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, Alcoholic tendency
Brothers or Sisters,

Personal and Medical History of John Reed

1896

This patient was brought here by Deputy Sheriff Emanuel Johnson with the following history accompanying. No history of consanguinity or heredity. This is not first attack. Others occurring 2 or 3 years (ago) as delirium tremens. duration unknown Not sent to hospital result of treatment unknown. First symptoms of this attack manifested 10 years (ago) (sic.) Disease appears to be increasing. It is variable and there are rational intervals. On answer to question as to regularity of the intervals answer is given "chronic alcoholic." Derangment now manifested by patient wanting to kill wife. Not suicidal, nor filthy, nor destructive. No peculiarities of disposition &c. no predominant passions to be manifested before the accession of the disease. Has been subject to syphilis. No restraint or confinement has been employed. "Drink alcohol" is supposed to be the cause of the disease. No treatment. On personal examination "Alcoholic Delusions

Aug 29-'96 On admission (C.A.H.'s Report) was placed on B3 complexion dark hair black eyes brown, condition of skin good, large wart middle of forehead, slight bruise on right thigh, behaviour good.

Nurses Notes (Summary) Patient received on ward Aug 29th Temp. 100.8 Pulse 80 Resp. 18. Sleeps 4 hrs. during night. On regular & extra diet. Appetite good. Bowels regular. Habits clean: Patient very restless, walks floor most of time Talks none unless spoken to & then in a cranky way. Some rise of temperature first few days: Does not seem to care to associate with any of patients or to improve time in any way. No delusions noticed. Can see but little change in patient from day of arrival. Walks hall most of time & laughs to himself. Physical condition good: Appetite good: Bowels regular. Habits clean: Behavior fairly good: Sleep fair.

Sept 1-'96 to Apr 30-'97 Summary Nurses Notes by Dr. Phelps: Patient has been very quiet. Goes out walking most of the time: Laughs to himself: does not speak of his delusions: is clean, behavior good. Oct 1'96 No change. Sleeps well, Wt. 143 lbs. Oct 6 Tried to escape. Oct. 31 Made an attempt to elope at dinner time; walks floor continually, acts queerly. Dec. 1'96 No change in patient; is rather sulky and indifferent & at times seems afraid. Jan 2'97 Commenced to complain of pain & not feeling well. Jan 3'97 Temp. up. Trans. to sick ward: is quite lame. Jan. 9 up today- Removed from sick ward, having recovered quite well from mild attack of rheumatism. Apr. 1'97 No change: Wt. 150 lbs. Becomes more & more demented daily. May 20'97 Trans. to 6: having tried to escape & being noisy & violent. June Eloped: Was brought back from country by nurses. Jan 1'97 Tried to Elope. Very abusive when returned. Still tries to elope & today succeeded, Was brought back by nurse. Jan 30'98 Jan 31'98 Patient has been rather more quiet of late & has not made such active attempts to elope, but is watched closely still. Feb 1-July 31 1900 Wt. 151 lbs. Has delusions: is quiet: assists some with work.

Personal and Medical History of John Reed

1900

Aug 1-Jan 31 1900 (Dr. Chapple). Wt. 142½ No change of importance: Is quiet & well-behaved: Dirty in habits: Has delusions of a grandiose nature: Mental condition slightly impaired: Talks very little unless addressed: Is very indolent: Plays games but otherwise does little: Health very good. Feby 1 1900. Wt 153 lbs. P68. May 9. Transferred to Annex. July 30. Vaccinated: result negative. July 31. Health has been good. Is quiet: well-behaved: quite tidy in habits. Talks rationally. Has "delusions of greatness". Works on ward. Aug 1. 142 lbs. Sept 10 To D2. Jan 31 1901 Health good: does a little work on ward: very quiet: cleanly in habits: Talks rationally: takes no interest in anything. Feby 2 Feby 28. Wt 149 lbs. May 1 Wt 149 lbs. Aug. Wt 168 (17) Nov 1. Wt. 143 lbs. Dec 11 No change mentally: works regularly in ward dining-room: is good-natured: incoherent and silly: habits tidy. Today, was transferred to Hastings State Asylum.

Personal and Medical History of Frank Haseldeny.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4517
Residence, Lakeville, Dakota Co. Minn.
Date Admission, September 8' 1896.
Admitted by Dr. R. M. Phelps Hour,
How Sent, Thos. P. Moran, Jr of P Dakota Co.
Sex, - Male -
Age, - 36 -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, Farmer.
Degree Education, - Very limited -
Profession Religion, - yes Catholic.
Habits, Not intemperate -
Nativity, Minn. (Father Germany, Mother Bavaria)
Physicians Committing, A. Van Beeck - J.C. Fitch.
Correspondents,

No. for Year, 50.
Insane Relatives, None.
Cause Exciting, Disappointment in love -
Cause Predisposing, Probably previous attack.
Form, Dementia Terminal
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, About 1 year ago.
Duration, About 1 year.
No. of Attack, 2nd
No. of Admissions, 2nd
Age First Attack, -23-
Time of Leaving, Apr 26. 1900
Time in Hospital,
Result, Transferred to Hastings.
Ot pm

EXAMINATION ON ADMISSION.

Exam. by Dr. LaBerry Sept 10 '96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Fair
Recent Events, "
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Correct.
REASONING POWER:
Ordinary Subjects, About normal.
Own Mental State, Thinks he has been insane.
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Is in a melancholic state. Stands with his head hanging. Is probably never was very bright or of a very sanguine disposition.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, √
DELUSIONS: Has delusions of persecution.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS: Hears voices.
ILLUSIONS: None.
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Frank Haseldeny.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good.
WOUNDS OR ABNORMALITIES,
TONGUE, ~~Tremors,~~ Large, pale, flabby, Coatings, heavily coated. Promptness Movement, Prompt.
PUPILS, Equality, Yes. Size, dilated.
Response Light, Yes Accommodation, yes.
SIGHT, Fair.
HEARING, Good.
COORDINATION, Arms, Good.
Legs, "
TREMORS, Hands, None. Tongue, Fine
Facial Muscles, None. General, None.
REFLEXES, Patellar, Equal - About 0
Other
ARTICULATION, Good. has a
Slurred, slight foreign accent.
Hesitating,
FACIAL EXPRESSION,
Arteries Soft & Compressible.
SENSIBILITY,
Normal.
HEART, No Murmurs. Sounds
rather indistinct - Size Normal
Very frequent about 110
LUNGS,
Chest Symmetrical.
Breath Sounds normal.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Nov. 13'96 3rd Exam
Nov. 13' 2 P.M. passed.
Color Pale yellow.
Sp gr. 1012.
Reaction Acid.
Character Clear.
Albumen None.
Sugar None.

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

CRANIAL MEASUREMENTS,
HISTORICAL, Drank some.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Probably Gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Answers "dont know" to most questions
Mother or Mat. Relations, in regard to family history.
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Frank Haseldeny.

1895

* Note - for particulars see Vol. 4 Folio 89 No. 627

This patient was brought here by Sheriff Hyland, accompanied by Geo. Kehren - is in fair physical condition - with the following history - No history of consanguinity - First attack occurred in 1883 + patient was in this (Rochester) * Hospital from May 12 1884 until July 1887. he has never been entirely well since. First symptoms of present attack appeared about a year ago, showing violence to his father. Disease appears to be increasing, not variable, no rational intervals. He now talks to himself; takes no interest in his surroundings: will work if someone is with him. otherwise will do nothing - Struck his father, claims he is boss of the whole family. Patient disposed to injure others: Is not suicidal, filthy or destructive: No peculiarities previously shown: No history of heredity or of intemperance in parents or self: No severe disease or injury to head - Cause of disease disappointment in love. Patient has not been confined since leaving this Hospital: Has been taking some patent medicine. On personal examination is dull, pulse rapid, tongue coated: Answers questions in a rambling way: Imagines Frenchmen are made into bed bugs + he is destroyed by them - Claims to be sheriff of Dakota County.

Sept 23 On admission put upon B[th] & E (G.A.R. Rpt. Complexion dark, hair grayish: Eyes dark brown: Condition of skin good. Slight bruises on back. Is dirty: Behavior good)

Nurses Notes (Summary) Patient received on ward at 7[30] P.M. Given bath. Very restless during night. Habits clean. Temperature 100[2] on admission falling to 100 on second day. Seems quite restless, walks the floor continually. Laughs + talks to himself a good deal. Appetite good: bowels regular: Sleeps fairly well. Behavior good. Converses with no one. When spoken to simply answers "yes" or "no". Habits slouchy. on 13th Temp. 100[8] - Has ranged from 100[8] to 99[2] since admission on 21st 99[4]. Condition apparently unimproved since admission -

Sept 23 Summary Nurses Notes by Dr. Phelps Patient quiet and orderly for most part: Walks restlessly about, does not talk with anyone. Wt. 215 lbs. Oct 1 Has been at times noisy + swearing: Imagines at times that people are cheating him: Dec 1st Unchanged. Dec. 29 Exams. to amen. Apr. 30 No special change: Does some work. July 31 '97 Wt. 215.5 Works in Laundry: Is quiet in behavior: dull + demented. Oct 28 '98 Visited by friends. Jan 31 '99 Of late has worked in kitchen Is at times somewhat noisy. General behavior about the same -

Feb 1 - 1900 - 30 - Jan 31 July 31 1900 Wt. 224. Appetite good: Behavior fair: Physical condition seems very good. Aug 1. Jan. 31 1900 Dr. Chapple Wt. 227. Health very good: Is demented: Incoherent: untidy in habits: works on ward + in kitchen: Noisy at times otherwise behavior good. Feby 1 1900 Wt 220 lbs. BP. 126. Apl 26 No change in condition. Is well-behaved, though has "noisy spells", occasionally. Appetite good: Sleeps well. Physical condition good. Is very dull + demented: habits untidy: Works on ward.

Feby 1 Apl 26

Was today transferred to Hastings Hospital —

Personal and Medical History of

Personal and Medical History of Edward Bourcier.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. H519

Residence, Marquette Co., Mich.

Date Admission, 9th September, 1896.

Admitted by Dr. S. L. Phelps Hour, 7:30 PM.

How Sent, Geo. A. Watson, Dep. Vasco Co. Minn.

Sex, - Male -

Age, - 39 -

Civil Condition, - Single -

Children, —

Age Youngest Child, —

Occupation, Tramping -

Degree Education, - Common School.

Profession Religion, yrs Catholic.

Habits, Not known.

Nativity, Canada (Parents Canada)

Physicians Committing, D Shumming, M. J Taylor.

Correspondents,

No. for Year, 52.

Insane Relatives, No knowledge.

Cause Exciting, Not known

Cause Predisposing,

Form, Melancholia acute agitated

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not known.

Date of this Attack, 8th September, 1896.

Duration, 24 hours.

No. of Attack, Not known.

No. of Admissions, 1st

Age First Attack, Not known

Time of Leaving, June 29. 1897

Time in Hospital, 9 mos. 20 da

Result, Transferred to Fergus Falls.

J K Hm

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,

File Mr Bourcier

PRICE---WHAT YOU PLEASE TO GIVE

The Blind Mans' Appeal.

Eward Bourcier became blind from an explosion while blasting rock in a stone quarry. He is a man of family and must rely upon the generosity of the public for his and their support.

Oh ye whose eyes are open to
The glorious light of day,
Consider how the darkness falls
Upon the blind man's way;
And let Compassion's finger strike
Upon your heart's pure strings;
That hope may o'er his darkened life
Throw her protecting wings.

Ah me! Ah me! the blind man's lot
Is freighted deep with woe;
The thorns that throng his daily path
None but the sightless know;
Then, Oh, let Mercy's gentle voice
Soft o'er your senses steal,
And listen to kind charity—
To this, my sad appeal.

Oh think of this, ye happy one,
In palace or in cot,
And drop a tear in pity for
My hard, my weary lot.
The grandest structure man can rear
In pride of human power,
Is touched by Time's remorseless hand
And crumbles in an hour.
And man with all his boasted ills,
Must yield to Death's embrace—
Must find within a narrow grave
A silent resting place.

That furrowed brow with hoary locks
Must soon be laid away;
No power on earth the stream of life
Those tottering steps can stay.
That noble youth whose bosom swells
With prospects bright and fair,
Must see those prospects laid away,
For life is ebbing there.
And that sweet maid with buoyant steps,
With spirits glad and free,
Must feel the icy hand of death—
Must cold and lifeless be.

Then Oh, turn not away from this,
My sorrowing appeal,
But let the voice of Mercy sweet
Soft o'er your heart strings steal.
And this pure truth from Holy Writ
Shall be your sweet reward;
To whosoever helps the poor,
Lendeth to the Lord.

Remember, too, that from Holy Writ,
You cast your blessings 'round:
They will yield rich and precious fruit
In God's own holy ground;
And Oh, how great will be the joy,
That unto you is given,
When the blind man can see and bless
Your entrance into Heaven.

...TION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, NUTRITION,

Coatings, Promptness Movement,

Size,

Accommodation,

Tongue,

General,

EXAM. URINE, Nov. 13 9:3 PM

Passed Nov. 13'96 2 PM.

Color yellow.

Sp. gr. 1025

Reaction Acid.

Character Clear.

Albumen None.

Sugar None

TAKEN,

LUNGS,

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 Edw

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. H 519

Residence, Marquette Co., Mich

Date Admission, 9th Septem

Admitted by Dr. S. L. Phelps

How Sent, Geo. A. Watson, Jo P. Co

Sex, - Male -

Age, - 39 -

Civil Condition, - Single -

Children, —

Age Youngest Child, —

Occupation, Tramping -

Degree Education, - Common School.

Profession Religion, yes Catholic.

Habits, Not known.

Nativity, Canada (Parents Canadas)

Physicians Committing, D Shumming, M. J Taylor

Correspondents,

...oned.

...known, 1896.

...Not Known.

...dmissions, 1st

Age First Attack, Not Known

Time of Leaving, June 29. 1897

Time in Hospital, 9 mo. 20 da

Result, Transferred to Fergus Falls.

O.K. Pm

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Edward Bourcier.

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, Nov. 13 9.3 Pm

Passed Nov. 13'96 2 Pm.

Color yellow.

Sp. Gr. 1025

Reaction Acid.

Character Clear.

Albumen None.

Sugar None

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Edward Bourcier

1896

This patient was brought here by Sheriffs Deputy Chas Gottschalk with the following history:- Patient is in good physical condition: No history of Consanguinity; Nothing is known of patient further than that on September 8th he attempted to injure others & showed derangement in thinking his brother was attempting to murder him:- No information concerning heredity, intemperance, habits, remediseases or injury to head. Nor as to cause, treatment or confinement: On personal examination No further facts learned than that on September 8th he appeared in Jamesville, Minnesota & attempted to injure people with whom he came in contact on the street.

Sept 30 Nurses Notes (Summary) Upon coming on ward patient seemed very much afraid. Appeared to hold delusion that he would be injured here & asked if he was going to be killed. Said people would take advantage of a blind man. About 3rd day seemed to realize where he was & the character of the institution but said he could not recollect anything that had happened at time or of day or two preceding his commitment here. He has been obstinate at times: Refused to allow temperature to be taken & is somewhat nervy at times. When engaged in conversation talks rationally. Has been kept in bed & wants to get up. Can be reasoned out of delusions of fear but after a short time they return to him. Appreciates care & treatment given him. Has shown delusions of poisoning & at times eats but little. Physical condition quite good. Oct 7 Patient has been up and about ward past few days. Makes but little trouble. Appetite of late very good & behavior good. Talks rationally & does not mention old delusions. Does out with rest of patients daily. Physical condition good: Appetite good: Bowels regular: Habits clean: Sleeps well. Trans to A.4. Oct 20 Complained this afternoon of sick stomach: went to bed - refused supper.

Oct 21 Up on ward: Appears quite well. Oct 29 In bed during afternoon: Vomited supper. Oct 29 Up & dressed. Complains of slight aching in arms & legs Appetite Good. Oct 31 Health seems good both physically & mentally: Is well behaved. Nov 1 Wt. 186½ Pulse 60. Nov. 15 Has been complaining of late of aching in limbs, especially legs. Appears restless all the time: Vomited, to day at 11:30 Put to bed - No dinner, light supper: Slept well during night.

Nov 16 Up & dressed - Nov. 24 Has been talking quite irrationally during last few days. Says nurses have been putting something in his food which causes his bones to ache: Became very wild when tried to get shaved: Held in Barbers chair

Nov 30 Became noisy & pugnacious while at dinner: was removed from dining room Appears to be in good physical health: Dec 1 Wt. 192 Pulse 74.

Dec 9 Became noisy & pugnacious at supper. Joe Warner prevented him from striking B. McCumber with a chair. Said someone had canned his victuals with salt. Removed from dining room & confined to north end of ward. Very abusive to nurses. Night nurse reports patient as getting up

Personal and Medical History of Edward Bourcier.

as early as 4:30 A.M. & refusing to go back to bed. Dec 12 Quiet & well behaved during day: Bowels ~~were~~ constipated, salts given.

Dec 16 Very quarrelsome & ugly. Attempted to strike Nurse with cuspidor: Complains of toothache

17 Right cheek & side of neck badly swollen: Dec 23 Behavior quite good during last few days. Dec. 26 Again became disobedient & abusive. Removed to lower end of ward. Is continually rolling about on floor. Will give no reason for doing so.

Jan 3/97 Wild & noisy all day jumping & rolling about on floor. Chews tobacco: Was given bed on floor - Rolled about greater part of night. Slept 3 hrs. Appetite good: Bowels seem in good condition. Says "he will not behave because we do not understand the last part." Jan 4 Behavior unchanged

Jan 5 Troublesome & obstinate all day. Had to be held: 7th Rec. trans to B:

6 Slept worse last night - rolled about all night. 7th Slept 3 hrs.

8th Very restless during night. Ate light dinner. Vomited - Some complaint of pain in stomach & also of being chilly - Vomited twice in afternoon & once in evening 9th Slept 2 hrs. Very restless - Was kicked by C. Asp. when rolling on floor - Causing several bruises about left hip. (Witness N. Bear)

Jan 10 Jos Rhodes struck patient between eyes causing slight swelling. Ate fair supper - Vomited same: Complained of pain in stomach. Vomited during night.

Jan 11 Very troublesome still rolls on floor. When he thinks he has an opportunity Gets angry if interfered with. Jan 15 Kicked in chest by Rec. Hague.

20 Very noisy & violent: Tried to bite Nurses: Physical Condition apparently good: Appetite & sleep good: Bowels normal. Feb 1 Wt. 182 P. 80.

Feb 5 Appetite Good bowels regular. Behavior restless & troublesome & pugnacious: Needs a great deal of care on account of his being blind: Seems to know what is taking place around him: Habits clean.

Feb 18 Struck on head with shoe by Rec. Hague. March Wt. 177. Pulse 76.

March 18 More restless - Constantly walking up & down hall. March 19 Violent today - March 30 Appetite & bowels normal. Very restless Apr 2 Wt. 169 lbs P. 88. Left limb pains him & is swollen - Has stopped rolling on floor & is much quieter. Apr 12 Still complains of limb. Apr 17 Taken to Infirmary & sore on left limb opened by Dr Herzog. Three stitches put in wounds. Very restless: Constantly walking floor this P.M. Apr 21 Stitches removed from wound & ~~was~~ washed & redressed - Slightly inflamed: May 3 Wt. 170 P. 76.

May 6 Appetite good: Bowels regular: Behavior of late fairly good: Will walk floor constantly if allowed but does not roll on floor: Habits neat & clean: Eats & sleeps on Hall.

22 Noisy & restless put in bag. 24 Had vomiting spell. June 24 Has delusions of persecution Behavior changeable: Habits neat & clean.

June 29 Transferred to Fergus Falls.

Personal and Medical History of Edward Crotty

EGBERT, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4523
Residence, Stillwater, Minn.
Date Admission, September 12'1896.
Admitted by Dr. R.M. Phelps - Hour, ✓
How Sent, E.G. Butts, Dep't. Washington R.
Sex, Male
Age, 23
Civil Condition, Single.
Children, -
Age Youngest Child, -
Occupation, Driving team in piney
Degree Education, Common school
Profession Religion, Yes Catholic.
Habits, Not intemperate.
Nativity, Minn. (Father N. Brunswick, Mother Ireland)
Physicians Committing, M.C. Voight & W.H. Pratt.
Correspondents,

No. for Year, 56.
Insane Relatives, None.
Cause Exciting, Not known.
Cause Predisposing, Not known.
Form, imbecile
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, Not.
Date of this Attack, 2yrs. ago after spell of illness
Duration, 2 years.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, -21-
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps M.D. 10/1/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, } Probably fair.
Recent Events, }
Special Subjects, }
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Incorrect
REASONING POWER:
Ordinary Subjects, -
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Patient is feebleminded in all his actions. Answers in rational form but dull & incorrectly at times. "Dont know why here" "is all right" "Never worked" etc. No delusions noted - simple lack of mental power. Sits about in dull listless way. Hands show he never worked.

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,

Physically no special disease is noted.

Personal and Medical History of Edward Crotty.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Some impaired.
WOUNDS OR ABNORMALITIES, Condition of skin fair - slightly anaemic.
TONGUE, ~~Tremors,~~ Normal Coatings, Promptness Movement, normal.
PUPILS, Equality, Equal. Size, normal.
Response Light, yes Accommodation, yes
SIGHT, Normal.
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, Fairly steady Tongue, Fairly steady
Facial Muscles, " General, "
REFLEXES, Patellar, Normal.
Other
ARTICULATION, Fair
Slurred, "
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Normal.
LUNGS, Normal
Arteries Normal.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Nov. 12/96 4:30 P.M.
Passed Nov. 12 7:30 P.M.
Color Yellow.
Sp. Gr. 1025
Character Clear.
Reaction Acid.
Albumen None
Sugar None.

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

CRANIAL MEASUREMENTS, Circ (H) 55 (Fm) 65 Nose 36 Ima 34 Aut. pd. 19.4 Fmor. d. 15.2 Bim. d. 12.5 Fac. length 11.7
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any.
Mother or Mat. Relations, Living - healthy
Father or Pat. Relations, " "
Brothers or Sisters, 2.

Personal and Medical History of Edward Crotty.

1896

This patient was brought here by Sheriff Deputy Jno Lund with the following history:- Patient is in fair physical condition. This is 1st attack: Disease seems increasing; remains with irregular rational intervals: Derangement now manifested by general delusions with melancholia. Patient has shown no disposition to injure others: Is not suicidal, filthy or destructive: No history of consanguinity or heredity, nor of intemperance in self or parents: No severe disease or head injury - Cause of disease is unknown. Patient has not been confined or restrained - Treatment pursued has been unsatisfactory. On personal examination patient is melancholic & is inclined not to talk or answer questions asked him.

Sept. Nurses Notes (Summary) Received on ward Sept. 12 - given bath: Temp. 99.5 Pulse 90 Resp. 18. Physical condition seemingly very poor. Very quiet & orderly talks none unless spoken to & sits quietly in one place. Habits clean, no delusions noticeable. Medicine 3 times a day since 15th On extra diet but appetite very poor: bowels regular sleeps very well. Shower bath 90° reduced to 60° given 3 times per week. No change until 23rd inst. when patient became more quiet & stupid than usual. Brightened up on following day & has since improved rapidly since. Appetite improved & has gained a little in flesh. Has normal temperature since 17th

Nov. 1 Summary Nurses Notes by Dr Phelps. Converses little: Sits in one place as boy usually. At times is noisy and swearing: Is easily irritated: Wt. 115 lbs. Jan 1897 Very noisy during morals, swearing & talking to himself: There seems to be no improvement. Mch 1 Previous notes continue good: Is occasionally irritable but has not been violent but once, when it took three nurses to control him. Apr 30 Patient Apparently the same: Rarely talks & then answers only in monosyllables. Wt. 127 lbs.

July 31 97 Very well-behaved & Quiet. Will sit quietly in one place in a dull way. Wt. 114.# Nov 1898 Visited by Mother. Jan 31 1899 Condition unchanged in any essential respect: Rather dull, usually quiet, seems to have no mischievious or dangerous tendencies: Talks to himself. Assists some with work in Centre Feb 1 - July 31 '99 (Dr. Watsons) Wt. 115.# Has delusions: works in Centre dining room: Feb. 16 Patient much depressed. Slept very little during night. July 31 No change. Aug 1 - Jan 31 1900 Wt. 111.# Very little Change during period: Health fair: Is very nervous: Talks to himself a good deal. Usually sleeps well: Has worked in center: Oct. 8 Visited by Mother & sister. Feby 1900 Wt 111.# Pg 6. July 3. Visited by mother. July 17. Vaccinated: result negative

1900 - Jo - Jan 31 Feby 1 July 17 31 Aug 1 1901 July 31

July 31. Very little Change. Is somewhat emaciated, but has had no illness. Appetite good: somewhat restless: habits steady. Helps about the Centre building. Is almost constantly muttering to himself in a way that cannot be understood. Is quite nervous & becomes more so, if questioned. Will talk very little. Aug 1 Wt 110.# Jany 31/1901. Very little Change: is quite thin in flesh: never complains: works about "Centre" regularly: talks to himself. Seems different to

Personal and Medical History of Edward Crotty.

1900 Jan 31 Feby 1 1901 Jan 31

Everything: When not at work, is very restless, fumbling his fingers. At times, very noisy at night. Feby Wt 119.# Mays Wt 117.# Augt 1 - 117.# Nov 1 - 117.# Dec 25. Visits by mother - Scarcely any change, from month to month: health only fair: is somewhat emaciated. Works about "Centre": always well-behaved: constantly muttering to himself & making motions - Sometimes, becomes noisy & agitated - Habits quite tidy - July 17. Has been eating poorly and is growing very emaciated. Visited by mother. Sept. 18 Trans. to A4; Jan. 1/03 (Weight has been down as low as 105#) is now 122.#

Jan. 31/03 Eats somewhat better; kept on ward; does not work.

Personal and Medical History of C. Reed Dewey.

ROBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4524
Residence, St. Paul, Minn.
Date Admission, September 12' 1896.
Admitted by D & B. Eby Hour, 7:15 P.M.
How Sent, G. Millrich. Joy P. Ramsey Co.
Sex, - Male -
Age, - 38 -
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Architect.
Degree Education, — Graduate -
Profession Religion, yes Presbyterian.
Habits, Not intemperate.
Nativity, Iowa (Parents U. S.)
Physicians Committing, Park Ritchie & Arthur Swasey.
Correspondents,

No. for Year, 57 -
Insane Relatives, None. (Father intemperate)
Cause Exciting, Not known.
Cause Predisposing, Probably previous attack.
Form, Paranoia
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, Not stated
Duration, Not stated.
No. of Attack, ?
No. of Admissions, 2nd
Age First Attack, - not stated.
Time of Leaving, Nov. 24. 1897
Time in Hospital, 1 yr. 2 mo. 12 da.
Result, Discharged May 4. 1898 Unimproved

EXAMINATION ON ADMISSION.

Exam. by P.M. Phelps. Sept. 12'96 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Fairly Clear
Quick or Sluggish, " Quick
MEMORY:
Past Events, } Gone.
Recent Events, }
Special Subjects, }
PERCEPTIVITY:
Alert or Dull, } gone.
Correct or Illusive, }
REASONING POWER:
Ordinary Subjects, Fair.
Own Mental State,
Special Subjects, No.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Yes. as described + only those as far as known
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Denies that he wrote to girl or father. Admits not being married in regular way - didn't quite know whether married or not. Admits similar trouble with another girl in Chicago. Saw a girl in Public Hall. + a lady looked at him + a sensation peculiar, or affinity as he thought + as far as he can tell. One year later in Central Music Hall felt same sensation, looked around + this girl was looking at him. Afterward in this Hall saw her several times finally followed them with carriage + found where they lived - Enquired about the family of ether - After this the young ladies didn't come to church. This was in 1896.

Personal and Medical History of C. Reed Dewey.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good.
WOUNDS OR ABNORMALITIES, Condition of Skin Good.
TONGUE, Tremors, None. Coatings, normal. Promptness Movement, Good.
PUPILS, Equality, Equal. Size, Normal.
Response Light, Accommodation,
SIGHT, Normal.
HEARING, Normal.
COORDINATION, Arms, } Normal.
Legs, }
TREMORS, Hands, None Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Normal
LUNGS, Normal.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ. (H) 56.7 (Tem.) 68 - N. oc. a. 37° Bin. a. 34 Aur. p. d. 18.5 Transv. d. 15.3 Bimd. 13.6 Fac. L. 13.2
HISTORICAL, Had Typhoid fever at age 4. Lagrippe build 5 yrs ago. Thinks was overheated once
LENGTH OF INVASION, Probably 10 years. ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any
Mother or Mat. Relations, Died Pneumonia
Father or Pat. Relations, Died. Diphtheria - drank a good deal but after patient was born.
Brothers or Sisters, 2 brothers + 5 sisters.

Personal and Medical History of A. Reed Dewey.

1896

This patient was brought here by Sheriffs Deputy Chas. Richon with the following history:- Patient is in fair physical condition This is apparently 3rd attack of insanity Four years ago in Chicago patient was arrested for addressing a young lady with whom he was in love; on May 10 1895 was committed to this (Rochester) * Hospital where he remained until November 17 95 when he was discharged unproved. Patient believes he is married to a young lady + that her marriage to another man is pretended: Disease appears stationary + variable with irregular rational intervals when he can be reasoned out of his delusions - but they return with greater force. Patient has made threats to injure others: Is not filthy destructive or suicidal. No history of heredity or consanguinity: Patient has recently become religious. No history of nerve disease or head injury. Cause of disease unknown: Has received only treatment + restraint at Rochester Hospital. On personal examination his delusions are fixed but he is less logical than formerly in defending them.

* Note - As stated above, patient was here from May to November '95 - when his delusions were the same as at present - (for further particulars concerning case see Vol. 31 Fol. 57. No. 4090)

Sept 12 Nurses Notes (Summary) Came on ward at 8 P.M. Given bath. Physical condition good: Talks rationally: Behavior good. Sept 14 Very quiet during day reads most of time. Appetite good: bowels regular: Seems to think that he is better than rest of patients - Always the last in + out. When alone laughs to himself at times + acts queer. When talking with anyone rarely looks him in the eye. Is very active when out of doors. always moving around, doing something. Physical condition seemingly excellent. Appetite good: Bowels regular: Sleeps well. Temperature normal after 3rd day. On regular diet. Oct. 1 No change in patient. Appetite good. Bowels regular + Sleeps well. Wt. 175½ Pulse 72. Oct 21 No change - Trans to A'. Nov 4 Patient well-behaved but talks a good deal: Seems a little simple or foolish: No delusions: Physical condition good: Bowels regular: Sleeps well. Wt. 165 P. 85. Dec 1 Jan No change Feb 1 Patient quiet + well-behaved: Talks rationally on all subjects Apr 30 Works in dining room: No change mentally or physically. May 15 Has been working in dining room for past week. Trans. to A3. July 1 Physical condition good. Sleeps well. Has been making violins for some time: Thinks he can make better ones than any yet made. Thinks he knows everything: Dictates to everyone: Is growing quite disagreeable. Aug 4 Wt. 181½ P. 94. No change. Sept 1 No change since previous notes. Has gone camping at Oronoco for 2 wks. Oct 7th Out camping with Dr Kilbourne. Oct 20 Patient returned today: Physical condition good: Appetite good: Sleeps well: Is on parole. Nov 2 Physical condition good. No change mentally. Behavior is good but will argue upon most any subject + is easily irritated if contradicted. Nov 14 Went home today.

Discharged

Personal and Medical History of

Personal and Medical History of John E. Voak.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4525

Residence, St. Paul, Minn.

Date Admission, September 14 1896.

Admitted by Dr. C. B. Eby Hour, 6:45 P.M.

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

Sex, Male.

Age, 68.

Civil Condition, Married.

Children, 2.

Age Youngest Child, —

Occupation, Physician.

Degree Education, Good.

Profession Religion, Yes. Methodist.

Habits, Not intemperate.

Nativity, New York (Parents New York)

Physicians Committing, A. M. Dunning & H. O'Brien

Correspondents,

No. for Year, 58

Insane Relatives, None.

Cause Exciting, Not known

Cause Predisposing, Probably

Form, Manic exhaustion

Accompanying Bodily Disorder, None

Suicidal or Not, Not.

Date of this Attack, 4 Weeks

Duration, 4 Weeks.

No. of Attack, Not first.

No. of Admissions, 1st here. (Has been in Hospitals in Minn. & Iowa)

Age First Attack, not known

Time of Leaving, Feb. 13 1897

Time in Hospital, 4 mo. 30 ds.

Result, Recovered. Discharged 2/13/97

HERE'S SOMETHING NEW.

An Excursion by Schooners Down the Mississippi and a Season in the Sunny South.

An enthusiastic believer in the seventy-seven miles of coast lying between Bay St. Louis and Mobile Bay has a plan on foot that is worth the consideration by those people who are casting longing eyes to the sunny South as the place for health, happiness and inexpensive living.

The name of the enthusiast is Dr. J. E. Voak, and he lives at 671 Smith avenue south.

On Oct. 1 he proposes to run a fleet of schooners from St. Paul and Minneapolis to the gulf, taking pilgrims at almost unheard of low rates, together with their effects, and returning in the spring on May 1.

The regular railroad rates will be discounted by 25 per cent, and the charge on returning will be about equal to the full railroad fare, as the boats must be towed up stream.

In conversation with the Dispatch, he sets forth the attractions of this gulf coast in glowing language; its fertility, the health-giving quality of the air, its delightful scenery, its twelve open months of the year, the certainty of making a livelihood and the sure recovery to health of those who have been living at high pressure in the nervous North.

His boats will start, he says, from the foot of the falls in Minneapolis and from a point on the West side near the high bridge. The plan is an ambitious one, and the doctor seems thoroughly in earnest.

EXAMINATION ON ADMISSION.

Exam. by R. M. Phelps. 9/22/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Full of ideas about trip down the Mississippi. Talks with fair clearness except somewhat feeble-minded. Don't think there was anything unreasonable in his scheme. They were to drift down in a houseboat, & others wanting to go, would get another boat & take them along.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of John E. Voak.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, — WEIGHT, — NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, Condition of skin fair.

TONGUE, ~~Tremors,~~ Normal. Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, normal.

Response Light, yes. Accommodation, yes

SIGHT, Uses glasses.

HEARING, Normal.

COORDINATION, Arms, —

Legs, —

TREMORS, Hands, None of note Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal EXAM. URINE,

Other —

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No impairment noted.

LUNGS,

Good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ. (by) 56.5 (cm) 66 Nas.a 36 Bin.a. 34.5 Ant.p.d. 19.8 Trans.d. 15.4 Bin.d. 13.3 Stac.h. 12.6

HISTORICAL, Was at St. Peter 11 years ago

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Dead - Dysentery - Sick for 10 years - Insane for few months 2 yrs before death.

Father or Pat. Relations, Died - old age.

Brothers or Sisters, All dead - children 2 in poor health.

Personal and Medical History of John E. Voak,

EBBERT, FIGLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4525

Residence, St. Paul, Minn.

Date Admission, September 14/1896.

Admitted by Dr. Le B. Eby Hour, 6:45 P.M.

How Sent, G. Millich, J. & P. Ramsey Co.

Sex, - Male.

Age, - 68 -

Civil Condition, - Married.

Children, - 2 -

Age Youngest Child, -

Occupation, Physician -

Degree Education, - Good -

Profession Religion, Yes. Methodist.

Habits, Not intemperate.

Nativity, Newyork (Parents New-York)

Physicians Committing, A.W. Dunning & H.J. O'Brien

Correspondents,

No. for Year, 58

Insane Relatives, None.

Cause Exciting, Not known.

Cause Predisposing, Probably Previous attack.

Form, Manic exhaustion

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, 4 weeks ago.

Duration, 4 weeks.

No. of Attack, Not first.

No. of Admissions, 1st here. (has been at St. Peter)

Age First Attack, not known

Time of Leaving, Feb. 13 1897.

Time in Hospital, 4 mo. 30. da.

Result, Recovered. Discharged 2/13/97

EXAMINATION ON ADMISSION.

Exam. by R. M. Phelps. 9/22/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Full of ideas about trip down the Mississippi. Talks with fair clearness except somewhat feeble-minded. Don't think there was anything unreasonable in his scheme. They were to drift down in a house boat, & others wanting to go, would get another boat & take them along.

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,

Keep Well
TARRANT'S SELTZER APERIENT
TRADE MARK
By taking an Occasional Dose of
The cooling, refreshing, invigorating Cure for Constipation, Indigestion and Sick Headache.
Pleasant to take. Sold by Druggists 50 years.
MUNYONS!

al and Medical History of John E. Voak.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, - NUTRITION, Fair -

Condition of skin fair.

Coatings, Promptness Movement,

Size, normal.

Accommodation, yes

SIGHT,

HEARING,

COORDINATION Arms, -

Legs, -

TREMORS, Hands, None of note

Facial Muscles,

Tongue,

General,

REFLEXES, Patellar, Normal

EXAM. URINE,

Other -

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No impairment noted.

LUNGS,

Good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ. (h.) 56.5 (com.) 66 Nas.a. 36 Bim.a. 34.5 Ant.p.d. 19.8 Trans.d. 15.4 Bim.d. 13.3 Tac.h. 12.6

HISTORICAL, Was at St. Peter 11 years ago

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Dead - Dysentery - Sick for 10 years - Insane for few months 2yrs before death.

Father or Pat. Relations, Died - old age.

Brothers or Sisters, all dead - children 2 in poor health.

Personal and Medical History of John E. Voak.

1896

This patient was brought here by Sheriff Deputy D. M. Chapel with the following history: Patient is in fair physical condition: No history of Consanguinity or heredity: First attack occured 11 years ago & others have occurred at intervals since: Lasting a few weeks at a time. Patient was confined for a time at St Peter & was much benefitted by treatment received then: First symptoms of present attack were manifested about 4 weeks ago by wild schemes: Disease appears increasing; is variable with irregular rational intervals: Derangement shown in patients brain determined to fit a fleet of schooners for the Mississippi to New Orleans Etc., Patient is not suicidal, destructive or filthy: No previous peculiarities discovered: No history of intemperance in self or parents or of Venere disease or head injury. Cause of disease is unknown: Patient has received no treatment of late but 11 years ago was confined in the St Peter hospital as above stated: No further particulars learned on personal examination.

Sept 27 Nurses Notes (Summary) Came on ward Sept. 14 at 7 PM. Temperature normal: Talks freely & rationally. Oct 15. Quiet & well behaved, employs the time intelligently, reading, writing & playing checkers. Seems to be religiously inclined. Reads Bible a great deal. Makes no complaints & is seemingly contented. Appetite good. bowels regular & sleeps fairly well. No change in patient until Sept 24 when patient became very nervous & fidgety, unable to stand still while conversing. Continued very nervous until 26th when he became quiet as on admission. Slightly constipated last few days. Sept 29 Quiet & orderly: Habits neat & clean: Appetite good: Bowels slightly constipated at times: Spends time reading, writing & playing checkers Oct. 1 No change Wt. 142 lbs. Oct. 2 Trans. to A'

Nov 4 Talks rationally on all subjects: Physical condition seems good: Bowels & appetite normal. Sleeps well. Has been doing some office work for Dr Phelps Wt. 153 lbs. Dec. 20 No apparent change in patient. always quiet & well behaved. Is on parole. Physical condition good. Jan 1 Still works in library. No change either mentally or physically. Jan 11 Wt. 159 lbs.

Feb 1 No change in condition or behavior: Converses sensibly on all subjects: Seems slightly demented. Physical condition good.

Feb 13 was discharged recovered today.

Discharged

Personal and Medical History of

Personal and Medical History of Theodore Brunn

BURKET, FIELAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4527
Residence, Lanesboro, Minn.
Date Admission, September 15' 1896.
Admitted by Ko. B. Eby, M.D. Hour,
How Sent, E. V. Barrington, Jos. Fillmore Co.
Sex, -Male-
Age, - 20 -
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Farmer.
Degree Education, -Common School-
Profession Religion, Yes Lutheran.
Habits, Not intemperate.
Nativity, Minnesota. (Norway, parents)
Physicians Committing, Geo. A. Love - J. H. Phillips
Correspondents,

No. for Year, 60
Insane Relatives, Mothers sister.
Cause Exciting, Masturbation
Cause Predisposing, —
Form, Confusional insanity
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, No?
Date of this Attack, Sept. 6'96.
Duration, Since Sept. 6'96.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 20-
Time of Leaving, Apr. 26; 1897.
Time in Hospital, 7 mo. 11 d.
Result, Discharged Sept. 28. 1897. Recovered.

EXAMINATION ON ADMISSION.

Exam. by R. M. Phelps. 9/23/96

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient rather anaemic; slow to talk; sluggish in all motions to some extent. Appears slightly melancholy. Says was crazy now & then - was weak. Hung back about telling anything about self - unwilling to say - Seemed slightly confused about it. In his answers gave no delusions, incoherents or hallucinations but says they thought he was off. Keeps back information.

Personal and Medical History of Theodore Brunn.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Slightly impaired
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, no. Coatings, normal. Promptness Movement, prompt.
PUPILS, Equality, Equal. Size, Normal.
Response Light, — Accommodation, —
SIGHT, Good.
HEARING, "
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None - Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION, Good.
Slurred, Not.
Hesitating, v slow.
FACIAL EXPRESSION,

4527

SENSIBILITY,
HEART, Normal.
LUNGS, Normal.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ.(h) 52½ (fm) 62½. N.o.e.a. 33 B.m.a. 32 Aur.p.d. 18 Fr.m.r.d. 14½ B.m.d. 12½ Fac.l. 12.7
HISTORICAL, Drinks & smokes a little - Has headaches at times.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies insanity
Mother or Mat. Relations, living rheumatism.
Father or Pat. Relations, living sickly - catarrh.
Brothers or Sisters, 4 brothers healthy.

Personal and Medical History of Theodore Brenno.

1896

This patient was brought here by Sheriff Henry Nupson, attended by Knute Brennon with the following history:- Patient is in fair physical condition:- No history of consanguinity. The first symptoms of attack were manifested Sunday, Sept. 13th 1896- began by talking incoherently. Disease appears stationary, variable with irregular rational intervals. Derangement now manifested by hallucinations + delusions; hears voices at night- imagines that someone is trying to shoot him. Patient has made threats to injure others: is not suicidal, filthy or destructive: Has always been headstrong + always would have his own way: No history of intemperance in self or family: nor of severe disease or head injury: Patient has not been confined or restrained + has received no treatment. On personal examination no further particulars noted.

Sept — Nurses Notes- (Summary) Patient came on ward at 7 P.M. Sept. 15. Given bath. Quiet. Talks none unless spoken to. Has delusions: thinks he has been shot in head. Acts very foolish, laughing to himself continually. Habits slouchy + dirty. Had Temp. of 100 on admission, rising to 100² on second day, + falling to normal on 3rd. Appetite good: bowels constipated during first few days: Sleeps well. Remained about same mentally until 19th when he began to improve, continued to do so until 21st when he was able to converse quite rationally. on 22nd resumed his former behavior + has not changed since: Bowels regular since 21st Appetite remains good, sleeps well.

Sept 29 — Patient rather stupid- Talks none unless spoken to + then answers in monosyllables Acts very foolishly at times + laughs to himself: Physical condition rather poor. Appetite fair- bowels regular: Sleeps well. Oct. 1 wt. 138½ lbs. pulse 90.

Oct. 31 — Patient very slouchy in dress + habits: Is generally disagreeable.

Nov. 2 — Wt. 139 Pulse 78 No change in condition still has silly spells + is very stupid mentally. Nov. 14 Is steadily growing more stupid: Does not seem to know enough to care for himself; his appetite is failing Trans. to Infirmary, bathed + put to bed. T. 98° P. 72 R. 12.

Nov. 15 — 2.99 P. 84 R 21. Does not seem to know enough to help himself. Put upon bromide mixture. Nov. 27 Patient has remained in bed steadily since last note: Appetite good: Bowels irregular: Sleeps well: Habits filthy. Up on ward this P.M. Nov. 30 Up on ward each day: Cathartics & enemas given frequently. Dec. 1 Up on ward for a short time today. Mental condition very weak: Habits filthy: Lies in bed most of time in an awkward condition: Bowels usually constipated

Dec 14 — No change since last note. Does not talk - is very quiet + causes little trouble. Dec. 27 Behavior changed: became very noisy + was removed to a room in Bay. Dec 28 Noisy at times during night noisy all day.

Dec 31 — Very noisy at times + out of bed often: Talks incoherently.

Jan 1/97 — Up on ward: Trans. to B' Wt. 133 Pulse 102 - Quite troublesome for a while: would not sit on bench but wanted to roll on floor. Slept 1 hr.

Personal and Medical History of Theodore Brenno.

Jan 9 — was struck on right side of head by Geo. Wright - causing slight swelling. Behavior somewhat better tho still noisy at times Jan 10 Quite troublesome this afternoon: very noisy fought with Rutledge.

Jan 18 — Is allowed to eat in dining room: Appetite good: Is noisy + restless Has to be kept in bay: Jan 22 Slight improvement in behavior: Talks to himself incoherently in his own language most of time. Jan 31 Goes walking with crowd: Does no work. Feb. 1 Wt 147 lbs. P. 104. Still on medicine. Feb. 5 Is of a restless, mischievous disposition, requires constant watching: Talks but little, answers questions fairly well: Has spells of laughing to himself: Is slouchy in dress + habits.

Feb 8 + 9 — Visited by brothers + friends. Mar 1 Wt. 150 Pulse 96. Mar 13 Has commenced to work in dining room: Mar. 19 Right cheek swollen, says it is caused by ulcerated tooth: Mar 26 Appetite good: Bowels regular: Behavior good of late: Talks quite rationally, says he is well enough to go home. Still well enough to go home: Habits clean but untidy. Apr 2 Wt. 151½ Pulse 110. Trans. to B' Apr 10 Since on ward patient has been quiet + well behaved: Clean in habits + dress: Assists with work: Still on medicine 2 times a day. Trans to A 1-

Apr 26 — Allowed to go home. Dr. Herzog notes - "Since coming to A' has been very quiet + well behaved + shows no definite delusions: Is rather simple minded + does not realize that he has been insane. Had written home to his brother + we advised that he be allowed a trial altho not as perfectly recovered."

Discharged.

Personal and Medical History of Caspar Dieg.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4529

Residence, Not known

Date Admission, September 16' 1896.

Admitted by Dr. C. B. Eby Hour, 6:45 P.M.

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

Sex, Male.

Age, 31.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Laborer.

Degree Education, ?

Profession Religion, ?

Habits, Not known.

Nativity, Germany (Parents Germany.)

Physicians Committing, J. P. Baker, Jno. B. Darling.

Correspondents,

No. for Year, 62

Insane Relatives, Not known.

Cause Exciting, Not known.

Cause Predisposing, Not known.

Form, Dementia terminal

Accompanying Bodily Disorder, None known.

Suicidal or Not, ?

Date of this Attack, Not known

Duration, "

No. of Attack, "

No. of Admissions, 1st

Age First Attack, Not known

Time of Leaving, June 29. 1897

Time in Hospital, 9 mo. 13 da.

Result, Transferred to Fergus Falls.

C.F.Fm

EXAMINATION ON ADMISSION.

Exam. by C B Eby M.D. 9/19/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Seems confused, probably about his

Quick or Sluggish, Normal state.

MEMORY:

Past Events, Seems good.

Recent Events, Some impairment

Special Subjects, —

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Not good.

Own Mental State, great ability

Special Subjects, Probably never had any.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS: Does not show any particular delusions

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Probably patients mental state never was very much better than at present. Gives a fairly clear story of working for different ones at St. Cloud & then going to St. Paul to see friends who lived some miles out of the city. He also says he was born in Germany - served 3 years in the army & got his papers when he left. He worked hard & ascribes his stiffness to that cause. Is 31 years old & has been in this country 9 years.

Personal and Medical History of Caspar Dieg.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7½ WEIGHT, 159 NUTRITION, Good weight but anaemic.

WOUNDS OR ABNORMALITIES,

TONGUE, ~~Tremors,~~ Thick, pale, Coatings, slight. Promptness Movement, Prompt.

PUPILS, Equality, Not. Size, dilated

Response Light, Yes. Accommodation, Yes.

SIGHT, Fair.

HEARING, Fair.

COORDINATION, Arms, Fair

Legs, "

TREMORS, Hands, None. Tongue, None.

Facial Muscles, None. General, None

REFLEXES, Patellar, Equal ?

Other

ARTICULATION, Has an accent but

Slurred, otherwise articulation is

Hesitating, Good.

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

EXAM. URINE, Nov. 11'96.

Color Light yellow.

Sp. Gr. 1012.

Reaction Acid.

Character Cloudy, some sediment

Albumen Slight trace by heat, Tanrets & Ni. Cl.

Sugar None (Haines + by Bismuth)

Microscopical. Few mucococci urates. Considerable pus. Several long straight bacilli. Very little blood

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Long Probably ONSET GRADUAL OR SUDDEN, Developmental

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Casper Brig.

1896

This patient was brought here by Sheriffs Deputy Robert E. Anderson with the following history:- Patient is in fair physical condition: Patient was found wandering about streets of St. Paul & did not know where he was or where going. As to consanguinity, heredity, intemperance, habits, etc. nothing is known. On Personal Examination patient showed stunted mental development, physical training was all appearance of insanity. Believed him to be a fit subject for Faribault but recommend a term in the asylum. On admission put upon: B'E (A.P.M. Rpt. Complexion fair: hair light: Eyes blue: Condition of skin good: Marks: 3 on right arm & one on left leg. Has slight hernia: Is dirty: Behavior good. Is a little cross-eyed. Sheriff said he was inclined to be ugly.) Patient Received on ward 7 P.M. Sept 16

Sept 19 Nurses Notes (Summary) Behavior very restless & uneasy both on ward & when out with crowd: Talks but little, about only thing he says is that he wants to work on farm & thinks this is no place for him: Sits in bed in an awkward & stupid position, legs twisted, eyes closed, habits filthy & dirty: requires constant watching: Apparently no change since admission: Physical condition,- Appetite good, eats very rapidly & is very slouchy & untidy about eating: Bowels regular: Has symptoms of kidney trouble, says he cannot hold urine. Average amount of sleep per night 5 hrs. & a fraction.

Sept 20 Appetite good: Bowels regular: Behavior restless & uneasy: Requires constant care habits filthy. Oct 1 Wt. 158 Pulse 82. Oct 10 Attempted to run away. Oct 11 Was restless most of night. Slept two hours. Oct 13 Has boil on left side of neck:

Oct 16 Escaped from crowd while out for a walk. Captured by Nurses Barr & Bauson.

18 During dinner quarrelled with Geo. Wright - no one hurt. Oct 27 Made unsuccessful attempt to escape: Oct 30 Appetite good: eats rapidly: very slouchy: untidy about clothes: Bowels regular: Very troublesome & requires constant watching as he is suspicious at times: Habits very filthy: requires daily baths.

Nov. 1 Wt. 158 Pulse 88. Nov. 4 Passing bloody urine - Has symptoms of kidney trouble Complains of pain in back, urinates frequently. (See exam. of urine previous page) Very restless & troublesome in behavior: Constantly trying to escape when out. Always sits in awkward position with limbs crossed & head down: Habits filthy & dirty: Sleeps fairly well: Does no work: Trans. to Infirmary

Nov. 6 Physical condition fairly good: put to bed. Given plenty of milk, no meat: Bowels constipated: Seems to be in pain when urinating Note Says pain is most severe when bladder is full, feels inclined to urinate every 20-30 minutes. Considerable burning pain at time & for short time after urinating. Says he was all right up to a few days ago when he was kicked - This hardly seems probable as he has not himself for a long time past. The albuminous urine would seem to point toward the kidneys as the source of the pus while the pain on the bladder on becoming full would point toward it as the source of the inflammation.)

Personal and Medical History of Casper Berg.

1896

Nov 8 Temperature taken frequently went up as high as 105½: Considerable pain: Received several sponge baths: Nov. 9 Temp. nearly as high altho varying much - In morning down to 101⅘: Had only liquid diet. Nov. 10 Had chill in morning: Temp. somewhat lower altho up to 105 in afternoon: Had turpentine stupes & suppositories. Nov. 11 Temp. up to 104⅘ at noon but down to 101⅘ in afternoon & 102⅘ in evening. Nov. 12 Temp was seemingly not above 101 at any time: Pulse has not been very high during this attack: Pain has been at times severe: Temp. rest of week nearly normal: Rather restless but on whole doing well. Temp. during week from Nov. 13 to 20. ranged from 99 to 101, but usually above normal: More active & talks more rationally - wishes to go home. During remainder of month Temp. about same - rarely over 100. Dec. 1 Up on ward: Appetite good: Bowels regular: Habits filthy & dress untidy: Sleeps well: Sits about ward in awkward position: Talks but little. Dec. 4 Wt. 154. Urine Has been improving of late - Trans. to B'.

Dec. 14 Appetite & bowels regular: Goes walking with crowd: Requires constant watching Is always on the alert & knows where he can take advantage: Asks to be allowed to go to work on farm. Jan 1/97 No change. Wt. 162 Pulse 88.

Jan 13 Appetite good: Eats on hall - If allowed in dining room will eat all food he can reach. Bowels regular - No change in behavior: Sits on ward in same awkward & cramped position: Goes out with crowd: Seems very stupid Constantly asks to go home: Habits filthy: Does no work.

Feb 1 Wt. 162 lbs. Pulse 81. No change since last note. Feb 23 Made his escape while out with crowd: Returned at 6:30 P.M. Mar. 1 Wt. 158 P. 80.

Mar 29 Very melancholy to-day: When visitors were going through attempted to follow them: Afterward had crying spell. Apr. 1 Wt. 157½ lbs. Pulse 96 - Struck Louis Erickson in face. Apr. 14 No change in behavior or physical condition: Is filthy & slouchy Hard to care for: Kidneys still seem weak: Continually tries to escape when out. May 3 Wt. 163½ Pulse 86. May 10 Very stubborn disposition: Constantly trying to escape: Knows all that takes place around him. May 19 Had trouble with Alex Fair. May 23 Again had trouble with Fair: Brig had to be taken out of room by force - claimed that he was kicked in stomach by Nurse - Nurse denied charge - Examination held by Dr. Phelps & Nurse Opilane - no marks visible.

June 1 Wt. 160 - Pulse 100. June 24 No change in patient: Always requires close watching Tries to elope: Habits extremely filthy: Eats & sleeps on hall: Does no work.

June 29 Transferred to Fergus Falls.

Personal and Medical History of Henry S. Dawson.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4538
Residence, St. Paul. Minn.
Date Admission, Sept. 25- 1896.
Admitted by Dr. H.A. Herzog. Hour, 6.45 p. m.
How Sent, G. Wilbrich, Judge of Probati. Ramsey Co.
Sex, Male
Age, 36 years.
Civil Condition, divorced.
Children, none
Age Youngest Child, —
Occupation, clerk.
Degree Education, my well educated.
Profession Religion, none.
Habits, formerly drank + smoked excessively
Nativity, Louisiana, (parents also born there).
Physicians Committing, R.S. Bole + Arthur Swinney.
Correspondents, Mrs. Chas. Steele (sister)
337 N. Washington St. St. Paul Minn

No. for Year, 71
Insane Relatives, none
Cause Exciting, unknown
Cause Predisposing, syphilis + dissipation
Form, dementia paretic
Accompanying Bodily Disorder, none noted.
Suicidal or Not, no.
Date of this Attack, Gradual (1894)
Duration, 2 years
No. of Attack, 1st
No. of Admissions, 1st.
Age First Attack, 34 years
Time of Leaving, Oct. 10. 1896.
Time in Hospital, 15 da.
Result, Died - Exhaustion in Gen. Paresis.

Exd by Dr. Herzog Sept 26/96

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, yes on examination.
DELUSIONS:
Systematized or Not, unsystematized
Special Subjects,
Transitory or Not, transitory
HALLUCINATIONS: none noted.
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, incoherent
Voluble or Reticent, voluble.

GENERAL DESCRIPTIVE REMARKS: Patient has apparently been of good mental grade but is now quite demented. Shows symptoms of general paresis in 2nd stage latter part At time of examination was depressed, worrying because his own clothes were taken from him to be marked. He thought they were stolen + recurred again + again to the subject forgetting that he had just mentioned it. He expressed no delusions at examination but was quite plainly paretic.

Personal and Medical History of Henry S. Dawson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 feet 9 inches. WEIGHT, 132½ lbs (formerly 165) NUTRITION, poor
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, coarse + fine Coatings, clean Promptness Movement, slow.
PUPILS, Equality, right larger Size, contracted
Response Light, yes Accommodation, yes.
SIGHT, impaired
HEARING, good.
COORDINATION, Arms, considerably impaired (usual tests)
Legs, do.
TREMORS, Hands, some Tongue, coarse + fine
Facial Muscles, about lips on speaking General, yes,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred, yes
Hesitating, yes
FACIAL EXPRESSION, dull + blank eyes are shifting + sunken
SENSIBILITY,

HEART, no murmurs, sounds sharp. raped + irregular.
LUNGS, slight dulness over left apex. expansion lessened.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Wife says has been insane 2 years, growing worse, formerly dissipated.
LENGTH OF INVASION, long ONSET GRADUAL OR SUDDEN, gradual.
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, nothing obtainable from patient.
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Henry S. Dawson.

1896. This patient was brought here by his nephew Chas. Steele with the following history accompanying. Patient is in fair physical condition. No history of consanguinity or heredity. This is 1st attack. First symptoms manifested by gradual development of mental weakness, with hallucinations. Disease appears to be increasing. No rational intervals. Derangement now manifested by hallucinations of hearing, general silliness, lack of memory & loss of power to earn a living through mental defect. No disposition to injure others, not suicidal. General increase of carelessness in habits. No peculiarities of temper &c. Patient formerly drank & smoked excessively. Had syphilis in 1883. No restraint or confinement. Cause is supposed to be syphilis & dissipation. No treatment. On personal examination. Has many of the physical signs of paresis.

Sept 25. (U. H. No's Report.) On admission was placed on B3. Complexion dark, hair brown, eyes brown. Skin good. clean, behaviour good.

" 25 Nurses Notes - (Summary) On admission patient was in a very restless & excited condition & continued so all that night: On the following morning Sept 26 was transferred to infirmary & in afternoon was put to bed. He refused all nourishment & did not seem to realize where he was: Sense of well being very marked at times: became quiet though talked incessantly in an incoherent manner. Occasionally would say that he was very crazy & would never be well enough to be out on a bicycle again. He has been very restless & wakeful each night, sleeping very poorly & out of bed often. required to be held by nurse. Has slept a little during day.

Sept 30 Up today for first time: restless & easily agitated. Speech has become more drawling, thick & hesitating, some delusions of grandeur have been noticed. Oct 1 Dressed & taken out on grounds this afternoon.

Oct 2 Taken out of doors, became very excited & violent, held by two nurses for one hour. Seems to realize his condition at times but talk is nearly all the time incoherent & irrational. Oct 3 Had a similar spell while out on grounds. Oct 4 8 A.M. Had a maniacal spell with convulsive movements which lasted until about 11:30 A.M. Then became quieter. Oct 10 Since the 4th inst has had frequent maniacal spells & has had to be kept in restraint the greater part of time: was quieter while in restraint & when out required 3 or 4 nurses to hold him. Disease had made a very marked progress before admission here & since then ~~has~~ failed daily, more rapidly during last day or two. During last 2x has appeared unconscious, lost control of muscles of tongue twice. A nurse was constantly in attendance until his death. (For further particulars see nurses notes on file)

Died 8:25 A. M. October 10' 1896

Personal and Medical History of

Personal and Medical History of Robert Knox.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4539
Residence, St. Paul. Minn
Date Admission, Sept. 26. 1896
Admitted by Dr. R.M. Phelps Hour, 6 ½ p.m.
How Sent, G. Wilbrich, Judge of Probate, Ramsey Co,
Sex, Male
Age, 33 years
Civil Condition, single
Children, none
Age Youngest Child, —
Occupation, Brewer (?) (Coachman)
Degree Education, Good
Profession Religion, Presbyterian
Habits, temperate
Nativity, Edinburgh Scotland (parents also born there)
Physicians Committing, Chas J. Meade & J. M. Linnell
Correspondents, Robert Knox (father) Woodside, Cambus By Stirling Scotland.

No. for Year, 41
Insane Relatives, None
Cause Exciting, unknown
Cause Predisposing, syphilis
Form, dementia paretic
Accompanying Bodily Disorder, none
Suicidal or Not, no
Date of this Attack, Sept. 29. 1896 (sic) (probably more 22nd
Duration, 4 days. (probably longer)
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 33 years
Time of Leaving, Jan. 4. 1897
Time in Hospital, 3 mo. 9 da.
Result, Died - General Paresis

Exd by dr. Herzog Sept 29 1896

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, somewhat confused
Quick or Sluggish, somewhat sluggish
MEMORY:
Past Events, fairly good
Recent Events, much impaired
Special Subjects,
PERCEPTIVITY:
Alert or Dull, slightly dull
Correct or Illusive, fairly correct
REASONING POWER:
Ordinary Subjects, some impairment
Own Mental State, realizes something is wrong
Special Subjects, general

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, slightly
Depressed,
DELUSIONS:
Systematized or Not, no definite ones brought out
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, quite coherent
Voluble or Reticent, fairly voluble.

GENERAL DESCRIPTIVE REMARKS: Is quite plainly paretic. Shows no definite delusions on examination but a quite well marked sense of well being. Has been of fair mental grade Was a sergeant in the British army (Lancers). Has been a coachman of late. Father was a brewer. He contracted syphilis while in the army. Considerable dementia. Shown particularly by loss of memory for recent events.

Personal and Medical History of Robert Knox.

N ON ADMISSION, CONTINUED.

YSICAL CHARACTERISTICS.

GHT, 152 lbs (usual 172) NUTRITION, somewhat impaired.
shaped linear slightly depressed scar 4 in. long over to Parietal region received 11 years ago in barrack room fight.
t gray coat over ns somewhat marmic
Promptness Movement, fairly prompt but jerky.
Size, left much dilated
ed Accommodation, right sluggish left fixed.

d usual tests as specimen of hand writing
an stand on one foot with difficulty usual tests
Tongue, fine
General, slight

EXAM. URINE, Nov. 7/96 2.30 P.M.
Color Light yellow.
Sp. gr. 1030.
Reaction Acid.
Character Clear.
Albumen None.
Sugar None (Haines.)

Robt Knox Esq
Woodside
Cambus
By Stirlin
Scotland

Scotland.

Specimen of handwriting
of Robert Knox
Sept 29. 1896

Robert Knox.
Horfth Bte
Brewer
Cambus
on
Ecdlaad.

Dec '96

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

CRANIAL MEASUREMENTS,
HISTORICAL, syphilis 12 years ago. clear history of primary sore + eruption.
LENGTH OF INVASION, probably long ONSET GRADUAL OR SUDDEN, probably gradual
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations, Nothing brought out.
Brothers or Sisters,

Personal and Medical History of Robe[illegible]

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4539

Residence, St Paul. Minn

Date Admission, Sept. 26-1896

Admitted by Dr. R M Phelps Hour, 6 ½ p.m.

How Sent, G. Wilbrich, Judge of Probate, Ramsey Co,

Sex, Male

Age, 33 years

Civil Condition, single

Children, none

Age Youngest Child, —

Occupation, Brewer (?) (coachman)

Degree Education, Good

Profession Religion, Presbyterian

Habits, temperate

Nativity, Edinburgh Scotland (parents also born there)

Physicians Committing, Chas J. Meade & J. M. Linnell

Correspondents, Robert Knox (father) Woodside, Cambus By Stirling Scotland.

No. [illegible]

Insane Relatives, none

Cause Exciting, unknown

Cause Predisposing, syphilis

Form, Dementia paretic

Accompanying Bodily Disorder, none

Suicidal or Not, no

Date of this Attack, Sept. 29. 1896 (sic) (probably means 22nd

Duration, 4 days. (probably longer)

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 33 years

Time of Leaving, Jan. 4. 1897

Time in Hospital, 3 mo. 9 da.

Result, Died - General Paresis

Exd by Dr. Herzog Sept 29-1896

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, somewhat confused

Quick or Sluggish, somewhat sluggish

MEMORY:

Past Events, fairly good

Recent Events, much impaired

Special Subjects,

PERCEPTIVITY:

Alert or Dull, slightly dull

Correct or Illusive, fairly correct

REASONING POWER:

Ordinary Subjects, some impairment

Own Mental State, realizes something is wrong

Special Subjects, general

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, slightly

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects, no definite ones brought out

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, quite coherent

Voluble or Reticent, fairly voluble.

GENERAL DESCRIPTIVE REMARKS: Is quite plainly paretic. Shows no definite delusions on examination but a quite well marked sense of well being. Has been of fair mental grade Was a sergeant in the British army (Lancers). Has been a coachman of late. Father was a brewer. He contracted syphilis while in the army. Considerable dementia. Shown particularly by loss of memory for recent events.

al and Medical History of Robert Knox.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7½ in. WEIGHT, 152 lbs (usual 172) NUTRITION, somewhat impaired

WOUNDS OR ABNORMALITIES, crescent shaped linear slightly depressed scar 4 in. long over right fronto parietal region received 11 years ago in barrack room fight.

[illegible] gray eyes Promptness Movement, fairly prompt but jerky.

[illegible] somewhat myopic Size, left much dilated

[illegible] Accommodation, Right sluggish left fixed.

[illegible] usual tests see specimen of hand writing

[illegible] can stand on one foot with difficulty usual tests

Tongue, fine

General, slight

EXAM. URINE, Nov. 7/96 2nd P.M.

Color Light yellow.

Sp. gr. 1030.

Reaction Acid.

Character Clear.

Albumen None.

Sugar None (Haines.)

Sample of Knox's Writing

Robert Knox

Robert Knox.

Horfh [illegible]

Brewer

Cambus

on

Ecclaud

Dec '96

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

CRANIAL MEASUREMENTS,

HISTORICAL, syphilis 12 years ago. clear history of primary sore + eruption.

LENGTH OF INVASION, probably long ONSET GRADUAL OR SUDDEN, probably gradual

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

Mother or Mat. Relations, Nothing brought out.

Father or Pat. Relations,

Brothers or Sisters,

Personal and Me

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4539

Residence, St. Paul. M

Date Admission, Sept. 26

Admitted by Dr. R.M.P he

How Sent, G. Kilbuck, Judge

Sex, Male

Age, 33 years

Civil Condition, single

Children, none

Age Youngest Child, —

Occupation, Brewer (?) Coachman

Degree Education, Good

Profession Religion, Presbyterian

Habits, temperate

Nativity, Edinburgh Scotland (parents also born there)

Physicians Committing, Chas J. Meade & J. M. Linnell

Correspondents, Robert Knox (father) Woodside, Cambus By Stirling Scotland.

... (probably means 22nd)

... days. (probably longer)

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 33 years

Time of Leaving, Jan. 4. 1897

Time in Hospital, 3 mo. 9 da.

Result, Died - General Paresis

Exd by Dr. Herzog Sept 29 - 1896

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, somewhat confused

Quick or Sluggish, somewhat sluggish

MEMORY:

Past Events, fairly good

Recent Events, much impaired

Special Subjects,

PERCEPTIVITY:

Alert or Dull, slightly dull

Correct or Illusive, fairly correct

REASONING POWER:

Ordinary Subjects, some impairment

Own Mental State, realizes something is wrong

Special Subjects, general

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, slightly

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

No definite ones brought out

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, quite coherent

Voluble or Reticent, fairly voluble.

GENERAL DESCRIPTIVE REMARKS: Is quite plainly paretic. Shows no definite delusions on examination but a quite well marked sense of well being. Has been of fair mental grade Was a sergeant in the British army (Lancers). Has been a coachman of late. Father was a brewer. He contracted syphilis while in the army. Considerable dementia. Shown particularly by loss of memory for recent events.

...nal and Medical History of Robert Knox.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7½ in. WEIGHT, 152 lbs (usual 172) NUTRITION, somewhat impaired

WOUNDS OR ABNORMALITIES, crescent shaped linear slightly depressed scar 4 in. long over right fronto parietal region. received 11 years ago in barrack room fight.

TONGUE, Tremors, fine Coatings, light gray coat over dorsum somewhat mammic Promptness Movement, fairly prompt but jerky.

PUPILS, Equality, left larger Size, left much dilated

Response Light, right sluggish left fixed Accommodation, right sluggish left fixed.

SIGHT, impaired

HEARING, good

COORDINATION, Arms, considerably impaired manual tests see specimen of hand writing

Legs, do. can stand on one foot with difficulty manual tests

TREMORS, Hands, yes Tongue, fine

Facial Muscles, about lips General, slight

REFLEXES, Patellar, 10 equal

Other ankle clonus

ARTICULATION,

Slurred, yes

Hesitating, yes

FACIAL EXPRESSION, dull & blank

TAKEN,

EXAM. URINE, Nov. 7/96 2nd R.

Color Light yellow.

Sp. g. 1030.

Reaction Acid.

Character Clear.

Albumen None.

Sugar None (Haines.)

SENSIBILITY,

HEART, No murmurs, fairly strong & regular

LUNGS, seem good

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, syphilis 12 years ago. clear history of primary sore + eruption.

LENGTH OF INVASION, probably long ONSET GRADUAL OR SUDDEN, probably gradual

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

Mother or Mat. Relations, Nothing brought out.

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Robert Knox.

1896. This patient was brought by Deputy Sheriff E. J. Hurst with the following history. Patient is in fair physical condition. No history of consanguinity or heredity. First attack. First symptoms manifested Tuesday Sept. 29. 1896 (sic) Broke lamp. Crawled on hands & knees up stairs. At present time does not remember anything of his actions 4 days ago. Derangement now manifested "Is melancholic. Loss of memory". No disposition to injure others. Has been filthy while in County Jail. Threw clothes of his bed on floor of cell. Head was hurt in 1869(?) Syphilis is supposed to be the cause of the disease. No treatment. On personal examination Pupils unequal, speech stammering. Memory of recent events lacking.

Sept 28 On admission was placed on 133. (G. H. N's Ref't) Complexion dark. Hair brown, eyes blue. Skin good. Clean. Behaviour good.

Nurses Notes (Summary) On admittance here seemed confused & stupid. Answered questions fairly well but in a slow hesitating manner & was somewhat unsteady on his legs. Seemed to sleep well each night. Appetite good. Bowels regular. Habits neat & clean. Temperature since admission ranged from 101⅖ down. Yet he did not appear very sick. During 4th 5th & 6th of month was very well behaved, appeared contented & would play ball. On morning of 7th showed a change for the worse. Much confused in the morning, refused to dress himself, gradually became worse & about noon was completely helpless. Trans. to Infirmary at 7.45 P.M. Put to bed, seemed very much frightened. Temp. 101.6 Slept 7 hrs. Daily quiet during night.

Oct 1 was quiet in bed during day but somewhat restless at night. Bowels have been constipated: enema given. Oct. 9 very restless all day; could not be kept in bed. was somewhat destructive. Put in restraint sheet at 7.30 P.M. His speech still seems to become more thick & hesitating. Only delusion so far noticed: is imagining that he is driving a hack. Is in very good physical health. Oct 17 Dressed & up on ward today. Oct. 20 Remains up daily. Appetite good: Bowels constipated: was given pills. He is quiet & well-behaved. Is clean & in good personal habits. Speech is slow & hesitating. Gait slightly unsteady. He does not seem to realize where he is. Thinks one of the men on ward is his employer in St Paul & often asks him "when he will want the horses". Says he feels very well & will soon be at work. Physical condition good. Sleeps better at night. Nov. 1 Wt. 154½ Pulse 84. Up on ward & does considerable work. No change. Nov. 27 Trans. to B³. Is very neat & clean in habits & dress: Appetite good: Bowels regular. Dec 1 Wt. 160½ P. 72. Dec. 6 Slight swelling appeared on face & continued to spread until forehead & one side of face was covered. Complained of no pain until night of 14th was taken with severe chills: Temp. 101⁸ P. 90 R 21. Dec 15 Trans. to Infirmary Dec 15 Put to bed - Has erysipelas on face. Lies quietly in bed. Temp. 101⁷ P 76 R 16. Dec. 16 Face seems to be improving. Refuses medicine: Tears poison. Temp. lower - 100⁴ A.M. 100⁶ P.M. Face has been painted daily with Ichthyol - Dec 19 came out on hall several times during night

Personal and Medical History of Robert Knox

Inclined to be pugnacious. Temp. 101⁴ A.M. 103 P.M. Dec 20 Temp. 100⁴ A.M. 103⁴ P.M. Pulse 72 A.M. 96 P.M. Out of bed often last night. Very restless today. Refuses food before eating fears being poisoned Dec 22 Temp 99⁶ A.M. 103² P.M. Bowels constipated & has not urinated for some time. More stupid today. Abdomen much swollen. - Examined by Dr. Herzog & Catheterized. Dec 23 Catheterized several times daily; erysipelas nearly gone: Patient had bad spell today, lies in comatose condition. Temp. has been about 101. Dec 25 Slightly better but still comatose T. 102⁸. Dec 26 Much better - Sponge bath given: Still has to be catheterized Temp. (A.M.) 103 P. 108 R 21 P.M. Temp 102 P. 96 R 22. Appetite variable. Dec 27 Has been somewhat delirious this A.M. Temp. 101. Dec 28 Quite weak & out of bed often: Catheterized 4 times. Ate good dinner: Drank only milk for tea. Dec. 29 Given 1/40 gr. strych. at 4 & 8½ P.M. Bowels constipated. Patient very stupid. Dec. 30 Temp. 101⁴ A.M. 102² P.M. Fed by nurse, habits filthy: Enema given - no result. Dec 31 Temp A.M. 103⁴ P. 88 R 18. P.M. T. 101² P. 80 R 22. Ate fair breakfast & dinner. Urinates in large quantities. Is gradually losing in flesh: Mental condition weak: Hypo. strych. given 3 times day.

Jan 1 '97 Temp. 104⁸ - P. 116. R 20. A.M. - 5 P.M. 107⁶ P. 136 R 40 7.30 P.M. 106⁴ P. 100 R 36 Patient has been in partly comatose condition all day: Seemed somewhat stranger after tub bath. Whiskey given every two hrs. Jan. 2 8 A.M. T. 99⁸ P. 84 R 24 - 5 P.M. T. 105⁴ P. 29 R 26 10.30 P.M. Temp. 106⁶. 1¹⁰ P.M. T. 106⁴. Lies in bed in very weak helpless condition: Hands & feet cold. breathing labored - Whiskey given every three hrs. Temp from 104² to 105⁴ Cold packs & cold sponge baths given every two hrs. In comatose state all day. Seemed to be in considerable pain. Liquid diet given Jan 4 12.30 A.M. Groaning as if in pain. 7.05 Somewhat easier, very weak & evidently dying. Died at 2.45 A.M.

Died.

Personal and Medical History of Daniel Saunders.

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4542

Residence, Hay Creek, Minn.

Date Admission, 0 September 28 96.

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

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

Sex, Male.

Age, - 88 -

Civil Condition, Married

Children, - 5 -

Age Youngest Child, -

Occupation, - Carpenter -

Degree Education, Common school.

Profession Religion, Methodist.

Habits, Intemperate

Nativity, Wales (Parents Wales)

Physicians Committing, B Jachwig & F. W. Dimmitt

Correspondents,

No. for Year, - 75 -

Insane Relatives, Grandfather said to have had fits. Son Ike Saunders patient here

Cause Exciting, Drink.

Cause Predisposing, Not known - possibly heredity.

Form, Dementia senilis

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Threatened but never attempted.

Date of this Attack, 3 years ago.

Duration, 3 "

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, -85 -

Time of Leaving, Mar. 20. 1897

Time in Hospital, 5 mo. 20 da.

Result, Died. Erysipelas.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: As he cant answer correct, cant get much information so at present in dull stolid dementia or weak minded state - Has stooped position & dull look of senile dementia & its content to sit quietly all day. But his feebleness of body is not extreme nor his mental state at all active.

Personal and Medical History of Daniel Saunders.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Seems fair.

WOUNDS OR ABNORMALITIES, Skin fair for age.

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Equal. Size, About normal.

Response Light, Accommodation,

SIGHT, Probably poor

HEARING, Cant hear much of anything

COORDINATION, Arms,

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs (c) Sounds rather weak - Rather irregular.

LUNGS,

TAKEN,

EXAM. URINE, Nov. 9 96 48 hr.

Color Light Yellow.

Sp. gr. 1022

Reaction Acid.

Character Clear.

Albumen None.

Sugar None.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

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, 1 son Epileptic.

Personal and Medical History of Daniel Saunders.

1896

This patient was brought here by Sheriff's Deputy Ag Schenck with the following history:- Is in fair physical condition: No history of consanguinity: Suit symptoms of this (4th) attack were manifested three years ago by incoherent talk & violent behavior: Disease appears increasing, not variable, with no rational interals: Patient has shown disposition to injure others & has threatened although never attempted suicide: Is filthy & destructive in habits: Before accession of disease had a violent temper & drank to excess No history of severe disease or head injury: Patient has required constant watching & manuel restraint: No particulars known concerning treatment. On personal examination there was evidences of Senile dementia.

Oct 11 Nurses Notes (Summary) Ever since admission patient has been quite troublesome both day & night: Our infirmary is kept in "Green Bay" but will not remained seated for any length of time. Always wants to get up looking for his hat wants to go home to his wife. Appetite good: bowels regular: He has been taken out on grounds on five days but is too weak & feeble an old man to go for a walk. On a number of occasions has given trouble to nurses as he resists all interference & is too deaf to understand what is required of him. Says he does not know why he is here "never did anyone any harm & never stole anything" No special delusions have been noticed: Has not been on medicine.

Nov. 1 Wt. 155 P. 78. Patient up on ward: Bowels regular: Sleeps eats well. Nov. 30 Sleeps on B2. Dec. 1 Wt. 156 P. 76. Is very troublesome: Continually hunting for his hat. Says he has been here long enough & wants to go home. Jan 5/97 No change Trans. to A4. Jan 31 Has had rattling sound in chest ever since receind on ward: Coughs slightly at times, raises great amount of phlegm. Feb. 1. Wt 153 Patient's appetite is good: Finds difficulty in masticating solid food. Bowels regular: Sleeps well: Quite feeble - seems to be gradually failing: Still searches for his hat: Thinks he is in jail: Memory very poor: Quite deaf Habits clean: Untidy in dress.

Mar 1 Wt 150. P. 70. No change. Mar. 7 Fourth finger on left hand found torn open at joint: dressed: Marg Finger seems worse - is somewhat swollen: Repeatedly dressed:

Mar. 14 Swelling increasing: grows worse instead of better: Complains of pain.

Mar 16 Swelling has extended to hand & wrist: Considerable inflammation: Restless during night: Refused breakfast: Seems very weak in legs. Hot bichloride dressings applied. Trans. to Infirmary. On liquid diet: Given bath & put to bed: Appears quite weak: Left hand & fore arm inflamed & swollen: Seem to be very sore & painful. Hot applications bichloride seem to relieve it somewhat Temp. Am. 102⅘. Pm. 103⅘.

Mar. 17 Slept none last night: Breathing labored: Habits filthy: Seems somewhat weaker: Bowels constipated. Mar. 18 On Liquid diet. Pulse intermittent - Temp. 100⅘ Am. 102⅘ Pm.

19 Seems to have grown weaker during day: Arm appears worse: Hot bichloride applications continued since 16th 5:20 Patient appears in an unconscious state. Breathing labored & pulse intermittent & weak. N. N. reports - no change noticed in

Personal and Medical History of Daniel Saunders.

patient until 3 A.M. when he began to fail rapidly & expired at 3:25 A.M.

Died.

Personal and Medical History of William Baldwin.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4573
Residence, Winona, Minn.
Date Admission, 30th September, 1896
Admitted by Dr. R. M. Phelps Hour,
How Sent, H. L. Buck, J. of P. Winona Co.
Sex, - Male -
Age, - 38 -
Civil Condition, - Widower -
Children, - 2 -
Age Youngest Child, -
Occupation, Engineer.
Degree Education, Fair.
Profession Religion, Yrs Catholic.
Habits, Not intemperate.
Nativity, Germ. (Father Belgium, Mother Ireland)
Physicians Committing, L. Houghton & J. S. Tracy.
Correspondents, Wm. Baird - 606 Indiana Ave, Winona Minn.

No. for Year, 76
Insane Relatives, None.
Cause Exciting, Loss of Employment.
Cause Predisposing, Not known.
Form, Demential paretica
Accompanying Bodily Disorder, Insomnia.
Suicidal or Not, Not.
Date of this Attack, 4 months ago.
Duration, 4 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, - 38 -
Time of Leaving, May 10 - 1897
Time in Hospital, 7 mos. 10 ds.
Result, Died - Ex Lanction in Gen. Paresis

EXAMINATION ON ADMISSION.

Exam Oct 8'96 By Dr. H. H. Kenyon

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused -
Quick or Sluggish, Somewhat sluggish.
MEMORY:
Past Events, Somewhat impaired.
Recent Events, Considerably impaired.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull -
Correct or Illusive, Fairly correct.
REASONING POWER:
Ordinary Subjects, Slow.
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, √
Depressed,
DELUSIONS:
Systematized or Not, Unsystematized.
Special Subjects, of grandeur
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Fairly coherent.
Voluble or Reticent, Voluble

GENERAL DESCRIPTIVE REMARKS: On admission & for several days afterward was somewhat depressed said he was nervous & could not sleep. Now insists that he feels splendid - To the strongest man on the hall etc. The speech & forms are quite pastic & the handwriting attached is quite characteristic

Oct 8th

In Agust of 1877 General entered the cosl um of Havana at the hedd of a military force besieged and occopied it investegated the operations investagated the ~~coc~~ operations carried there and discharged every employee the act caused a great disaster but not one single one of the officials was indicted or suffered furthe punishment there three in 1891 three Hundred and fifty officalls indicted Cuba not one of the was punished

William Baldwin.

ADMISSION, CONTINUED.

CHARACTERISTICS.

44 NUTRITION, Somewhat impaired.

yish coat and dorsum Promptness Movement, Fairly prompt.
Size, Contracted
Accommodation, Gro.

Tongue, Coarse & fine
General, No.

EXAM. URINE,

HEART, Sounds at apex rough.
Strength sounds. Beat. fairly regular.
LUNGS,
Breath sounds normal.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Mother dead - Cause of death unknown.
Father or Pat. Relations, Father died - ulcer of stomach.
Brothers or Sisters, 1 brother died Consumption Children 3 - 9-6 & 5 well.

Personal and Medical History of

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4543

Residence, Winona, Minn.

Date Admission, 30th September

Admitted by Dr. R. M. Phelp

How Sent, H. L. Buck, J

Sex, - Male -

Age, - 38 -

Civil Condition, - Widow

Children, - 3 -

Age Youngest Child, -

Occupation, Engineer.

Degree Education, Fair.

Profession Religion, Yes Catholic.

Habits, Not intemperate.

Nativity, Penn. (Father Belgium, Mother Irela

Physicians Committing, L. Hugetten & J. J. Tracy.

Correspondents, Wm. Baird - 606 Indiana Ave, Winona Minn.

8 10-1897

mo. 10 da.

Ex Lunatico in Gen. Paresis

EXAMINATION ON ADMISSION.

Exam Oct 8'96 By Dr H H Kings

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused-

Quick or Sluggish, Somewhat sluggish.

MEMORY:

Past Events, Somewhat impaired.

Recent Events, Considerably impaired.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull-

Correct or Illusive, Fairly correct.

REASONING POWER:

Ordinary Subjects, Slow.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: On admission & for several days afterward was somewhat depressed said he was nervous & could not sleep. Now insists that he feels splendid - Is the strongest man on the hall, etc. His speech & forms are quite particular & the handwriting attached is quite Characteristic

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Unsystematized.

Special Subjects, of grandeur

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Fairly coherent.

Voluble or Reticent, Voluble

istic. It is copied from a newspaper. Patient denies syphilis.

Personal and Medical History of William Baldwin.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7½ WEIGHT, 144 NUTRITION, Somewhat impaired.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Grayish coat in dorsum Promptness Movement, Fairly prompt.

PUPILS, Equality, right eye slightly larger. Size, Contracted

Response Light, Yes. Accommodation, Yes.

SIGHT, Somewhat impaired

HEARING, Good.

COORDINATION, Arms, Impaired

Legs, "

TREMORS, Hands, None. Tongue, Coarse - fine

Facial Muscles, About lips on speaking General, No.

REFLEXES, Patellar, 10 Equal. EXAM. URINE,

Other Marked ankle clonus.

ARTICULATION,

Slurred, yes

Hesitating, yes.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Sounds at apex rough. Strength sounds. Weak. Fairly regular

LUNGS, Breath sounds normal.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Mother dead - Cause of death unknown.

Father or Pat. Relations, Father died - ulcer of stomach.

Brothers or Sisters, 1 brother died consumption Children 3 - 9-6 & 5 Well.

Personal and Medical History of William Baldwin.

1896

This patient was brought here by Sheriffs Dpety Jonas Tisdale, with the following history:- Patient is in fair physical condition. No history of consanguinity, heredity or intemperance in self or parents. First symptoms of this (1st) attack manifested 4 months ago by insomnia: Disease appears increasing, variable with irregular rational intervals: Patient complains of loss of sleep & confusion of ideas: Has shown no disposition to injure others: Is not suicidal, filthy or destructive: No peculiarities previously shown: No severe disease or head injury: The supposed cause of disease is loss of employment: Patient has received no treatment; has not been confined or restrained. (On admission put upon B.3 E (G.H.M. Rx) Complexion dark: Hair black: Eyes blue: Condition of skin good: Thumb of right hand cut off. Scar over right temporo parietal region & over right external angle of the eye. Is clean: Behavior good: Enlarged veins on legs.)

Sept 30 Nurses Notes (Summary) Received on ward at 4 P.M. - given bath: Talks rationally & is well behaved. Temp. 99.8 P. 96. R. 18.

Oct 6 Makes no complaint: Says he has no complaints except loss sleep but has had slight rise of temperature: Appetite good: Bowels regular but seems quite restless nights: Walks out with crowd & seems quite active while out. Behaves very well. Today seems unusually quiet also appears stupid & forgetful.

Oct. 13 Appetite remains good but is loosing flesh: Skin is becoming a sickly color: Voice is quite unsteady at times, also seems very nervous. Remains neat & clean in habits & dress, mental condition apparently unimproved: Today has been in very good spirits: Singing, laughing & enjoying himself. Sleeps fairly well. Oct 14 Patient quiet & well behaved: Appetite good: Bowels regular. Sleeps well. Mental condition changeable: Very nervous at times. Nov. 1 Has been careful & tidy in appearance until lately - He is now unconsciously becoming quite careless, when spoken to seems embarassed & says memory is poor: To very question about his mental difficiency. Appetite fair: bowels constipated: Sleeps well. Wt. 147 P. 96.

Nov 14 Has been failing for some time: vomits often & complains of stomach: In bed today vomiting frequently Nov. 13 Still in bed. Temp. sub normal. Trans. to Infirmary & put to bed Nov. 14 Up on ward: Appetite good. Bowels regular: Behavior good: Habits clean: Trans to B.3. Dec 3 Patient has vomiting spells very frequently: Mental condition sometimes exalted & lively & at others depressed & ugly. Can't say mentally declining: Still very ill tempered at times: Wt. 148 Pulse 84 Has had no vomiting spells for some time.

Feb 1. Patient remains about same probably a little more unsteady & has less control of his tongue. Appetite fair: bowels regular. Wt. 153 P. 98. Feb 2 Remained in bed today: Vomited several times: Feb 3 Up on ward. Well as usual. Mar. 1 During last few weeks has rapidly grown worse mentally. Walks floor continually muttering & laughing to himself: Is very careless in dress & appearance. Talks irrationally

Personal and Medical History of William Baldwin.

Mar 4 Became very sick this P.M. vomiting several times: Mar 6 Speechless this A.M. Is unable to stand alone or control himself. Has eaten scarcely anything for two days. Mar 7 Restless & noisy all day. Slight rise of temp. Took no nourishment today. Mar. 8 Noisy & restless all night: Ate no breakfast. Trans. to Infirmary A.M. Temp. 100.6 P. 106 R 18 - P.M. 99.6 P. 106 - R 20. Out of bed often during day: Talks incoherently & irrationally: Has delusions. Mar 10 Still restless & noisy: Bowels constipated: Enema given. Mar. 18 Very little change during past week: Appetite has been good: Bowels constipated: Usually noisy & restless in behavior: Has many delusions. Temp. has not been above 99.4 until 5 P.M. on 17 when it was 101.8 -

Mar 23 Sick to stomach & vomited. Very restless all day. Pulse given. Temp. 100 (P.M.)

24 Very quiet, has slept most of day: Mar 31 No change in patients condition during past week. Apr 1 Still in bed: Very restless & pugnacious at times. Talks irrationally: Appetite good. Bowels quite regular. Apr 4 Visited by a friend: Called him by name but talked irrationally. Apr 6 Vomited this A.M. & Appeared quite sick. Apr 7 Vomited twice.

Apr 8 Did not sleep last night; very restless. Talks irrationally: Bowels regular. Refused dinner.

13 Not so restless of late: No change otherwise: Apr 22 No use of right side of body - appears paralyzed. Vomited in morning: Is stupid: Feet & knees cold: Perspires freely: Visited by Father Riordon: A.M. Temp. 100 R 16 P 132 - P.M. Temp. 104.4 P 132 R ∞. Apr 24 Still in stupid condition. Takes no nourishment: Perspires freely: Habits filthy. A.M. Temp. 104.6 P. 140 R 20. P.M. 105.2 P 72 R 24.

25 A little better today. Temp. 103.6 in A.M. 103.1 P.M. Visited by friend: Took some nourishment

26 A.M. Temp. 99.8 - P.M. 100.4 Seems better - Has bedsore on back & on right heel: -

27 Temp. 99.6 this A.M. P.M. 101.8 P 132 R 30. Is brighter: Talks some: Both legs very lame: On liquid diet: Slept 2 hrs. Apr 30 Seems to be improving: Is able to move right hand: Bed-sores dressed: Talks some. Temp. nearer normal this mut up to 100.4 on P.M. of 29th

May 6 Very little change in patient since last note: Temp. ranges from 99.4 to 102.4 being higher each afternoon than in morning: Bowels constipated: Enemata given: Breathing labored at times: Bed sores do not seem to improve: May 7 A.M. T. 101 P 136 R 30 P.M. T. 102 P 150 R 36 Is weaker today & more stupid - Enema given: On liquid diet for since Apr 26.

8 A.M. T. 104.4 P 160 R 32 P.M. T. 104.2 P 140 R 21. Much weaker. Habits filthy: Very stupid

9 A.M. T. 103.2 P. 160 R ∞ P.M. 105.9 P. 72 R 50 Weaker & more stupid: Mouth & lips dry: Breathing labored & irregular: Pulse rapid & weak: Visited by friend. In a comatose condition this P.M. Breathing Cheyne Stokes. Pulse very weak:

May 10 1 A.M. Has been growing weaker during night: 9.05 Expired.

Dr Herzog notes - Died of exhaustion in General Paresis - Temperature caused by septic absorption from bed-sores.

Died.

Personal and Medical History of John Dexter

EGBERT, FIGLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4552

Residence, St. Paul, Minn. (462 Rosabel Ave)

Date Admission, October 14th 1896.

Admitted by Dr. H.H. Kiggs Hour, 6.45 PM.

How Sent, J. Millrich, Jr. of P. Ramsey Co.

Sex, -Male-

Age, -44-

Civil Condition, Married.

Children, - one -

Age Youngest Child, -

Occupation, "Railroad"

Degree Education, Common School.

Profession Religion, Not a church member.

Habits, Has been intemperate.

Nativity, Canada (Father Canada, Mother Belgium)

Physicians Committing, Paul Ritchie + O. Mantel.

Correspondents,

No. for Year, 85.

Insane Relatives, None.

Cause Exciting, Not known

Cause Predisposing, "

Form, Mania acuta

Accompanying Bodily Disorder, Has a painful spot on back of neck caused by fall.

Suicidal or Not, Not.

Date of this Attack, Few days ago.

Duration, A few days.

No. of Attack, 2nd

No. of Admissions, 1st

Age First Attack, -44-

Time of Leaving, Apr. 28. 1897

Time in Hospital, 6 mo 14 da.

Result, Discharged Aug 11. 1897. Improved.

EXAMINATION ON ADMISSION.

Exam. Oct. 15 by Dr. H.H. Kiggs

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused-

Quick or Sluggish, Quick.

MEMORY:

Past Events, Fairly good

Recent Events, Impaired

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, disconnected

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient is in a sub-acute maniacal state - probably caused somewhat by drink - previous attacks + impaired physical condition. Has somewhat incoherent notions about being held here for political purposes as he is a Republican. Talks quite constantly about McKinley + protection -

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Un

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

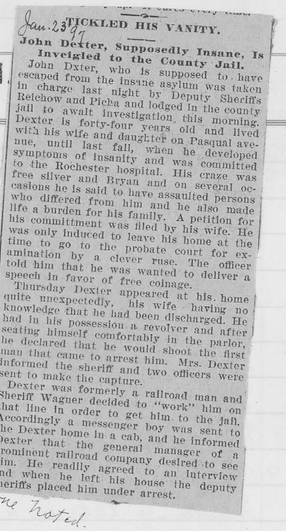
ILLUSIONS:

one hated.

CONVERSATION:

Coherent or Incoherent, Quite incoherent

Voluble or Reticent, Voluble.



Jan. 23 97

TICKLED HIS VANITY.

John Dexter, Supposedly Insane, Is Inveigled to the County Jail.

John Dxter, who is supposed to have escaped from the insane asylum was taken in charge last night by Deputy Sheriffs Reichow and Picha and lodged in the county jail to await investigation this morning. Dexter is forty-four years old and lived with his wife and daughter on Pascal avenue, until last fall, when he developed symptoms of insanity and was committed to the Rochester hospital. His craze was free silver and Bryan and on several occasions he is said to have assaulted persons who differed from him and he also made life a burden for his family. A petition for his committment was filed by his wife. He was only induced to leave his home at the time to go to the probate court for examination by a clever ruse. The officer told him that he was wanted to deliver a speech in favor of free coinage.

Thursday Dexter appeared at his home quite unexpectedly, his wife having no knowledge that he had been discharged. He had in his possession a revolver and after seating himself comfortably in the parlor, he declared that he would shoot the first man that came to arrest him. Mrs. Dexter informed the sheriff and two officers were sent to make the capture.

Dexter was formerly a railroad man and Sheriff Wagner decided to "work" him on that line in order to get him to the jail. Accordingly a messenger boy was sent to the Dexter home in a cab, and he informed Dexter that the general manager of a prominent railroad company desired to see him. He readily agreed to an interview and when he left his house the deputy sheriffs placed him under arrest.

John Dexter.

for history John Dexter

Rochester Minnesota
October 26th 1896

Hon - B. F. Doran mayor of St Paul
I am confined at this Hospital
have been here since Oct 14th
I am getting along fine and
should like to come home to
vote now you must surely
~~know~~ remember me as you
give me a letter of recommend
last spring I am entitled to a
straight republican vote if possible
please attend to this at once I have
never told you but will now that
I should know for Jim Hill to
pay you for that would which
you insisted me to when I Gived an
Longson at also worked for one
dollor for day to help nominate +
Elect you Your True friend John Dexter

ADMISSION, CONTINUED.

CHARACTERISTICS.

149 lbs. NUTRITION, Quite emaciated.

any grayish yellow coat Promptness Movement, Prompt.

Size, Small.

Accommodation, -yes-

Tongue, Quite Marked-

General, No.

EXAM. URINE, Nov. 12' 96.

Color	Pale yellow.
Sp. gr.	1005
Character	Clear
Reaction	Slightly Acid
Albumen	None.
Sugar	None.

HEART, No Murmurs noted-
Sounds - Impulse forcible

LUNGS, breath sounds Normal.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Numerous scars on head. Formerly Laid drinker.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") No history

Mother or Mat. Relations, No history

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of John Dexter

EBBERT, PUGH & CHAMBERS, DAVENPORT, IOWA

Whole No. 4552

Residence, St. Paul, Minn. (96 Ravoux Ave)

Date Admission, October 14th 1896.

Admitted by Dr. H. H. Huzzy Hour, 6.45 PM.

How Sent, J. Millrick, Jr. of P. Ramsey Co.

Sex, -Male-

Age, -44-

Civil Condition, Married.

Children, - one -

Age Youngest Child,

Occupation, "Railroad"

Degree Education, Common School.

Profession Religion, Not a church member.

Habits, Has been intemperate.

Nativity, Canada (Father Canada, Mother Belgium)

Physicians Committing, Park Ritchie & O. Martel.

Correspondents,

No. for Year, 85.

Insane Relatives, None.

Cause Exciting, Not known

Cause Predisposing,

Form, Mania acuta

Accompanying Bodily Disorder, Has a painful spot on back of neck caused by fall.

Suicidal or Not, Not.

Date of this Attack, Few days ago.

Duration, A few days.

No. of Attack, 2nd

No. of Admissions, 1st

Age First Attack, -41-

Time of Leaving, Apr. 28. 1897

Time in Hospital, 6-mo 14 da.

Result, Discharged Aug 11. 1897. Improved.

EXAMINATION ON ADMISSION.

Exam. Oct. 15 by Dr. H. Huzzy. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused-

Quick or Sluggish, Quick.

MEMORY:

Past Events, Fairly good

Recent Events, Impaired

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, disconnected

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient is in a sub-acute maniacal state - probably caused somewhat by drink - furious attacks & impaired physical condition. Has somewhat incoherent notions about being held here for political purposes as he is a Republican. Talks quite constantly about

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Unsystematized

Special Subjects,

Transitory or Not, -Yes-

HALLUCINATIONS: None Noted.

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Quite incoherent

Voluble or Reticent, Voluble.

McKinley & protection-

for history John Dexter

Rochester Minnesota
October 26th 1896

Hon - B. F. Doran mayor of St. Paul
I am confined at this Hospital
have been here since Oct 14th
I am getting along fine and
should like to come home to
vote now you must surely
~~Work~~ remember me as you
give me a letter of recommend
last spring I am entitled to a
1st republican vote if registered
attend to this at once I have
you but will now that
w for Jim Hill to
ould which
how I stand and
d for one
inate &

John Dexter

John Dexter.

ADMISSION, CONTINUED.

CHARACTERISTICS.

149 lbs. NUTRITION, Quite emaciated-

...ry grayish-yellow coat Promptness Movement, Prompt.

Size, Small.

Accommodation, Yes.

Tongue, Quite marked-

General, No.

EXAM. URINE, Nov. 12. 96.

Color	Pale yellow.
Sp. Gr.	1005
Character	Clear
Reaction	Slightly Acid
Albumen	None.
Sugar	None.

TAKEN,

LUNGS, ...Normal.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Numerous scars on head. Formerly hard drinker.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") No history

Mother or Mat. Relations, No history

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of J

HERBERT, PIDLAR & DIAMBURG, DAVENPORT, IOWA

Whole No. 4552

Residence, St. Paul, Minn. (964 Pascal Ave)

Date Admission, October 14th 1896.

Admitted by Dr. H.H. Hugoy Hour, 6:45 PM

How Sent, G. Millrich, Jr. of P. Ramsey

Sex, -Male-

Age, -44-

Civil Condition, Married.

Children, -one-

Age Youngest Child,

Occupation, "Railroad"

Degree Education, Common Sch

Profession Religion, Not a church

Habits, Has been intemperate.

Nativity, Canada (Father Canada, Mother

Physicians Committing, Park Ritchie & O. Martel.

Correspondents,

EXAMINATION ON ADMISSION. MENTAL CHARACTERISTICS.

Exam. Oct. 15 by Dr. H. Hugoy.

MENTAL ACTIVITY:

Clear or Confused, Confused-

Quick or Sluggish, Quick.

MEMORY:

Past Events, Fairly good

Recent Events, Impaired

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, disconnected

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient is in a subacute maniacal state - probably caused somewhat by drink - previous attacks & impaired physical condition. Has somewhat incoherent notions about being held here for political purposes as he is a Republican. Talks quite constantly about

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Un

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

None noted.

CONVERSATION:

Coherent or Incoherent, Quite incoherent

Voluble or Reticent, Voluble.

McKinley & Protection-

Hon. R. T. Doran
Mayor of
St. Paul
Minnesota
U. S. A.

Personal

Dr. H. H. H. Hugoy
at office and obliged
your true friend
John Dexter
10th & 6th Sts
1896

LED HIS VANITY.

er, Supposedly Insane, Is ed to the County Jail.

er, who is supposed to have om the insane asylum was taken last night by Deputy Sheriffs and Picha and lodged in the county jail, await investigation, this morning. Dexter is forty-four years old and lived with his wife and daughter on Pasqual avenue, until last fall, when he developed symptoms of insanity and was committed to the Rochester hospital. His craze was free silver and Bryan and on several occasions he is said to have assaulted persons who differed from him and he also made life a burden for his family. A petition for his committment was filed by his wife. He was only induced to leave his home at the time to go to the probate court for examination by a clever ruse. The officer told him that he was wanted to deliver a speech in favor of free coinage.

Thursday Dexter appeared at his home quite unexpectedly, his wife having no knowledge that he had been discharged. He had in his possession a revolver and after seating himself comfortably in the parlor, he declared that he would shoot the first man that came to arrest him. Mrs. Dexter informed the sheriff and two officers were sent to make the capture.

Dexter was formerly a railroad man and Sheriff Wagner decided to "work" him on that line in order to get him to the jail. Accordingly a messenger boy was sent to the Dexter home in a cab, and he informed Dexter that the general manager of a prominent railroad company desired to see him. He readily agreed to an interview and when he left his house the deputy sheriffs placed him under arrest.

Personal and Medical History of John Dexter.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8½ in. WEIGHT, 149 lbs. NUTRITION, Quite emaciated-

WOUNDS OR ABNORMALITIES,

TONGUE, ~~Tremors,~~ Large. Coatings, Heavy grayish yellow coat Promptness Movement, Prompt.

PUPILS, Equality, Equal. Size, Small.

Response Light, Yes Accommodation, Yes.

SIGHT, Fairly good.

HEARING, Fairly good.

COORDINATION, Arms, Slightly impaired

Legs, " "

TREMORS, Hands, Some. Tongue, Quite marked-

Facial Muscles, No. General, No-

REFLEXES, Patellar, Equal 5. Fast dip

Other Feeble-

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No Murmurs noted-
Sounds- Impulse forcible

LUNGS, Breath sounds Normal.

TAKEN,

EXAM. URINE, Nov. 12' 96.

Color Pale yellow.
Sp. Gr. 1005
Character Clear
Reaction Slightly Acid.
Albumen None.
Sugar None.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Numerous scars on head- Formerly hard drinker.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") No history

Mother or Mat. Relations,

Father or Pat. Relations, No history.

Brothers or Sisters,

Personal and Medical History of John Dexter.

1896

This patient was brought here by Sheriff's Deputy Chas. Ruchow with the following history: Patient is in fair physical condition: No history of consanguinity, heredity or intemperance in self or family. First attack occurred three years ago & lasted three weeks - patient was in hospital at Pontiac Michigan & was cured - First symptoms of present attack were manifested a few days ago by hallucinations: Disease appears stationary, variable with irregular rational intervals: He has delusions, is noisy & talkative & fears injury from animals - particularly cats & dogs with hydrophobia. Patient has shown no disposition to injure others: Is not suicidal, filthy or destructive: Showed no previous peculiarities. Three months ago patient had a fall: No restraint or confinement employed & no treatment pursued: Cause of disease unknown. On personal examination: patient has a painful spot on back of neck where he fell. On admission put on B^3E (G.H.N. Rpt Complexion dark: Hair black: Eyes brown: Condition of skin good. Has marks on thighs: several small scars on scalp: First & little finger on left hand bruised: has hernia: Is dirty: behavior excited & talkative.)

Oct 14 Summary Nurses Notes. Patient came on ward 7.30 P.M. Seemed in excited
Oct state of mind. Talks much & irrationally Oct 19 Has had slight rise of temperature for a few days. Normal to-day Has been noisy & ill behaved: has required constant watching. Put on bromides on 17th with no apparent effect. Oct 21 Quieter yesterday & today - attended dance this evening & behaved well. Appetite good: bowels regular: Oct. 27 Has been noisy & excited since 21st No apparent change in patient since admission:

Oct 28 Very noisy & ill behaved. Is continually annoying other patients
Appetite ravenous, bowels regular, sleeps well: Has delusions.

Nov. 6 No change since last note. Is very talkative. Habits clean but untidy:
Is incoherent. Nov 23 Has been very troublesome & has trouble with other patients - often striking them. Says today that someone kicked him: Nurse says not. Nov. 24 Complained of pain in right side: Same blistered:

26 Still complains of back which was again blistered. Dec 1 Wt. 142 P. 108

Dec 5-6 Visited by wife: went walking with her attended by Nurse.

10 Very pugnacious today: Attacked Nurse Anderson twice. Dec 15 A slight improvement noticed in behavior: Goes walking with crowd: Sits quietly on ward & will do what is asked of him: Is anxious to go home for christmas: Appetite good: Bowels regular: Trans to B^3 on Dec 20.

Jan 1/97 Was quiet for a few days after transfer - since then has been noisy. Works on ward
Wt. 147½ P. 96. Jan. 6 Extremely noisy & troublesome since last note Trans to B^1

Jan 14 Has refused to talk last two days. Appetite good: Bowels regular: Jan 15 Behavior
much better: Is working in dining room: Jan 21 Appetite good: Bowels regular: Very talkative at times also silly & incoherent. Habits clean: Works in dining room.

Jan 21 Went Home.

Discharged

Personal and Medical History of

Personal and Medical History of Andrew L. Johnson

ROBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4556

Residence, Hayward, Minn.

Date Admission, October 19' 1896

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

How Sent, Herman Blackmer, J. of P. Freeborn Co.

Sex, -Male-

Age, -24-

Civil Condition, -Single.

Children, —

Age Youngest Child, —

Occupation, Laborer.

Degree Education, Limited - Common school.

Profession Religion, Yes Lutheran.

Habits, Not intemperate, so far as known.

Nativity, Sweden (Parents Swedes)

Physicians Committing, A. L. Wedge + D. W. Bank

Correspondents,

No. for Year, 89

Insane Relatives, Not known.

Cause Exciting, Not known

Cause Predisposing, Not known.

Form, mania acute

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Oct. 13' 1896.

Duration, six days.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 24

Time of Leaving, 9/23/97.

Time in Hospital, 11 mo. 4 da.

Result, Discharged Mch. 23/98 Recovered.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by Dr H. H. Hyzer.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Fair.

Recent Events, Somewhat impaired.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, illusive.

REASONING POWER:

Ordinary Subjects, Very poor

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Patient has probably been of fair mental grade. Type approaches acute mania of subacute character. Acute mania in tendency to rhyme in his talk + to repeat poetry, songs etc. Subacute by reason of his age (24) + religious delusions mixed with sexual ideas. Is loud, noisy +

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, V

Depressed,

DELUSIONS:

Systematized or Not, Unsystematized

Special Subjects,

Transitory or Not, Transitory

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

~~Coherent~~ or Incoherent,

Voluble or ~~Reticent,~~

incoherent - Admits masturbation.

Medical History of Andrew L. Johnson

A BULLET IN HIS BRAIN

Andrew Johnson's Suicidal Attempt Not an Immediate Success.

Andrew Johnson, 25 years old, and employed in the dairy owned by Charles Turnquist, Hiawatha avenue and Fifteenth street, shot himself in the head with suicidal intent yesterday afternoon. His groans discovered him to people driving along the road and from the tree under which he lay, with a 32-caliber revolver in his hand, he was carried to a dairy attended by Dr. Sicaro, and from there taken to St. Barnabas hospital. Although the bullet is lodged in his brain he was still alive this morning, but had not regained consciousness. Johnson was recently discharged from the insane asylum at Rochester and had long been subject to fits of insanity.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 152½ lbs. NUTRITION, Considerably emaciated

MALITIES,

TONGUE, Tremors, Coatings, Yellowish coat. Promptness Movement, Slow, heavy.

PUPILS, Equality, Equal Size, Normal.

Response Light, Excess Accommodation, Excess

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms, Fair

Legs, "

TREMORS, Hands, None Tongue, Slight

Facial Muscles, None General, None.

REFLEXES, Patellar, 8 Equal.

Other

ARTICULATION,

Slurred, Nervous + fierce accent.

Hesitating,

FACIAL EXPRESSION, Eyes bloodshot fierce expression.

SENSIBILITY,

HEART, Slight blowing sound - 1st apex beat 2nd pulmonic sharp - all sound weak - irregular

LUNGS, Normal

TAKEN,

EXAM. URINE, Nov. 11' 96.

Color, yellow.

Sp. Gr. 1028

Reaction, acid

Character, Slightly cloudy.

Albumen, None.

Sugar, None.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Moderate drinker + smoker.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Mother died childbirth.

Father or Pat. Relations, Father has been insane

Brothers or Sisters, 1 brother 2 sisters healthy.

Personal and Medical History of Andrew L. Johnson

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4556

Residence, Hayward, Minn.

Date Admission, October 19 1896

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

How Sent, Herman Blackmer, Jo of P. Freeborn Co.

Sex, - Male -

Age, - 24 -

Civil Condition, - Single -

Children, —

Age Youngest Child, -

Occupation, Laborer.

Degree Education, Limited - Common school -

Profession Religion, Yes Lutheran.

Habits, Not intemperate, so far as known.

Nativity, Sweden (Parents Swedes)

Physicians Committing, A. L. Wedge + G. M. Bacon

Correspondents,

No. for Year, 89

Insane Relatives, Not known.

Cause Exciting, Not known

Cause Predisposing, Not known.

Form, Mania acute

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Oct. 19 1896.

Duration, Six days.

No. of Attack, 1st

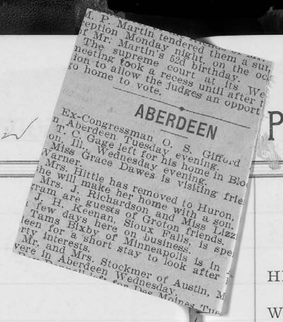
No. of Admissions, 1st

Age First Attack, 24

Time of Leaving, 9/23/97.

Time in Hospital, 11 mos. 4 da.

Result, Discharged Mch. 23/98 Recovered.



ABERDEEN

Ex-Congressman O. S. Gifford
n Aberdeen Tuesday evening.
n T. C. Gage left for his home in Bo
on. Ill. Wednesday evening.
Miss Grace Dawes is visiting frie
arner.
Mrs. Hittle has removed to Huron.
he will make her home with a son
ram are Richardson and Miss Lizz
J. H. Keenan of Groton, friends
days here on business.
Tams Hixbo of Minneapolis is spe
for a short stay to look after
Mr. and Mrs. Stockmer of Austin, M
interests.
ere in Aberdeen Wednesday

EXAMINATION ON ADMISSION.

Exam by Dr H H Herzog.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Fair.

Recent Events, Somewhat impaired.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, illusive.

REASONING POWER:

Ordinary Subjects, Very poor

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Patient has probably been of fair mental grade. Type approaches acute mania of subacute character. Acute mania in tendency to rhyme in his talk + to repeat poetry, songs etc. Subacute by reason of his age (24) + religious delusions mixed with sexual ideas. Is loud, noisy +

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, V

Depressed,

DELUSIONS:

Systematized or Not, Unsystematized

Special Subjects,

Transitory or Not, Transitory

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

~~Coherent~~ or Incoherent,

Voluble or ~~Reticent~~,

incoherent - Admits masturbation.

Personal and Medical History of Andrew L. Johnson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 9 in WEIGHT, 152½ lbs. NUTRITION, Considerably emaciated

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Bromish coat, Promptness Movement, Slow, heavy.

PUPILS, Equality, Equal Size, Normal.

Response Light, Excess Accommodation, Excess.

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms, Fair

Legs, "

TREMORS, Hands, None Tongue, Slight

Facial Muscles, None General, None.

REFLEXES, Patellar, 8 Equal.

Other

ARTICULATION,

Slurred, Vicious + fine accent.

Hesitating,

FACIAL EXPRESSION, Eyes bloodshot fierce expression.

SENSIBILITY,

HEART, Slight blowing sound. 1st Apex 2nd pulmonic sharp. all sound weak - irregular

LUNGS, Normal

TAKEN,

EXAM. URINE, Nov. 11 '96

Color, Yellow.

Sp. Gr., 1028

Reaction, Acid

Character, Slightly cloudy.

Albumen, None.

Sugar, None.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Moderate drinker + smoker.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Mother died childbirth.

Father or Pat. Relations, Father has been insane

Brothers or Sisters, 1 brother 2 sisters healthy.

Personal and Medical History of Andrew L. Johnson.

1896

This man was brought here by E. H. Ellickson, Sheriffs Deputy, attended by Lewis Torgusson with the following history:- Patient is in fair physical condition: Nothing known as to consanguinity, heredity or intemperance in rely on family: First symptoms of this (1st) attack were manifested October 13'96 by singing things & threatening to Kill E.E. Gulbrandsen: Disease seems increasing: not variable & with no rational intervals. Derangement manifested by delusions - patient is boisterous & wants to fight & is religious at intervals - Patient has shown disposition to injure others: Do not suicidal, filthy or destructive: Little is known of personal history as he is a stranger in this part of the country. Cause of disease not known: Patient has been confined all the time during last four days but has received no treatment: On personal examination patient talked wildly & insanely all the time. no further particulars noted. On admission put upon C.E. Office Rpt. Complexion dark: hair brown: Eyes gray: Condition of skin good: Scar on left cheek. Is dirty: behavior noisy)

Oct 31 Nurses Notes (Summary) Patient received on ward at 7:30 P.M. Oct. 19.
Appetite has been fairly good all the time: Bowels somewhat constipated the first week, of late Regular: Food healthy: In behavior has been very restless & troublesome most of time: Is always worst when out with crowd: hallooing, jumping & throwing up his hands.
Does not speak English but understands fairly well: Has delusions: says Mr. Horr is King Oscar Is more mischievious than pugnacious
Has been taking medicine since 20th Bromide after meals & several doses of salts. Habits dirty first few days, of late clean but untidy.
Sleeps in room: average amount of sleep 5 hrs.

Nov 2 Wt. 157 Pulse 90. Appetite fairly good: is an extra diet: Behavior fairly good: during meals but is noisy & troublesome both on ward & when out with crowd. Nov 3 Struck in face by one of other patients slightly bruising same.
Habits filthy & dirty: Slept 4 hrs. Nov 9 Has been very restless & noisy at night since last note & is very troublesome today. During night was destructive, pulled heaters out of place & tore clothes & bedding. Habits filthy & dirty.
Nov 10 Put in restraint at bedtime & given medicine Slept 7 hrs. Nov. 11 Destructive & & noisy during night, tore blanket. wore wristlets 9 hrs. Slept 2 hrs.
" 14 Lame in right limb, cause unknown: Still noisy & restless at night.
" 16 In restraint at bed-time - Penis blistered: was destructive during day: tore clothing
" 30 Is pugnacious irascible & greatly disturbed. Talks a great part of the day in an insane way in Swedish language. Is destructive almost daily.
Appetite good: Bowels generally regular: Habits untidy. Dec 1 Wt. 156 Pulse 89.
Dec 20 Struck twice during day by F. Saunders. bruising him slightly.
Jan 1. Wt 160 Pulse 72. Appetite good: Bowels quite regular: Very noisy most of time. Jan 9 Struck by Soren Johnson in left eye & a little later by Thos. Lantry in same eye. Jan 13 Attacked Nurse Severson in clothes room while taking bath & was held for a short time by nurses, Ear scratched slightly in scuffle. Feb 1 Wt. 163 Pulse 76. Bromide mixture given after meals

Feb 3 medicine discontinued. Feb 13 Behavior much better of late & patient is not kept in bay: Appetite good: Bowels regular. Has a habit of putting trash into his pockets: Feb 27. Is improving some - Goes out working occasionally. Feb 26 Trans. to B3. Apr 1 Has been quiet & well-behaved since on ward; Assists with work on ward. Today commenced working with painter. Appetite & bowels normal. Wt. 157½. Pulse 72.

Apr 30 Patient is very quiet, seldom speaking to anyone. Shows no delusions & acts fairly rational. May 1 Trans. to A'. May 31 Neat in appearance: Quiet & well-behaved. Works with painter June 4 Wt. 158. Pulse 76

July 3 Wt. 154 Pulse 72. July 31 Seems able to care for himself. Works outside every day. No peculiarities noticeable except dullness & a peculiar stare when spoken to - probably due to inability to understand language.

Aug 5 Wt. 157 Pulse 80. Aug. 30 Works with painter still: Habits clean: dress neat. Health apparently good. Sept 8 Wt. 152 Pulse 80. Sept 23 Went home.

Discharged.

Personal and Medical History of John Harrison

EGBERT, PICLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4558
Residence, Albert Lea, Minn.
Date Admission, 25th October, 1896.
Admitted by Dr. R. M. Phelps. Hour,
How Sent, Herman Blackmer, J. of P. Freeborn Co.
Sex, - Male.
Age, - 30 -
Civil Condition, - Single.
Children, —
Age Youngest Child, —
Occupation, Works on farm.
Degree Education, Can read & write.
Profession Religion, Yes Lutheran.
Habits, Not intemperate.
Nativity, Wisconsin (Parents Norway).
Physicians Committing, J. A. Blackmer, G. M. Bauck.
Correspondents, Frank Blackmer, Family Physician.

No. for Year, 91
Insane Relatives, Brother & sister. Son. Father intemperate
Cause Exciting, Masturbation.
Cause Predisposing, Probably heredity.
Form, Dementia terminal
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, About year ago
Duration,
No. of Attack, 2nd (one slight attack)
No. of Admissions, 3rd
Age First Attack,
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. 10/23/96 by H. H. Herzog M.D. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Clear.
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Fair -
Recent Events, Fair -
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Correct.
REASONING POWER:
Ordinary Subjects, Slow.
Own Mental State, Realizes condition
Special Subjects,

EMOTIONAL STATE:
Normal, Calm, ✓
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, None Noted.
Special Subjects,
Transitory or Not,
HALLUCINATIONS: —
ILLUSIONS: —
CONVERSATION:
Coherent or Incoherent, Coherent.
Voluble or Reticent, Slightly reticent.
Not sleep very good. in fact never did.

GENERAL DESCRIPTIVE REMARKS: Patient says he is not so crazy as when here before. Says he got to quarreling with his sister-in-law & talked pretty rough. Shows some feebleminedness. probably in part the result of previous attacks. Physical condition fairly good, somewhat under nourished. Admits masturbation, says not excessive. Says does

Personal and Medical History of John Harrison.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 6 WEIGHT, 132 lbs. NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES, —
TONGUE, Tremors, Slight tremor Coatings, Clear. Promptness Movement, Prompt
PUPILS, Equality, Equal. Size, Dilated.
Response Light, Sluggish Accommodation, Respond sluggishly.
SIGHT, Good.
HEARING, "
COORDINATION, Arms, Good
Legs, "
TREMORS, Hands, None Tongue, Slight
Facial Muscles, " General, None.
REFLEXES, Patellar, ✓ Equal.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,

TAKEN,

EXAM. URINE, Nov. 12' 1896.
Color Light Yellow
Sp. Gr. 1026
Reaction —
Character Clear.
Albumen None
Sugar None.

SENSIBILITY,
HEART, No Murmur.
LUNGS, Good.

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, 1 brother, Harley Harrison, here also 1 sister, Tilda Selsted. 2 brothers & 2 sisters well.

Personal and Medical History of John Harrison

1895

This patient was brought here by Sheriff Deputy E. H. Ulrickson with the following history:- No information concerning consanguinity but has brother & sister insane. This is apparently third attack & patient has been confined in this institution* twice before - from Jan. 19 to Mar. 25 '89 & from Mar. 12 to June 16 1890. was discharged recovered first time - improved second. First symptoms of present attack were manifested about a year ago - began to act strangely & be violent. Disease seems increasing, variable with irregular rational intervals. Derangement now manifested by being dissatisfied with everything. Has threatened to shoot people: Is not suicidal: Is not filthy but is destructive of furniture: Has always had a bad temper: No history of severe disease or head injury. *Note As above stated this is patients third admission here - (For particulars of case see Vol 11. Fol. 164 No. 1964 & Vol. 13 Fol. 152 No. 2312) On admission put upon B[3] (G.H.N. Rpt.) Complexion dark: hair brown: Eyes blue: Condition of skin good Is clean: behavior good.)

Oct 22 Nurses Notes (Summary) Came on ward 7 Pm. Was quiet & talked rationally: Physical condition fair. Oct 24 Is very quiet & well behaved: when indoors sits quietly in one place & rarely speaks unless spoken to first. Can notice no delusions: Appetite good: Bowels. Regular: Sleeps well.

Oct 26 Has been quite active today assisting nurses with ward work.

Nov 4 Continues to assist with work. Talks more freely than at first: Makes no complaints & seems contented. Is improving in general appearance: Is very neat in habits & dress.

Nov 5 '96 to Apr 30 '97 Summary Nurses Notes by Dr. Phelps. Nov 5 Noted as quiet and well-behaved: Is neat & clean: Does a little work. Dec 1 Wt. 139# Jan 1 Wt. 141#. Does some work. Mch 1 Of late is hiding under beds & sleeping during day. Apr. 30 Works some in kitchen. Is somewhat better in behavior.

May 1 '97 - 143# July 15 '97 Eloped today: Brought back from Albert Lea: Is very quiet Can answer questions fairly well: Does not talk about any delusions

Jan 30 '99 No change in any essential respect: Seems to be watching any chance to get away: Is very quiet. Feb 1 - July 31 '99 (Dr Manous) Patient silly in actions: & continually in mischief. Wt. 140. Works in center dining room: Appetite good: Bowels regular. (Dr. Chapple) July 31 - Jan. 31 1900. Wt. 133# No change of importance during period Health good: Is quiet: Sits in room most of time. Assists a little with work on ward: Is very reticent: Says little: Jan 31 1900 Appears quite intelligent: Is tidy: Appetite & health good. Feb 6 1900. Wt 137#. P84 Feby 6 Vaccinated: result negative: July 31. No change of importance, during period: Health good: well-behaved: works on ward: Attends amusements. Very quiet: seldom speaks, unless addressed: answers July 31/00 readily & rationally. Aug 31. Well-behaved: Stays in room most of time: Takes part in amusements: Aug 31 Shows no delusions: works on TW. Jany 4/1901 Wt 144#. Jany 31. Condition Shows no change. — Nov 1 1900 Still very quiet & seldom speaks. Goes to amusements. Feby 1 Wt 139# P80. Feby 28. Quiet- Jan 31 1901 well-behaved: Mentally, quite well - Works on TW. attends dances & entertainments. Feby 28 Transferred to A[1] July 31. No apparent change in patient's condition. Is well- March July 31 -behaved. neat & clean in habits. Aug 1. Wt 139#. Jany 31/01. Health good —

Personal and Medical History of John Harrison

1902 cont'd

Jan 31 Usually quiet in behavior: talks freely: answers questions fairly well: occasionally tries to elope: Has done considerable work. Nov. 25/02 Patient has been doing well and quiet for the whole past year. Today he eloped. Dec. 9 Upon notice he was returned today.

Jan 31/03 Is rather dull in manner but does not talk of delusion. Health seems good.

Personal and Medical History of Julius Voright.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4561
Residence, Lansing Township, Minn.
Date Admission, October 26 1896.
Admitted by Dr. H.H. Herzog Hour, 7½ P.M.
How Sent, C.S. Washburn, J of P. Mower Co.
Sex, Male.
Age, 37.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, School Teacher.
Degree Education, College education.
Profession Religion, Yes - Lutheran.
Habits, Not Intemperate
Nativity,
Physicians Committing, E.N. Washburn & A.W. Allen MD.
Correspondents, Mrs. Lizzie Voright. Austin Minn.

No. for Year, 94.
Insane Relatives, Uncle & Aunt. (Father drank)
Cause Exciting, Heredity.
Cause Predisposing, Heredity
Form, Paranoia.
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not
Date of this Attack, 10 years ago.
Duration,
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 27
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam by R.M. Phelps 11/4/97.

MENTAL CHARACTERISTICS.

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

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

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

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

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

DELUSIONS:
Systematized or Not, Yes.
Special Subjects, of persecution.
Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient does not think he is insane. Says was in Austin 2 weeks before he was sent here. Said he was "driven home" (This idea of being driven or "talked against is a common one) A continual impression received from those about for over a year. Has a dull quiet Katy dementia with incoordination. Not enough symptoms however to indicate General Paresis.

Personal and Medical History of Julius Voright.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8½ WEIGHT, 154½ NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, None Condition of skin good.
TONGUE, Tremors, Coatings, Promptness Movement, Good.
PUPILS, Equality, Equal Size, Normal.
Response Light, Good Accommodation,
SIGHT, Good.
HEARING, "
COORDINATION, Arms, Poor.
Legs, "
TREMORS, Hands, Very marked tremors. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 8-9
Other
ARTICULATION, Fair.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs noted. Strength sounds max. distinct.
LUNGS, Good.

EXAM. URINE, Nov. 12' 1896.
Color Yellow.
Sp. gr. 1030
Reaction Alkaline.
Character Clear.
Albumen None.
Sugar None.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, 6 yrs. ago in Dacota had dizzy spells. for 2 months - has not had them since - 10 yrs ago brain trouble "fever"
LENGTH OF INVASION, One a year. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Healthy — brothers brother & sister - a pair of twins - were insane - only ones he knows.
Father or Pat. Relations, drank.
Brothers or Sisters, 2 brothers 3 sisters Healthy - 1 dead.

Personal and Medical History of Julius Voight.

1896

This patient was brought here by Sheriffs Deputy J.E. Johnson, attended by J.E. Flood with the following history: Patient is in fair physical condition. No history of consanguinity but there is of heredity. This is 1st attack: First symptoms manifested 10 years ago when patient was ill for three weeks with brain trouble: Disease appears increasing; variable with regular rational intervals - will be rational for 3 days then deranged for a week: Is deranged on all subjects when attack is on. Wanders about - thinks he will be poisoned. Has shown disposition to injure others: Is not suicidal; filthy on destruction: No previous peculiarities shown. Supposed cause of disease heredity: Patient has received no treatment: has not been confined or restrained. On personal examination patient moody & taciturn; does not answer questions. Commitment recommended because it is reasonably certain by his threats that he has dangerous tendencies & uncontrollable propensities to crime. On admission put on 3rd Gen Rpt. Complexion dark: Hair dark brown: Eyes blue: Condition of skin poor: Small scar on right hip: Eruption on arms & shoulders to clean: behavior good: appears stupid.)

Oct 26 Nurses Notes (Summary) Came on ward 7 Rm. Given bath appeared very quiet & well behaved: would not talk: Spoke to no one until afternoon of 28th when he asked for a cathartic. Did not speak again until 31st when he was induced to answer a few questions: Behavior quiet until Nov. 5th when he made an attempt to escape. When caught & brought back began to converse quite freely & rationally & has talked when spoken to since. Bowels have been slightly constipated: Appetite good since admission: Sleeps well.

Nov. 9 to Apr. 30 Summary Nurses Notes by Dr. Phelps Patient quiet and well-behaved, is neat & clean. Talks more than he did: Health good. Dec 1 No change mentally or physically: Jan. 14 Has been in bed since the 9th. Complains of headache: Is now very quiet & not willing to speak to anyone. Apr 30 Has been rather dull and depressed until 29th when he became suddenly violent striking one of the patients severely. May 1897 Wt. 174# June 31/97 Visited by relatives: Is generally rather good natured, quiet & well-behaved. At times however has been rather sullen & obstinate. Oct. 31/97 Has been of late rather sullen & stupid muttering to himself & occasionally inclined to be violent.

Jan 31/99. Intervening notes show patient as having occasional spells in which he will talk loudly & complainingly & appear to be stuped - Is more deranged mentally than usual. Feb 1 - July 31/99 (Dr Wanous) Wt. 168#. Patient is quiet: Has a bad temper & frequently strikes patients. Mch 14 Refused dinner & supper. Mch 16. Struck by patient with floor polisher: No marks. Apr. 30. Threatened to kill Carl Lauprecht. May 26. Complained of pain in legs & back. Nothing definite found to be the matter with him.

Aug 1 - Jan 31/1900. Dr Chapple: Wt. 163½#. No change mentally or physically. Health & appears good but has complained some. Works a little on ward but generally very indolent. Sits in room most of time. Aug 28 Threatened to kill another patient. Did no harm. Sept 21 Struck patient F. Haines. Is irritable

Personal and Medical History of Julius Voight

1900

Feby 1 - July 31 but behaves well if not molested. Feby 1/1900 Wt 169#. Pso. July 31. No change during period. Health uniformly quite good: works about ward & outside with other patients. Usually well-behaved: Has a particular aversion for J.F. Haines and threatens to do him bodily harm. Thinks that Haines tries to bother him: Stays in his room, most of time. Does not associate with others. Augs. Wt 169#. Nov 30. No change specially noticeable. Jany 31/1901 Can see no change: works on the ward: does not associate with other patients, but stays in his room, most of time: has special dislike for certain patients to whom he uses bad threatening & abusive language: has numerous "delusions of persecution" - Wt 172# - Feby 27. Tooth extracted - May 1. Wt 168# - Augs. Wt 165#. Jany 31/01. No change noticeable: does some) work on ward: also extra hand in kitchen. Usually very quiet, but is surly and frequently threatening. Has special dislike for patient Frank Haines, whom he abuses & shows violence toward, on every occasion: has "delusions of persecution": Health good.

Feby 1/1901 - Jany 31/02

Jan. 31-03 (Dr. Chapple) Has drifted along from day to day, about the same. Works in the kitchen and about buildings with nurse around. Is peaceable but has a dislike for certain patients on ward and will kick them whenever he gets a chance; has numerous delusions; but talks very little unless addressed. Nearly always in room by himself. Never associates with other patients.

Personal and Medical History of Edward A. Schwartz.

EGBERT, FIGLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4562

Residence, Rochester, Minn.

Date Admission, October 27 1896.

Admitted by Dr. R.M. Phelps Hour, 4 P.M.

How Sent, Thos. Fraser, Jr. of P. Olmstead Co.

Sex, Male.

Age, 53

Civil Condition, Married.

Children, 3

Age Youngest Child, —

Occupation, Saloon Keeper.

Degree Education, Common school.

Profession Religion, Not a church member.

Habits, Very intemperate.

Nativity, Germany (Parents Germany.)

Physicians Committing, W.W. Mayo & C.S. Granger.

Correspondents,

No. for Year, 95

Insane Relatives, None.

Cause Exciting, Intemperance.

Cause Predisposing, —

Form, Mania a potu

Accompanying Bodily Disorder, has had delirium tremens

Suicidal or Not, Yes - cut throat propensity at times

Date of this Attack, Several days ago.

Duration, Several days.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 53.

Time of Leaving, Jan. 11 '97

Time in Hospital, 2 mo. & 15 da.

Result, Recovered. Discharged 1/11/97

EXAMINATION ON ADMISSION.

Exam by R.M. Phelps 10/30/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Fairly accurate now the weak.

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events, Fair as far as can test.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dulled.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Not very good.

Own Mental State, Poor.

Special Subjects, Poor.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS: Delusion train of thought

Systematized or Not, concerning wife, children

Special Subjects, & property.

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Thinks was run down by worrying about wife & her abuse of children. Is rather vague & feeble in his reasoning about his troubles. Avoids saying he was insane. But practically admits it. His state now (1/30/96) shows mental impairment of symmetrical character. Physical state does not seem to figure largely unless it is by arterial degeneration - which is rather slight.

Personal and Medical History of Edward A. Schwartz.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8½ WEIGHT, 159. NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, Skin. fair condition.

TONGUE, Tremors, Coatings, Promptness Movement, prompt coor.

PUPILS, Equality, Equal. Size, Normal

Response Light, Respond. Accommodation, Respond.

SIGHT, Says good - has glasses

HEARING, Fair.

COORDINATION, Arms, Poor

Legs, "

TREMORS, Hands, Not marked Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal.

Other Equal.

ARTICULATION, not especially.

Slurred, No.

Hesitating, "

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Strength sounds fair. Nervous rapid - Regularity - palpitation.

LUNGS, Fair.

Arteries somewhat stiff

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Nov. 9'96 4 P.M.

Color yellow.

Sp. gr. 1018

Character Clear.

Reaction Acid

Albumen Trace by Nitric Acid & by Tanrets.

Sugar. None.

Microscopical -

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

CRANIAL MEASUREMENTS, Not taken.

HISTORICAL, 2 sunstrokes - once in army in '63 & once in '67 - Has catarrh. Blind piles - So rheumatic & think has kidney trouble

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual.

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Edward A. Schwartz.

1896

This patient was brought here by Sheriffs deputy - Mr Ryan - with the following history :- Patient is in fair physical condition : Nothing known as to consanguinity. Patient has been delirious for several days : Disease seems increasing ; is variable. Patient is disposed to injure others & is suicidal ; has cut throat : Is not destructive or filthy : Has been intemperate for a number of years, resulting in a continued delirium : Supposed cause of disease intemperance : Has not been confined but has received treatment frequently. On personal examination it was learned that patient attempted suicide previous to examination. On admission put on B^3 & Transferred to Infirmary (Gth N. Pt) Complexion dark : hair brown - a little gray : Eyes gray ; Condition of skin good. Enlarged veins on both legs : Scar on neck & on 1st & 2nd fingers of left hand one on right leg. Is dirty : behavior good : Is quite nervous.

Oct 27 Nurses Notes (Summary) Came on ward - suffering from wound in side of neck caused by attempting to cut throat. Wound, had begun dressed by Dr. Mayo. Patient quite dirty : given bath & put to bed. Very restless during night : Slept 2 hrs. Oct 28 Recognizes friends & talks rationally : Appetite poor : Habits clean : No delusions noticed : Behavior good : Bowels regular : Complains that he is tired of staying in bed : says he is used to exercise : Upon questioning says he is not sorry he tried to cut throat, but is sorry he was not successful : That if he had only been left a few minutes longer it would have been over & wife would have had to suffer instead of him. Wound dressed several times with Iodthyol & glycerine solution afterwards with iodoform. Has been visited by Dr Kalb, S.W. Eaton & relatives. Nov. 9 Has been up on ward for last few days & has assisted a little with ward work. Reads a good deal - seems contented ; makes no complaints : Bowels regular : Sleeps well : Cut on neck healed but still slightly swollen : Physical condition good.

Nov 11 Patient works on ward : Behavior good. Bowels regular : Sleeps & eats well.

Nov. 11 Is very agreeable, has no delusions Nov 17 Bandage removed from neck. neck washed with alcohol Nov. 13 Trans. to B^3. Dec 2 Patient neat & clean in habits & dress : Talks & acts rationally also seems bright & cheerful. Bowels regular & sleeps Well. Dec 4 Wt. 167 lbs. Pulse 80. Jan 4 Patient quiet & well - behaved. Talks rationally : Is a little nervous & complains of Rheumatism : Appetite good : Bowels regular : Sleeps well.

Jan 11 Patient Went Home.

Discharged.

Personal and Medical History of

Personal and Medical History of Robert W. Hague.

BUGBEE, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4563

Residence, St. Paul, Minn.

Date Admission, October 27 1896.

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

How Sent, G. Mellick, Jo. P. Ramsey Co.

Sex, Male

Age, Not given

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Helper in machine shop.

Degree Education, Common.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, England (Parents England.)

Physicians Committing, C.F. Woolsey — G. Stamm.

Correspondents, Mrs A. J. Oldman 1 Glover St. Preston, England.

No. for Year, 96

Insane Relatives, Not known

Cause Exciting, Not known.

Cause Predisposing, Not known.

Form, Dementia paretic

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, About 4 months ago.

Duration, About 4 months.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, Not given.

Time of Leaving,

Time in Hospital,

Result, See File (No 12)

EXAMINATION ON ADMISSION.

Exam. Oct 31'96 by Dr. Hitchcock

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Considerably impaired.

Recent Events, Very poor.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Much impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient has apparently been of fair mental grade. Has physical signs indicative of early general paresis but the dementia is decidedly more marked. He is very untidy about his personal habits & last night was filthy. He is slightly exhalted, feels first rate. walks with an important air & has other mental symptoms

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Not.

Special Subjects, Grandiose.

Transitory or Not, Yes.

HALLUCINATIONS:

ILLUSIONS: As to identity.

CONVERSATION:

Coherent or Incoherent, Incoherent.

Voluble or Reticent, Fairly voluable of a beginning paresis. He well defined delusions but slightly exaggerated his stories.

"The most remarkable feature of the unprecedented campaign for the governorship made by John Lind in Minnesota is that he should find it necessary to go outside of the state to find a man who will give him a certificate of character, particularly upon his attitude upon the matter of churches and religion.

R. W. Hague

The most remarkable feature of the unprecedented campaign to find it necessary to go outside of the State to find a Man who will give him a certificate upon the matter of Churches and his Religion

attempt to copy above article taken at random from a newspaper Oct 31. 96.

Robert W. Hague.

ADMISSION, CONTINUED.

CHARACTERISTICS.

43½ lbs. NUTRITION, Fairly good.

Promptness Movement, Fairly prompt.

Size, Normal.

Accommodation, excession.

Tongue, fine

General, No.

EXAM. URINE, Nov. 11'96.

Color	Light yellow.
Sp. gr.	1014.
Reaction	Neutral.
Character	Clear.
Albumen	None.
Sugar	None.

HEART, No murmurs. Bounds somewhat weak.

LUNGS, Fairly good.

TAKEN,

Arteries, Temporals somewhat tortuous & stiff. Veins of forehead prominent.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Denies syphilis says had head injury 5 years ago. Can not find marks. Drinks some.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, died Cancer.

Father or Pat. Relations, died heart disease.

Brothers or Sisters, 3 brothers & 2 sisters healthy.

Personal and Medical History of

ROBERT, FIDLAR & GRAMELING, DAVENPORT, IOWA.

Whole No. 4563

Residence, St. Paul, Minn.

Date Admission, October 27th 1896.

Admitted by Dr. Wm. Phelps

How Sent, G. Merrick, Jo of P.

Sex, Male

Age, Not given

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Helper in machine sh

Degree Education, Common.

Profession Religion, Not a church member

Habits, Not intemperate.

Nativity, England (Parents England.)

Physicians Committing, C. P. Woolway — G. Stamm.

Correspondents, Mrs A. J. Coleman 1 Clover St. Preston, England.

EXAMINATION ON ADMISSION.

Exam. Oct 31'96 by Dr. Hotchkiss

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Considerably impaired.

Recent Events, Very poor.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Much impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient has apparently been of fair mental grade - Has physical signs indicative of early general paresis but the dementia is decidedly more marked He is very untidy about his personal habits & last night was filthy. He is slightly exhalted, - feels first rate - walks with an important air & has other mental symptoms

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Not.

Special Subjects, Grandiose.

Transitory or Not, Yes.

HALLUCINATIONS:

ILLUSIONS: As to identity.

CONVERSATION:

Coherent or Incoherent, Incoherent.

Voluble or Reticent, Fairly voluble of a beginning paresis - No well defined delusions but slightly exaggerated his stories.

Personal and Medical History of Robert W. Hague.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8 in. WEIGHT, 143½ lbs. NUTRITION, Fairly good.

WOUNDS OR ABNORMALITIES, -

TONGUE, Tremors, Coatings, Slight yellowish Promptness Movement, Fairly prompt.

PUPILS, Equality, Left slightly large. Size, Normal.

Response Light, Excessive Accommodation, excessive.

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms, Slight incoordination

Legs, " "

TREMORS, Hands, Slight Tongue, fine

Facial Muscles, No. General, No.

REFLEXES, Patellar, 0 also on reinforcement.

Other

ARTICULATION,

Slurred, Slightly

Hesitating, English accent.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs Bounds Somewhat

LUNGS, Fairly good.

TAKEN,

EXAM. URINE, Nov. 11'96.

Color	Light yellow.
Sp. gr.	1014.
Reaction	Neutral.
Character	Clear.
Albumen	None.
Sugar	None.

Arteries - Temporals somewhat tortuous & stiff - Veins of forehead prominent.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Denies syphilis says had head injury 5 years ago Can not find marks. Drinks some.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, died Cancer.

Father or Pat. Relations, died heart disease.

Brothers or Sisters, 3 brothers & 2 sisters healthy.

Personal and Medical History of Robert W. Hague.

1896

This patient was brought here by Deputy Sheriff Richards with the following history: Patient is in fair physical condition: No history of consanguinity: About 4 months ago there was a change of his whole character: Disease appears increasing; is variable with irregular rational intervals. Patient went away from home without giving any reason: Saw spirits who "stopped" him & "treated him good" etc. Patient not disposed to injure others: not suicidal: Is careless about his dress & in exposing himself: No previous peculiarities: No history of intemperance in self or parents: About 3 months ago patient received a blow on head: Cause of disease unknown: Has received no treatment & has not been confined or restrained. On personal examination No further particulars noted. On Admission put on B3 E Off M. Rpt Complexion light: Hair light brown: Eyes blue: Condition of skin good. Is clean: behavior good: Talks rationally.)

Oct 27 Nurses Notes (Dunnaway) Came on ward at 7 PM. Was given bath. Talked some in a dreamy manner. Oct 31 Very slouchy in dress: Habits filthy: Appetite very good: Bowels regular: Requires constant watching: Behavior noisy & troublesome: Trans. to B' today. Nov. 2 Restless, singing & whistling: Has delusions: Remarks are all incoherent: Habits filthy: Goes out walking with crowd:

Nov. 5 A little quieter today: Very stupid & sleepy: Lies around on benches: Is unable to carry a conversation on any subject: Nov. 8 Is kept in bay: Very stupid, sits with eyes closed: Talks but little: Requires constant watching. Habits still filthy: Appetite good: Bowels regular. Average amt. of sleep 5 hrs. & a fraction.

Nov. 11/96 to Apr. 30/97 Summary of Nurses Notes by Dr Phelps. Appetite good: Is rather restless & troublesome, & dirty in habits: Talks sometimes when questioned but never rationally: Dec. 3. Slight improvement in habits: Still incoherent & Dec. 30 Still has to be under constant watch but obeys better & is less trouble. Wt. 146 lbs. Feb. 10 Still troublesome, will take off clothes, hide in rooms & & is generally mischievious. Wt. 143 lbs. Apr. 30 Loss of memory very marked: quite demented & is generally quite troublesome, is, however, somewhat better behaved than a couple of months ago.

May 1/97 Wt. 157 lbs. Patient quite neat in appearance: Seems to have a poor memory for recent events & thought for parties. June Has become somewhat troublesome & recently has been somewhat violent.

July 30 Has more active delusions, writes more abusive & troublesome letters: Seems to be changing somewhat Dec 23 Seems to be growing more violent, restless & incoherent. Dec. 27 Destroyed plants on ward: Trans. to B'. Aug 1/98 Wt. 169 lbs. Gradually growing more & more demented: Was for a while quite violent but recently is more demented & quiet. Aug 15 Transferred to Infirmary again. Had several convulsive movements: Does not seem to be able to talk. 21 Has had more or less spasmodic movements of arms, which seem to be improving.

Aug 24/98 Is rather unsteady on legs, & rather mixed & confused but is up &

Personal and Medical History of Robert W. Hague.

about again. Jan 29/99 Has gained in strength & ability to be up & about but is very deluded & rather restless & demented.

Feb 1 – July 31/99 (Dr Wanous) Wt. 160 lbs. Restless & noisy most of time also profane & pugnacious Feb 16 Eye discolored by another patient. July 27 Remained in bed: Temp. 100. Pulse 90. Refused breakfast: on treatment: Up next day.

Aug 1/1900 – Jan 31/1900. (Dr. Chapple) Wt. 179 lbs No change of note, mentally or physically during

Jan 31 – Febr period: Speech incoherent & noisy & abusive: frequently violent & pugnacious to nurses & patients. Has numerous delusions of grandeur: Does some work on ward: Plays games. Febr 1/1900. Wt 175 lbs. P 68. May 7. Transferred

July 31/1901 to Annex – July 11 Vaccinated: result negative. July 31: very little change, mentally or physically; has had no illness. Is very irrational & incoherent: has "grandiose" delusions: talks to himself a great deal, & often is very noisy: at times, troublesome & pugnacious. Does no

Aug 1 – Sep 18/1901 work. Quite tidy in appearance. Augs 163 lbs – Sept 16. Transferred to B1. Sept 18. Transferred to Infirmary Was

Oct 31/1901 is very maniacal: restless: was put to bed. Oct 31. Transferred to B1. Still very restless & noisy – Dec 4. Again transferred to TW.: is very excited & troublesome: also violent: filthy: Has some fever: has hematoma of left ear. Dec. Both ears tender: Dec 25. Is up on ward:

29/1901 – Jan 3/1902 is somewhat quieter. Dec 27 To B1. Dec 29. Swollen ear ruptured by L.K. Porter: Ear dressed (on TW). Dec 29 – Jan 31/1902: In camisole jacket – Jan 1 To TW. Has some fever.

Jan 20/1902 Jan 21. Abscess in right thigh: Hot applications applied – Jan 22. Abscess opened & drainage inserted. Jan 26. Leg re-dressed: Jan 31. Rather more quiet; otherwise no

Mar 21 – April 22 change: Dirty: tears dressings from leg. Is very demented. March 29. Has been in bed since last note. Discharging sinus of leg, which has been frequently irrigated – He has been very noisy & restless. Is growing somewhat stronger: Has slight fever.

May 9 – June 4/1902 Is up on ward, today. Has recently become very much more quiet – Aug 22. High operated upon by Dr. C – and old sinus removed – May 9 up, on ward: Health improved – Still discharge from leg. June 4. To B2. Augs. Wt 148 lbs – Nov 1. Wt 178 lbs. Jan 31/03. Has

July 31/1902 increased very much in flesh & is now very fat. Is very quiet: very rarely speaks: lies about, without interest in anything: very demented: Habits slouchy & filthy –

Sept. 30/02 (Dr. Chapple) Trans. to D.W. Patient is failing somewhat; and gets about with difficulty; habits filthy; still eats & sleeps quite well & is fairly quiet. (has abscess on leg, which was lanced) – Is moved to A4 – has improved somewhat in physical health.

Personal and Medical History of Timothy Vaughan

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4566
Residence, Janesville, Minn.
Date Admission, October 31st 1896.
Admitted by Dr. Hitzberg Hour, 7 30 P.M.
How Sent, Gro. A. Wilson, J. of P. Waseca Co.
Sex, Male.
Age, 30
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farmer.
Degree Education, Common school.
Profession Religion, Catholic
Habits,
Nativity, Wisconsin (Father Ireland. Mother Canada)
Physicians Committing, D. S. Cummings & M. J. Taylor.
Correspondents, Michael Vaughan (father)
Janesville, Wis.

No. for Year, 99
Insane Relatives, None
Cause Exciting, Syphilis
Cause Predisposing,
Form, melancholia Chronic
Accompanying Bodily Disorder, Syphilis
Suicidal or Not, not.
Date of this Attack, About Oct. 10'96.
Duration, Since Oct. 10th.
No. of Attack, 1st.
No. of Admissions, 1st.
Age First Attack, 30.
Time of Leaving, Mar. 2. 1897
Time in Hospital, 4 mo. 2 da.
Result, Died Phthisis Pulmonalis

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by R. M. Phelps. 11/9/96.

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

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

GENERAL DESCRIPTIVE REMARKS: Seems a plain case of Melancholia (in form) Quiet, depressed, slow & unwilling to talk much. Worried & anxious thinks is syphilitic. Seems to have worried ever since contracting the disease. (Brother says since he had La Grippe)

Timothy Vaughan

Brother states went to Hot Springs 10 years ago. returned well. took "grippe" 6 yrs ago. went to Hot Springs no better, has been to numerous places, for treatment, no better done no work for 6 years

ON, CONTINUED.

RISTICS.

NUTRITION, Somewhat poor.
Condition of skin. Rather pale.
Promptness Movement, Fair.
Normal.
ommodation,

HEARING, Good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Normal
Facial Muscles,
REFLEXES, Patellar, Normal.
Other
ARTICULATION,
Slurred, Yes
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs - Palpitates.
LUNGS, —
Arteries normal.

Tongue, Normal
General,

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Cir. (1) 54 (2) 64.5 N. o. a. 34.5 Bi. a. 32.5 Ant. p. d. 19.4 Trans. d. 15.1 Bi. d. 12.6 Fac. l. 11.3

HISTORICAL, 6 yrs ago stomach bothered him. - Syphilis 6 yrs ago took medicine one a year - Headache & vertigo

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denied except in case of mother

Mother or Mat. Relations, Living, Healthy - "Thinks has been insane" stayed at home.

Father or Pat. Relations, Living - Rheumatism

Brothers or Sisters, 5 brothers. family ill. 2 sisters.

Personal and Medical History of

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4566

Residence, Janesville, Minn.

Date Admission, October 31st 1896.

Admitted by Dr. H.H. Herzog Hour, 7 30 P.M.

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

Sex, Male.

Age, 30

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Farmer.

Degree Education, Common school

Profession Religion, Catholic

Habits,

Nativity, Wis cousin (Father Ireland. Mother Canada)

Physicians Committing, D.S. Cummings & M.J. Taylor.

Correspondents, Michael Vaughan (father)
Janesville, Wis.

No. for Yr

Insane Relatives,

Cause Exciting,

Cause Predisposing,

Form, melancholia

Accompanying Bodily Disorder, Syphilis

Suicidal or Not, not.

Date of this Attack, About Oct. 10 '96.

Duration, Since Oct. 10th.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 30

Time of Leaving, Mar. 2. 1897

Time in Hospital, 4 mo. 2 da.

Result, Died Phthisis Pulmonalis

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by R.M. Phelps. 11/9/96.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Seems a plain case of Melancholia (in form) Quiet, depressed, slow & unwilling to talk much. Worried & anxious thinks is syphilitic. Seems to have worried ever since contracting the disease. (Brother says since he had La Grippe)

Personal and Medical History of Timothy Vaughan.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8½ WEIGHT, 116½ lbs. NUTRITION, Somewhat poor.

WOUNDS OR ABNORMALITIES, Condition of skin. Rather pale.

TONGUE, Tremors, Coatings, Promptness Movement, Fair.

PUPILS, Equality, Equal. Size, Normal.

Response Light, Responds. Accommodation,

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms,

Legs,

TREMORS, Hands, Normal Tongue, Normal

Facial Muscles, " General, "

REFLEXES, Patellar, Normal. EXAM. URINE,

Other

ARTICULATION, Good

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Palpitates.

LUNGS, —

Arteries normal.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ (t) 54 (m) 64.5 F.o.a. 36.5 Bi.a. 32.5 Ant-p.d. 19.4 Trans.d. 15.1 Bi.d. 12.6 Fac.l. 11.3

HISTORICAL, 6 yrs ago stomach bothered him. — Syphilis 6 yrs ago took medicine one a year. Headache & vertigo

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denied except in case of mother

Mother or Mat. Relations, Living. Healthy. "Thinks has been insane" stayed at home.

Father or Pat. Relations, living — rheumatism

Brothers or Sisters, 5 brothers. family ill. 2 sisters.

Personal and Medical History of Timothy Vaughan.

1896

This patient was brought here by Dep. Sheriff Theodore Brown, attended by Dan Vaughan who the following history. Patient is in poor physical condition. No history of consanguinity or heredity: First symptoms manifested about October 10th 1896 by fear of being left alone. Disease appears increasing: not variable; with no rational intervals: Derangement manifested by fear of bodily harm: Has shown no disposition to injure others. Is not suicidal, filthy or destructive: Had syphilis 5 years ago & it has preyed upon his mind ever since. No history of intemperance in parents or self. No injury to head. Patient has not been confined or restrained - has received antisyphilitic treatment. On admission put upon Infirmary Ward (Q.H.M.Rpt. Complexion light; hair sandy; Eyes blue: Condition of skin fair: Bruises on both shoulders & on left arm. Is clean - behavior good: Very thin & emaciated.)

Oct 31 Nurses Notes (Summary) Came on ward at 7.45 PM. Given bath & put to bed. Talks but very little: Physical condition poor: Very restless first part of night: out of bed often & bumping his head against wall: was held by nurse for some time: at 12.45 put in restraint sheet: Slept none during night.

Nov. 1 Taken out of restraint at 6 AM. Still talk none: Lies quiet in bed this forenoon: Fed dinner by nurse: Out of bed frequently this afternoon. Slept 4 hrs during night. Nov. 4 Has been up on ward all day. Very quiet: Talks only when spoken to: answers questions fairly well.

Nov 13 Has complained at times of pain in head & stomach. Realizes where he is says head has been bothering for some time. Has been visited by relatives several times & always wants to go home with them. Is inclined to wander about ward & is very contrary at times. Habits fairly clean: Appetite good: Bowels irregular: Behavior contrary: Is sleeping much better of late: Is on medicine. Nov. 20 Visited by brother

Dec 1 Wt. 106 P. 72. Appetite very poor, has to be fed by nurse at times. Is very melancholy, stands up most of time. Sleeps well: Bowels irregular. Jan 1 Wt. 108½ P. 78. Seems to be improving: Behavior good Bowels regular: Eats & sleeps well. Jan 6 Visited by brother Jan 8 Trans. to B3.

Jan 21 Appetite poor: Bowels regular: Has to be forced to take medicine.

Feb 1 Seems restless & discontented: walks about slowly & seems quite weak & very despondent Wt 108 P. 106. Appetite poor. Bowels slightly constipated: Massage treatment given, 1x mak ½ oz. Codliver oil rubbed in at each treatment. Feb. 11 Became suddenly very weak, was unable to stand alone: On medicines 3 x per day. Trans. to Infirmary.

Feb. 16 Has been in bed since received on ward. Temp. ranging from 100.4 to 102.6. Pulse 96 to 120 Resp 26 to 30: Coughs & expectorates greenish mucus: Physical Condition very poor: Appetite poor. Feb 16 A.M. Temp 100.2 P.M. 103 Massage omitted on account of Temp. Bowels constipated: Talks irrationally.

Feb 24 Temp. ranges from 98.4 to 103.8. Seems to be gradually failing: Takes principally liquid food. Coughs & expectorates: Bowels irregular. Visited by relatives today: Talked considerable: Is restless. Feb 26 A.M. Temp. 99.6 P. 124 R 40 P.M. Temp 103.4 P. 128 R. 40 Complains of pain in stomach: vomited: Back slightly red: bathed with alcohol. Visited by relatives: Feb 27 A.M. Temp. 102 P 130 R. 40 P.M. T. 104 R 40 P 136. Feb 28 A.M. T. 101.4 P 136 R 40. P.M. T. 104.2 P 152 R 40. Apparently growing weaker. Visited by relatives: Restless day & night

Mar. 1 A.M. T. 102 P 144 R 40 P.M. 104.4 P 160 R 40 Visited by Father Riordan & relatives: Growing very weak. Mar 2 Diet changed to hot liquids. Habits filthy T. 102 P. 96 R 52. Breathing labored: Talks incoherently - Died 7.25 PM.

Note by Dr. Hugg Had been failing gradually in strength for some time past. Was with difficulty induced to take nourishment or medicines. Very stubborn about everything he was asked to do. Rubbing in of C.L. Oil failed to improve nutrition: Death was due to phthisis - Mental condition remained about the same - fear of being killed with other vague fears. Failure was rapid during last three days. Relatives wished to take him home but he was too weak to be moved.

Died

Personal and Medical History of

Personal and Medical History of Richard Ryan.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4567

Residence, Caledonia - Houston Co., Minn.

Date Admission, November 2nd 1896.

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

How Sent, Thos. Fraw, J. of P. Olmstead Co.

Sex, -Male-

Age, 37.

Civil Condition, -Single-

Children, —

Age Youngest Child, —

Occupation, Merchant.

Degree Education, Common school.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, Ireland (Parents Ireland)

Physicians Committing, F.R. Morse & C.J. Granger.

Correspondents,

No. for Year, 100

Insane Relatives, None.

Cause Exciting, Not known.

Cause Predisposing,

Form, Dementia Paretic.

Accompanying Bodily Disorder, None. mentioned.

Suicidal or Not, Not.

Date of this Attack, About 3 months ago.

Duration, About 3 months.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 37.

Time of Leaving, Feb. 2. 1900

Time in Hospital, 3 yrs. 3 m.

Result, Died. General Paresis

EXAMINATION ON ADMISSION.

Exam. by H.H. Herzog M.D. Nov. 4th, 1896.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Impaired.

Recent Events, do.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Poor

Own Mental State, Does not realize condition

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓ slightly.

Depressed,

DELUSIONS:

Systematized or Not, None Noted.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Fairly Coherent.

Voluble or Reticent, Voluble.

GENERAL DESCRIPTIVE REMARKS: At present in fair physical condition & with a mixed symmetrical dementia - Somewhat slouchy & careless in dress - Gives the general appearance of paresis. Brother says has noticed something wrong for 3 months. Says he has been smoking opium - been neglectful of business.

Previous mental grade good.

Eruption simulates syphilis.

Personal and Medical History of Richard Ryan.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fair - somewhat impaired.

WOUNDS OR ABNORMALITIES, Scar over right temple: eruption on chest & back like psoriasis.

TONGUE, Tremors, Coatings, light coat Promptness Movement, Somewhat slow.

PUPILS, Equality, Right ~~eye~~ larger Size, both slightly dilated.

Response Light, Slow Accommodation, slow.

SIGHT, of right eye much impaired. Corneal scar over right pupil - slight internal squint - slight ptosis both Eyes.

HEARING, —

COORDINATION, Arms, Some impairment.

Legs, Considerable impairment

TREMORS, Hands, Slight Tongue, Coarse & fine

Facial Muscles, Slight about lips General, No.

REFLEXES, Patellar, & Equal.

Other

ARTICULATION,

Slurred, Slightly

Hesitating, Slightly

FACIAL EXPRESSION,

SENSIBILITY,

Arteries slightly stiff.

HEART, No Murmurs. Sounds somewhat weak - Fairly regular

LUNGS, —

TAKEN,

EXAM. URINE, Nov. 6/96. 3 P.M.

Color yellow.

Sp. gr. 1026

Character clear.

Reaction acid.

Albumen none.

Sugar none (Haines)

Microscopical Few uric acid.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Is moderate drinker. Denies syphilis

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,

Brothers or Sisters,

Personal and Medical History of Richard Ryan.

1898

This patient was brought here by Sheriff Stewart with the following history: In fair physical condition. No history of consanguinity, heredity or intemperance. parents are dead. First symptoms of attack manifested by stupidity & dullness. sleeping in store during business hours. making mistakes in business. Disease seems increasing with no rational intervals: Derangement now manifested by inability to attend to business transactions: restless use of money; loss of memory. Patient has shown no disposition to injure others; is not suicidal; filthy or destructive. Previous peculiarities irritability, sudden passion & being very unreasonable. Patient had mountain fever for six months eight years ago. Has not been confined or restrained: no treatment pursued.

On personal examination manifests some lack of memory:- States that he desires to undergo treatment at the State hospital. On Admission put upon Dispensary ward (Off. Rept. Complexion light; hair brown: Eyes gray: Scars on right eye: under left ear & on instep of right foot. Skin on chest covered with small scales & other parts of body with small blotches. Is clean: behavior good).

Nov. 4 Nurses Notes (Summary) Patient came on ward at 10 AM. was given bath & put to bed for a few hours. Up & dressed after dinner: Very restless & incoherent & inclined to wander about ward. Habits inclined to be dirty: Slept good during night. Memory very poor. Nov. 4 Attempted to get out of window in B. Hall: Talks only when spoken to but will answer questions fairly well. Physical condition fairly good.

Nov. 6 Patient appears to be getting more nervous: Continually rubbing hands over head & pulling at moustache, more restless at night. Nov 7 Very restless today: Pulling out moustache which had to be cut off. At 3 PM. had spell. convulsive movements of limbs for about 5 minutes & appeared to lose his sense: was very noisy for a while: put to bed. Very talkative, irrational. On coming out of spell said he had been dreaming. Had spells of similar nature several times during afternoon: On coming out of them required 2 nurses to hold him. Fed by nurse. Nov 10 On liquid diet: Has had several spells since 8 AM. both day & night & requires nurse in room most of time. During spell today, patient fell out of bed & bruised head. Nov. 11 Visited by brothers this morning: very restless & talkative. recognized them. During day patient got out of bed & moved bed against door after closing it. Door forced open. Nov. 12 In a maniacal condition all last night. Held in bed until 12.45 when he became unmanageable & was put in restraint sheet. Nov. 13 Taken out of sheet at 8.30 AM. Slept none during day: Has been very quiet. Nov. 14 Out of bed several times during night & was very noisy: Has numerous delusions: one in particular being that he is in Little Falls in shoe store. Says he feels good & there is nothing the matter with him. Nov. 15 Very noisy from 4 to 7 PM. had to be held in bed. Fed daily by nurse. Has been taking different kinds of medicine

Personal and Medical History of Richard Ryan.

Habits filthy: Behavior restless & noisy & inclined to be pugnacious: Bowels irregular has had enemas. Physical condition failing, no change mentally.

Nov 20 '96 to Apr 30 '97 Summary Nurses Notes by Dr Phelps. Nov 20. Temp. running along about normal. Patient rather talkative & talks in girly manner, & movements unsteady. Nov 26 Commencing to be up on ward, at times quite demented. Burned himself by dropping a hot potato, was seemingly too stupid to prevent its burning him. Jan 16 Has been in straight shirt of late. Jan 20 Attacked by convulsive twitchings & unsteadiness: Had to be held in chair. destructive of late. Jan 24 Paretic spell at 10 AM. & another in PM. Feb. 1 Is again on sick ward: Rather pugnacious & noisy, in restraint at times. Feb. 9 Has had convulsive movements today & yesterday. Feb 13 Somewhat comatose today, has had convulsive movements from time to time. Mch 5 Seems to have had no convulsive movements of late - Is rather noisy & restless, & emotionally disturbed: Tells all sorts of stories. also incoherent. Apr. 30 Patient still restless & noisy, is always demented & disturbed. May 1897 Patient lying in bed. Temperature occasionally slightly above normal. Is very dirty & demented Wt. 117 lbs. Aug 1 Wt. 115 lbs. Sept. 1897 Wt. 122 lbs. November 12 lbs up & about but very stupid & answers are irrelevant & unreliable. Jan 31 '98 Has been for last six months or more quite steadily in bed. No prominent symptoms, lowers, simply demented & quiet Wt. 127 lbs Jan 31 '99. No change. Feb 1 - July 31 '99 (Dr Watrous) Remains in bed all the time. is noisy most of the day. Bowels frequently constipated & has to be given enema. June 1 Very excited. throwing himself from bed. bruising body. put in protection sheet for a couple of days. July 1 Patient is apparently failing gradually. Continues noisy during day. Still in bed. Physical condition gradually declining - Aug 1. Patient in bed Aug 31 Still in bed: very stupid & physical condition poor; Sept 8. Patient is constipated badly: condition does not improve. Oct 1. Oct 1. Wt 117 lbs. Is very noisy & restless and frequently out of bed. Dec 10. Very noisy: Struck several blows in ward by patient Smith. Jan 26/1900. Has water blister and bed sores on back & on legs. Jan 29. Refused nourishment Jan 31 Is getting Eggnog, every 3 hours. Feb 1 Patient steadily failed and Died. 1 day

Died

Personal and Medical History of Andrew O. Byr.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4572
Residence, Vinton, Iowa.
Date Admission, November 7th 1896.
Admitted by Dr. R. M. Phelps Hour,
How Sent, Dept Olson, J. of P. Dodge Co.
Sex, Male.
Age, -61-
Civil Condition, - married.
Children, -6-
Age Youngest Child, —
Occupation, Farmer
Degree Education, Common school.
Profession Religion, Lutheran.
Habits, Formerly intemperate.
Nativity, Norway (Parents Norway)
Physicians Committing, A.H. Vanblen + C.O Hughes
Correspondents, —

No. for Year, 105.
Insane Relatives, - None -
Cause Exciting, Not known
Cause Predisposing, Not known.
Form, melancholia acuta Senilis
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not
Date of this Attack, April 1896
Duration, about 6 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 61
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by R.M. Phelps 11/9/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Slightly confused.
Quick or Sluggish, Rather sluggish.

MEMORY:
Past Events, } Fair slightly doubtful.
Recent Events, }
Special Subjects, }

PERCEPTIVITY:
Alert or Dull, Rather dull -
Correct or Illusive, In some ways incorrect.

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

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

DELUSIONS:
Systematized or Not, "Anxious" "Afraid prosper"
Special Subjects, "will kill him + will go to Hell"
Transitory or Not, "No drunkard shall inherit etc".

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient quite fair in Atheroma or gross brain disease in appearance Has sluggish walk with gross tremors. (paralysis agitans.) Has considerable atheroma + evidently declining. Brother's mental state doubtful. Says has had tremors since age of 21

Personal and Medical History of Andrew O. Byr.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 10½ WEIGHT, — NUTRITION, -
WOUNDS OR ABNORMALITIES, -
TONGUE, Tremors, — Coatings, Promptness Movement,
PUPILS, Equality, - Size,
Response Light, Accommodation,
SIGHT, -
HEARING, -
COORDINATION, Arms, -
Legs,
TREMORS, Hands, Extreme - Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 4-5
Other
ARTICULATION,
Slurred, Normal.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs.
Sounds fair -
LUNGS,

TAKEN,

EXAM. URINE, Nov. 12 1896.
Color Yellow.
Sp. gr. 1024
Reaction Acid.
Character Cloudy.
Albumen None
Sugar None
Amt. 24 hrs. XXXVII ℥.

Arteries - Considerable impairment.
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Circ (h) 57 (r.m) 66 N.o.c.a. 36.5 Bi.a. 33.8 Ant.p.d. 20.+ Trans.d. 15.4 Bi.d. 14. Fac. l. 13.2
HISTORICAL, Had ague - Pretty nearly had Sunstroke once. Drank a good deal from 20 - to 45 - more lately
LENGTH OF INVASION, Anxious since last Spring. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters, 1 sister Half brother 6 children

Personal and Medical History of Andrew O. Bye.

1896

This man was brought here by Sheriffs deputy Joel Tucker with the following history: In fair physical condition. Nothing known as to consanguinity. First symptoms manifested in April 1896. Disease appears increasing; not variable + with no rational intervals: Derangement shown by manifestations of great fear: Not disposed to injure others: Is not suicidal, filthy or destructive: No previous peculiarities shown. Head was run over by a reaper 35 years ago: No history of intemperance of late years. Has not been confined or restrained: No information as to treatment. On personal examination no further particulars noted. On Admission put on B.3 (Occ. & Rpt. Complexion dark: Eyes blue: Hair dark brown: Mole on back, on left shoulder + on right side of nose. Is dirty: behavior good.)

Nov. 7 Nurses Notes (Summary) Received on ward at 4 P.M. Seemed very nervous + frightened: Has delusions. Rpt Nov. 8 Quiet + well behaved but nervous. Believes that we are going to kill him. Temp. 99°. Nov. 12 Has been quiet + well-behaved since admission: Appetite fair: bowels regular: Sleeps from 4 to 5 hrs. Sits quietly in one place while on ward: Slouchy in dress + habits: Temp. normal since 8th inst. Nov. 13 While out walking today became very stubborn + would not walk. Was carried to house by Nurses. Nov. 20 No apparent change since admission: Very nervous + seems afraid: Talks very little + irrationally, remains quiet + well behaved: Bowels regular: Appetite fair: Sleeps fairly well.

Summary Nurses Notes by Dr. Phelps Patient quite stubborn, sits about in a slouchy, dull way, talks none, appears melancholy - No special sickness noted. Nov. 3. Still stubborn, will not talk: If taken out has to be carried back. Wt. 169 lbs. Jan 1897 Wt. 174 lbs. Is now walking out. Is on extra diet. Jan 29 Given general Faradization: Is weak + quite tremulous: No special sickness. Feb 16 would not eat. Mch 1 Has refused food for several days but is now eating again: Wt. 166 lbs. Apr. 1 Wt. 170 lbs. Takes daily exercise: Maintains the same attitude and stupid behavior. May 1 97 Wt. 170#. July 1 Rather tremulous in manner. Usually quiet: Will smile in a rather silly way. Has mild delusions but is fairly intelligent with regard to his behavior. Jan 31 99 - Has drifted along without any essential change in any way during period. Feb 1 - July 31 99 Wt. 182#. Has delusions: Sleeps well: Bowels regular: Appetite good: No change mentally. Aug 1 - Jan 31 1900. Wt. 185#. Little change: Is physically well: Has numerous delusions of a religious nature + expresses them freely: Is well behaved: Tidy + works on ward. — .. ——

1900 -Jo- Jan 31 Feby 1 Wt 186#. P86. Apl 10 Transferred to TW. Coughs some + complains of various pains: has slight fever: (probably La Grippe): bowels constipated. Apl 23 Patient up, on ward - June 23. Transferred to TB. — Apl 10/23 July 7 It is as well as usual. Still on medicine. July 17 - Vaccinated: result negative. July 31. Physical 31 Condition is somewhat improved. Is inclined to be constipated. Is very quiet + well behaved. Answers

Personal and Medical History of Andrew O. Bye.

1900

Jo

July 31 1901 Jan 31 questions readily + rationally. Talks very little. Does some work on ward. Aug 1. 174#. Sept 2. Visited by friends. Jany 31/01. No change in mental condition: in rather poor physical condition: "paralysis agitans" slightly developed recently, complains considerably of pains in feet + knees (rheumatic): very quiet: talks rather incoherently: works a little on the ward. Feby 15. Up + dressed: on ward: patient is clean + neat in appearance: not inclined to talk: seems rather nervous + restless in action. Febry 25 Complained of being sick + again sent to bed: has been constipated: given salts + soft diet: complains also of rheumatism in legs. Mar 14. Up, on ward. Apl 4. To Apl Mar 14 May 1 Wt 173#. July 31. No change, mentally. Works a little on ward: Quiet, good natured. July 31 Talks to himself, irrationally: Goes out with crowd. Augs. Wt 176#. Jany 31/01. Quiet: 1901 Jany 31 rather dull: somewhat demented. (Aug 23 Was visited by friends; refused to recognize them). Condition chronic + unchanging.

03 Jan 31. (Dr. Phelps) No event of importance has occurred during period. is quiet; health good; neat; talks but little; is somewhat silly + dull.

Personal and Medical History of Frederick Roberts

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4574

Residence, Has none.

Date Admission, November 10th 1896.

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

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

Sex, Male.

Age, 33.

Civil Condition, Single.

Children, –

Age Youngest Child, –

Occupation, Newspaper reporter

Degree Education, Common school - well read.

Profession Religion, Not a church member

Habits, Not intemperate.

Nativity, Germany. (Parents Germany)

Physicians Committing, A. W. Dunning & Frederick Leavitt

Correspondents, –

No. for Year,

Insane Relatives, None. so far as ascertained

Cause Exciting, Not known

Cause Predisposing, "Heredity?"

Form, paranoia

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, patient not able to tell.

Duration, Not known

No. of Attack, gives history of several attacks.

No. of Admissions, 1st here.

Age First Attack, not known

Time of Leaving, July 7. 1897

Time in Hospital, 7 mos. 27 da.

Result, Discharged Aug 11. 1897. Unimproved

EXAMINATION ON ADMISSION.

Exam. by. R.M. Phelps 11/18/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: –

Clear or Confused,

Quick or Sluggish,

MEMORY: –

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY: –

Alert or Dull,

Correct or Illusive,

REASONING POWER: –

Ordinary Subjects,

Own Mental State,

Special Subjects,

EMOTIONAL STATE: –

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS: –

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS: –

ILLUSIONS: –

CONVERSATION: –

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Was too weak to talk about it first of week. May have an attack & wants to die before another. Was in an Asylum last Feb. before had had nervous prostration about once in 2 years. Lately overwork - main cause lack of sleep. Predisposed to nervous activity. Patient very loquacious - is trying to explain himself but does not progress in his explanations. Always tries to make fine legal distinctions

Personal and Medical History of Frederick Roberts.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8½ WEIGHT, 142½ lbs. NUTRITION, Not my good.

WOUNDS OR ABNORMALITIES, Condition of skin Fair.

TONGUE, Tremors, Coatings, Promptness Movement, Normal.

PUPILS, Equality, Left slightly larger. Size, Normal.

Response Light, Accommodation,

SIGHT, –

HEARING, Normal

COORDINATION, Arms,

Legs,

TREMORS, Hands, Not notable. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal. EXAM. URINE,

Other

ARTICULATION,

Slurred, Good.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Slightly irregular. irritable & slight palpitation.

LUNGS, Fair.

Fibres - full. vascillating

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS, Long. f. 6.7 (r.w.) 6.9 H. circ. 56 Bin. a. 36½ Ant. p. d. 19.4 Fronto. d. 16.8 Bin. d. 13.3 Fac. l. 11.

HISTORICAL, Denies any nervous disease - Lately several attacks of Nervous Prostration - Dont drink - Last Feb. in Danvers.

LENGTH OF INVASION, Previously defective ONSET GRADUAL OR SUDDEN, Gradual.

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any insanity.

Mother or Mat. Relations, Died consumption.

Father or Pat. Relations, Died of gout.

Brothers or Sisters,

Personal and Medical History of Frederick Roberts.

1896

This man was brought here by Sheriffs deputy George Roche with the following history: Patient in fair physical condition. Patient could not tell anything concerning consanguinity: Gives a history of several attacks of several months duration was confined in hospital in Massachusetts: seems to have been benefited but little. Do not able to tell when symptoms were first manifested: Disease appears stationary, not variable. Can not make out a history of rational intervals. Patient is under delusion that he is persecuted & effort made to get him into insane asylum. Is disposed to injure others but is not suicidal, filthy or destructive. No previous peculiarities known of. No history of intemperance in self or parents, or of severe disease or head injury. Has recently been confined in Ramsey County Jail. Nothing known as to treatment. On personal examination hallucinations & insane beliefs shown, - believes he is being persecuted. General neurotic condition. On admission put upon B3 E. (Opt. & Sept. Complexion dark hair black: eyes gray: condition of skin good. Is clean: behavior good.)

Nov. 10 Nurses Notes (Summary) Came on ward at 7:30 PM. Talked rationally:
" 13 Patient is irritable & ill tempered, continually complaining about something. Talks a great deal about his nervous troubles & other imaginary complaints Nov. 19 Appetite good: Bowels constipated: Requires cathartics frequently. No change mentally: Is still irritable & cross when making complaints: becomes highly excited & agitated; sometimes quite noisy. Nov. 22 Has been fairly quiet & agreeable today: Went out for walk for first time: No apparent change in patient since admission.

Nov 28 Has become more agreeable & quiet: Is clean in habits but slouchy in dress Appetite good: Bowels fairly regular. Dec 1 Has been extremely agitated during last few days: Is continually walking floor & complaining: Wt. 141½ Pulse 72. Jan 1/97 Still extremely agitated Jan 17 Became seriously ill, Temp. rising to 103.4 Pulse 78. Medicine given: Much better next day. Continued to improve & fully recovered by 20th.

Feb 1/97 More quiet of late: Not so troublesome: Appetite good: Bowels regular: Sleeps well. Wt. 145 Pulse good. Feb. 17 Note by Dr. Herzog. Patient stated that between 3 & 7 PM a small package containing four 5.00 bills & a draft made out to some other person Dining room & room searched. (Stated that he had concealed same in rectum when examined & on admission): Suspected patient Frank Reibel & he & his room searched by Dr Herzog Nothing found.

Feb 17 Since losing money patient has relapsed into former state: Is agitated & very talkative. Recites his alleged wrongs at every opportunity & dilates upon them, states that searching of Reibel was not thorough; that he was prevented from going quietly to dining room to search for the package without explaining reason; that nurse spoke aloud saying he had lost some money, thereby setting other patients to work searching for it

Personal and Medical History of Frederick Roberts.

threat & other grievances all repeated with much circumstantiality of detail much as on admission. -

Mar 1 Still agitated & irritable continually complaining: Appetite good: Wt. 140 Pulse 90.
" 5 Became extremely noisy this A.M. Taken to B' until he subsided
Apr 1 Much quieter than formerly & quite well behaved: Appetite good: Bowels constipated: Wt 143. Pulse 72. Trans. to A'. Apr 4 Complained since kept him awake during night: Refused to get up. Is very noisy & agitated. Trans. to A2.
" 14 Worked on lawn today Apr 30 Dr. Eby notes - Since on A2 has been quite well-behaved, has, however, made many complaints about treatment of other patients - Before going out to work complained of his head & described a burning sensation which kept him thinking of himself so that he could not concentrate his mind on anything reading or mental work. This sensation fully disappeared a few days after he commenced to work outside. Physically he is now quite well. -

May 8 Works every day with gardener. No change in behavior - Complains continually - especially of not being able to get sufficient amount of sleep.
" 18 Has done no work since 9th. Became very noisy & abusive today - So angry that he frothed at mouth - Trans. to B2. June 1 Has had parole Wt. 135 Pulse 80. Sleeps some on hall during day. June 18 Patient has been so noisy & troublesome that he lost his parole today.

June 20 Dr Eby Notes - For last few days patient has been very excitable & more hypochondriacal than usual. After parole was taken away refused to go out with crowd & was taken out with nurses: Afterward claimed that he was injured. Has some slight bruises but no further marks of injury.
July 1 Wt. 140 P. 84 Has been out walking several times: Complains much of pain in right foot of late: Walks very lame - No change mentally.
July 7 Eloped while coming in with crowd this evening & could not be found.

Discharged

Personal and Medical History of James Smith.

ROBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4575

Residence, Unknown.

Date Admission, November 11th 1896.

Admitted by Dr. H.F. Herzog. Hour,

How Sent, J. Wellisch. Jr of P. Ramsey Co.

Sex, - Male.

Age, - 32 -

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Laborer

Degree Education, - None.

Profession Religion, Unknown.

Habits, Very Intemperate.

Nativity, Scotland (Parents Scotland)

Physicians Committing, J. Chase & Jno. B. Brimhall

Correspondents,

No. for Year, 108.

Insane Relatives, Not Known.

Cause Exciting, Alcoholism.

Cause Predisposing, Not stated.

Form, Acute mania Syphilitic

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Yes - (Tried to hang himself)

Date of this Attack, Nov. 7 96.

Duration, 4 days.

No. of Attack, Unknown,

No. of Admissions, 1st

Age First Attack, unknown.

Time of Leaving, June 18. 1897

Time in Hospital, 7 mo. 7 da.

Result, Discharged. 6/18/97.

EXAMINATION ON ADMISSION.

Exam. by H.F. Herzog M.D. 11/14/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Very poor

Recent Events, do.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Poor

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient has Tattoo marks on each forearm & on the right hypothenar eminence. Has probably been a tramp or a sailor. Is now thoroughly demented; does not know his own name, his age or occupation. Has Tenderness over Top cranium - Syphilitic scars

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, None

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, ✓

Voluble or Reticent, ✓

On admission said noises came to his head from his arm. Wanted arm cut off.

Went out on trial Dec. 3' 96.
Returned May 3rd '97 with new papers which are filed under this Number (4575) with old papers.
M.S.

...N, CONTINUED.

...ISTICS.

NUTRITION, Impaired.

...th pustules.
...r chancroidal bubo. 2 scars on left forearm

Promptness Movement, somewhat slow

...normal.

...modation, Excessive.

HEARING,

COORDINATION, Arms, Slightly impaired

Legs, do.

TREMORS, Hands, No.

Facial Muscles, No.

REFLEXES, Patellar, 7-8 equal.

Other

ARTICULATION,

Slurred,

Hesitating, Somewhat.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries slightly stiff.

HEART, No murmurs. Sounds - Impulse forcible

LUNGS, Expansion Shallow - Breath sounds good.

Tongue, Slight fine

General, No.

EXAM. URINE, Nov. 13 96 4th P.M.

Passed Nov. 13 96 4 P.M.
Color. Light
Spec. — —
Reaction Acid.
Character Cloudy - Clears up on warming showing urates.
Albumen None.
Sugar None.
Microscopical Granular urates.
Quant. 24 hrs. XXXV Oz.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Unknown

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of James Smith.

ROBERT, FIELD & CHAMBERS, DAVENPORT, IOWA

Whole No. 4575
Residence, Unknown.
Date Admission, November 17th 1896.
Admitted by Dr. H.H.Herzog. Hour,
How Sent, J. Millrich. J of P. Ramsey Co.
Sex, - Male.
Age, - 32 -
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Laborer
Degree Education, - None -
Profession Religion, Unknown.
Habits, Very Intemperate.
Nativity, Scotland (Parents Scotland)
Physicians Committing, J. Chase & Jno. B. Brimhall
Correspondents,

No. for Year, 108.
Insane Relatives, Not known.
Cause Exciting, Alcoholism.
Cause Predisposing, Not stated.
Form, Dementia syphilitic
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Yes - (tried to hang himself)
Date of this Attack, Nov. 7. 96.
Duration, 4 days.
No. of Attack, Unknown,
No. of Admissions, 1st
Age First Attack, unknown.
Time of Leaving, June 18. 1897
Time in Hospital, 9 mo. 7 da.
Result, Discharged. 6/18/97.

EXAMINATION ON ADMISSION.

Exam. by H.H.Herzog M.D. 11/17/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Very poor
Recent Events, do.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Poor
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Patient has Tattoo marks on each forearm & on the right hypothenar eminence. Has probably been a tramp or a sailor. Is now thoroughly demented; does not know his own name, his age or occupation. Has Tenderness over Top cranium - Syphilitic scars

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, None
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, ✓
Voluble or Reticent, ✓
On admission said noises came to his head from his arm. Wanted arm cut off.

Personal and Medical History of James Smith.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8 WEIGHT, 142½ lbs. NUTRITION, Impaired.
WOUNDS OR ABNORMALITIES, 1 Small circular superficial scratch punctures. Large Scar on right groin looks like a chancroidal Bubo. 2 scars on left forearm
TONGUE, Tremors, - Coatings, Clear. Promptness Movement, Somewhat slow
PUPILS, Equality, Left slightly larger Size, normal.
Response Light, excessive Accommodation, Excessive.
SIGHT, Seems good.
HEARING,
COORDINATION, Arms, Slightly impaired
Legs, do.
TREMORS, Hands, No. Tongue, Slight fine
Facial Muscles, No. General, No.
REFLEXES, Patellar, 7-8 equal.
Other
ARTICULATION,
Slurred,
Hesitating, Somewhat
FACIAL EXPRESSION,
SENSIBILITY,
Arteries slightly stiff.
HEART, No murmurs - Sounds - Impulse forcible
LUNGS, Expansion Shallow - Breath Sounds good.

TAKEN,

EXAM. URINE, Nov. 13'96 4th Ward
Passed Nov 13 96 4 P.M.
Color Light
Spgr. — —
Reaction Acid.
Character Cloudy - Clears up on warming showing urates.
Albumen None -
Sugar None.
Microscopical Granular urates.
Qut. 24 hrs. XXXV Oz.

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, Unknown
Brothers or Sisters,

Personal and Medical History of James Smith.

1896

Was brought here by Sheriffs deputy George L. Rochet with the following history:- Patient is in poor physical condition. Was found intoxicated on Nov. 7th with marked delirium tremens disease seems increasing; has grown worse since Saturday night:. Nothing known as to consanguinity or heredity. Derangement now shown in idea that his arm should be taken off to cure noise in his head. Tried to hang himself with his suspenders. He is destructive of clothing but not filthy. Nothing known as to severe disease or injury to head. Has been kept in Ramsey Co. Jail since Nov. 7th & received usual treatment for alcoholism. On personal examination patient has staring expression, flushed face, nervous movements, wants arm cut off etc. On admission put on B3 E. Qt. N. Rpt Complexion light, hair brown; eyes blue; Condition of skin good - Tattoo marks on both arms - Coarse veins on both legs: Ulcer on left leg. Is clean: behavior good: Talks very little.)

Nov. 11 Nurses Notes (Summary) Patient received on ward at 7:30 P.M. Talked rather irrationally: Stupid but well behaved. Memory seems poor.

Nov. 12 Patient kept in bed today. Bowels regular. Appetite good. Is very quiet & stupid.

" 14 Mental condition is improving: memory is slowly returning: habits fairly clean: behavior good: Is up out of bed. Nov. 16 Patient still improving mentally: Can tell a little concerning his past life today on being questioned: Does not seem to realize yet where he is. Has been taking mercury 3 times daily since since 12th. Nov. 17 Has diarrhoea today. Complains of pain & of feeling very weak: medicine discontinued. Has had slight rise of temperature last 3 days.

Nov. 19 Patient improving mentally & physically each day: Still complains of having sore spot on top of head. Nov. 24 Patient seems perfectly rational now. Works on ward: Is full of fun & very good natured. Talks freely & memory is good.

Nov. 20 Works on ward & does all he can to assist nurses. Talks & acts rationally but seems rather anxious to go home. Appetite good. Bowels regular: Sleeps well. Dec 3 Sent Home -

May 3 Dr. Herzog notes - Talks rationally, worked for Mr. Rutherford of Stillwater up to Apr. 29 - quit & went to Stillwater & got drunk. May 1st drew $10 & all he had coming" went to St. Paul & was arrested that night. Resisted arrest, had clothing torn & got black eye. Had a letter from Dr. Kilbourne in his pocket by which he was recognized. He insisted in probate Court that he had been discharged, but they found notice & in fact he had not been. He still shows slight inequality of pupils, left larger - response to light excessive - Slight exaggeration of reflexes. Has loss of memory of events occurring while drunk.

June 5 Complains of soreness of glands of throat. June 7 Throat does not improve Did not go out with crowd: ate very little June 8 Did not go out this A.M.

Personal and Medical History of James Smith

8 P.M. went to bed. had a chill then slight rise of temperature: gave medicine during night: better in morning. Ate very little during day.

June 9 Very quiet & well-behaved while on ward: Talks rationally: Assists with work: Temp. 98° P 78 Trans. to Infirmary & put to bed

10 Up on ward this morning: Slept 8 hrs last night Trans. to B3.

19 Patient somewhat irritable since last note. Complains of food being unfit to eat. Has stopped working Went Home

Discharged.

Personal and Medical History of John Desmond.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4582

Residence, Lanesboro, Minn.

Date Admission, November 17th 1896.

Admitted by A. M. Phelps, M. D. Hour, 2.45 PM

How Sent, C. & M. Fairington Jct. P. Fillmore Co.

Sex, -Male-

Age, -22-

Civil Condition, -Single-

Children, -

Age Youngest Child, -

Occupation, Lineman on Telegraph line.

Degree Education, Common School.

Profession Religion, yes- Catholic

Habits, Not intemperate (?)

Nativity, Minnesota (Father Ireland - Mother N.Y.)

Physicians Committing, J.H. Phillips - G.A. Love.

Correspondents, -

No. for Year, 115

Insane Relatives, None.

Cause Exciting, Masturbation

Cause Predisposing, Not stated.

Form, Confirmed insanity

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Nov. 14th 1896.

Duration, Several days.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 22

Time of Leaving, July 2. 1897

Time in Hospital, 6 mo. 16 da

Result, Discharged Nov. 3. 1897. Unimproved.

EXAMINATION ON ADMISSION.

Exam. by P.M. Phelps Jan. 4 '97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Fairly clear on ordinary subjects.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Recent Events, Special Subjects, } Says fair.

PERCEPTIVITY:

Alert or Dull, Some dullness.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Own Mental State, Special Subjects, } Not very good

EMOTIONAL STATE:

Normal, Calm,

Indifferent, or normal.

Exalted,

Depressed,

DELUSIONS: None noted now.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient shows somewhat of feebleminidedness in his judgements & talk, but not extreme now. Was probably quite weld from drinking etc. at time of commitment but tries not to admit it. Health fair. Has evidently drank recklessly.

Personal and Medical History of John Desmond.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 11½ WEIGHT, 156 NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, None. Condition of skin - good.

TONGUE, Tremors, Coatings, Promptness Movement, Normal.

PUPILS, Equality, Equal. Size,

Response Light, Normal Accommodation,

SIGHT, Normal

HEARING, "

COORDINATION, Arms, -

Legs, -

TREMORS, Hands, None Tongue, None

Facial Muscles, " General, "

REFLEXES, Patellar, Normal.

Other

ARTICULATION,

Slurred, Hesitating, } Good.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal.

LUNGS, Good.

Arteries "

TAKEN,

EXAM. URINE, Exam. Nov. 23/96 3/4

Passed Nov. 23 10 A.M.

Color Yellow.

Character Clear.

Sp. Gr. 1024

Reaction Acid.

Quan. in 24 hrs. XXXVIII - 3j.

Albumen Trace by Heat, Tanret, Ritter Ag

Sugar None.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, No severe diseases. Drinks a good deal- for 5 years

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any insanity.

Mother or Mat. Relations, Healthy

Father or Pat. Relations, Died in 1880. Murdered at Elmira by blind man. They were boys & were put up to it. Struck him with club & cut throat.

Brothers or Sisters, Healthy.

Personal and Medical History of John Desmond.

1896

This patient was brought here by Sheriff Knipp deputy E. Erickson attended by George Hipp - with the following history: Patient is in fair physical condition - No history of heredity, consanguinity or intemperance in self or parents. First symptoms of this (1st) attack manifested last Saturday when patient was confined in Jail for assault. Had hallucinations + delusions. Stripped himself + masturbated openly - was fighting with imaginary enemies. Disease appears increasing variable with rational intervals: Is rational in presence of others but very violent when alone. Is disposed to injure others + is filthy + destructive. No previous peculiarities observed. No severe disease of head injury: Has not been confined or restrained: has received no treatment. No further particulars noted - on Personal examination. On admission put upon 6' E. (Ward Rpt. Complexion sandy: hair dark red: Eyes gray: Condition of skin good: face + hands scratched: Scars - 1 on leg + one on left side of chest. Is clean: behavior good)

Nov. 17 Nurses Notes (Summary) Received on ward 2 P.M. Bath given: behavior good: Talked fairly rationally: Nov. 19 Was restless today: walks + talks a great deal: Acts foolish, laughing to self: Goes walking with crowd: Appetite good: Bowels regular: Nov. 23 Still restless, walking floor: Minds very well when spoken to: works on ward: Amt. urine 24 hrs. 38 oz. Visited by brother + friend today: Nov. 25 While out walking told patients he was going to run away: Pulled off overshoes but did not attempt to run: Nov. 26 Apparently no change mentally or physically: Still restless + discontented: Is very inquisitive.

Nov. 30 Still no change in Patient: Appetite good: bowels regular: Sleeps well.

Dec 1 Patient behaves fairly well + talks quite rationally but acts very foolish at times, gesticulating + laughing to himself. Bowels regular: Sleeps well: Works on wards. Dec. 4 Wt. 154½ P. 78. Jan 1/97 Has made several attempts to unlock screens on windows by using a piece of bent wire + has tried in several ways to get away. No change mentally or physically since last note. Wt. 161½ Pulse 84

Feb 1 No change. At times will stay in room alone + swear at some one who had wronged him before coming here: At one time was found talking + swearing at a broom which he had set up, imagining it was the person. March Wt. 161 Pulse 84. March 11 Talks rationally in ordinary conversation but when alone talks + gesticulates foolishly to himself - As a rule behaves fairly well: Choked patient Captain Day because he refused to make beds. Reported by F. Roberts. Desmond transferred to B 2

Mar 1 Wt. 157½ Pulse 88. Neat in habits + dress: Works some on ward: Very anxious to go home: No change in behavior. Apr 1 Wt. 155 Lbs. Pulse 80 No change mentally or physically (May record missing) June 22 Trans. to Infirmary Complains of pain in right side. A.M. Temp. 99.9 P 74 R. 24 P.M. T. 102⅘ P. 80 R 28 Appetite good: Bowels regular: June 23 A.M. Temp. 102⅖ P 76 R 30 P.M. T. 100⅘ P. 84 R 19

Personal and Medical History of John Desmond.

Days he feels better today - has been very quiet + quite weak:

June 24 A.M. Temp. 100² P 72 R 26 P.M. T 102 P 80 R 32 Noisy this afternoon: Is quite weak.

25 A.M. Temp. 100 P 66 R 26 P.M. 102 P 80 R 28 Power of attention seems weak - talks a great deal to himself: Visited by mother today: June 28 Patient up on hall most of day: Out with crowd. Temp. still ranges from 98⅘ to 102

July 2 A.M. Temp. 100 P.M. 104. Up on hall all day: Walks about in restless manner: 3 99⅘. Put to bed this A.M. Talks + laughs to himself most of time -

July 1 No change of any kind either mentally or physically -

Went Home today.

Discharged.

Personal and Medical History of David A. Harrison.

EGBERT, PICLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4592
Residence, Dakota Co. Minn.
Date Admission, Nov. 24th 1896.
Admitted by H.H. Herzog, MD Hour, 7 PM.
How Sent, P. P. Moran, Jap P. Dakota Co.
Sex, Male.
Age, 50
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farmer.
Degree Education, Common School.
Profession Religion, Yes. Methodist.
Habits, Intemperance
Nativity, Illinois (Parents Illinois.)
Physicians Committing, H. Van Beest & A. M. Adsit.
Correspondents, B. J. Harrison (brother) ~~Randolph, Minn~~
Geo. L. Harrison (brother) Northfield, Minn.

No. for Year, 125
Insane Relatives, None.
Cause Exciting, Alcoholism.
Cause Predisposing, Not known.
Form, Dementia Terminal
Accompanying Bodily Disorder, None.
Suicidal or Not, Not.
Date of this Attack, 15 years ago.
Duration, 15 years.
No. of Attack, 1st
No. of Admissions, 1st time. has been at St. Peter & Indianapolis.
Age First Attack, 35 years
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by T. M. Phelps. 12/30/96. **MENTAL CHARACTERISTICS.**

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

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

GENERAL DESCRIPTIVE REMARKS: Says he was for 7 or 8 years in Marion W. Va. institution. Brother brought him out to Northfield to work for him. Seems imbecile. Imbecile in appearance, stooped shoulders, head hanging down etc.

In re. David A. Harrison.
Order for hearing petition for letters of Guardianship of George L. Harrison. Served upon D. A. Harrison & A. T. Kilbourne Sept. Oct. 15 '97. filed with commitment papers. MED.

ION, CONTINUED.

ERISTICS.

NUTRITION, Fair.
iny - Ear now bruised - Some years ago.
Promptness Movement,
e,
ommodation,

COORDINATION, Arms,
Legs,
TREMORS, Hands, Not notably tremulous. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, ?
Other Equal.
ARTICULATION,
Slurred, } Fair.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs.
LUNGS, - Pigeon breasted.
Arteries rather hard -

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Don't think parents crazy - but some relatives are -
Mother or Mat. Relations, Died - white swelling
Father or Pat. Relations, Died in Canada
Brothers or Sisters,

Personal and Medical History of [illegible]

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4592
Residence, Dakota Co. Minn.
Date Admission, Nov. 24th 1896.
Admitted by H.H. Herzog, MD Hour, - 7 PM.
How Sent, P.P. Moran, Jap.P. Dakota Co
Sex, - Male.
Age, - 50 -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, Farmer.
Degree Education, - Common School.
Profession Religion, Yes. Methodist.
Habits, Intemperance
Nativity, Illinois (Parents Illinois)
Physicians Committing, H. Van Beek & R.M. Adsit.
Correspondents, B.J. Harrison (brother) ~~Randolph Minn~~
Geo. L. Harrison (brother) Northfield, Minn.

Suicidal or Not,
Date of this Attack, 15 years ago.
Duration, 15 years.
No. of Attack, 1st
No. of Admissions, 1st here. has been at St. Peter & Indianapolis.
Age First Attack, 35 years
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by T.M. Phelps. 12/30/96. **MENTAL CHARACTERISTICS.**

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

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

GENERAL DESCRIPTIVE REMARKS: Says he was for 7 or 8 years in Marion N. St. institution. Brother brought him out to Northfield to work for him - Seems imbecile. Imbecile in appearance, stooped shoulders, head hanging down etc.

Personal and Medical History of David A. Harrison.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 Ft. 4 WEIGHT, 141 (usual 150) NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, Nose smashed in - old injury - Ear now bruised - Some scars etc.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size,
Response Light, Accommodation,
SIGHT, Probably fair.
HEARING, Fair.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Not notably tremulous. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, ? EXAM. URINE,
Other Equal.
ARTICULATION, Slurred, Hesitating, } Fair.
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs.
LUNGS, - Pigeon breasted. Arteries rather hard -
TAKEN,
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Don't think parents crazy - but some relatives are -
Mother or Mat. Relations, Died - white swelling
Father or Pat. Relations, Died in Canada
Brothers or Sisters,

Personal and Medical History of David A. Harrison.

1896

This patient was brought here by Sheriff's deputy J.S. Hyland with the following history. Patient in fair physical health. No history of consanguinity or heredity ~~or~~ First symptoms appeared about 15 years ago. Has been confined at St. Peter also Indianapolis Escaped from both institutions. Derangement manifested by loss of memory, imbecility. Disease appears increasing not variable + with no rational intervals. Patient not suicidal; not disposed to injure others. Is filthy + destructive: No peculiarities previously shown: no severe disease or injury to head. Supposed cause of disease alcoholism. On personal examination shows incoherency of thought has facial eczema. On Admission put upon 13 C (G.H.N. Rpt. Complexion light: hair red: eyes blue: skin poor: Scars + ulcer on left leg, sciatches on hands + face. Is dirty: left leg deformed: behavior good.)

Nov. 28 Nurses Notes (Summary) Patient received on ward at 7.30 P.M.: Extremely filthy: Given bath + put to bed: Nov. 27 Appetite good: bowels regular: Is quiet + seemingly understands what is said to him but answers irrationally. Habits very filthy: Trans. to B'. Nov. 28 Restless: very filthy in habits: Requires a great deal of care: Eats on hall: Appetite very good. Nov. 29 No apparent change in patient: Has habit of putting rubbish in pockets: Talks irrationally: Is feeble + a little lame: Does not go out. Has not slept well last 3 nights. Dec. 1 Still very troublesome + hard to watch: Very filthy in habits: Appetite very good. Medicine given for diarrhoea. Dec. 5 No change in patient: Very hearty eater, requires constant watching to prevent stealing others patients food. Has sores on hands + face, continually picking them: No improvement in habits. Is undersized, left limb deformed causing him to limp when he walks, which prevents his going out with crowd. Average amt. of sleep. 5 hrs + a fraction.

to Apr 3 99 Summary Nurses Notes by Dr Phelps. Dec. 7 Habits dirty: Has to be kept by himself because he is so mischievious, needs constant watching: Picks plaster off walls. Jan 1 Wt. 139 lbs. Jan 12 Has bruise upon forehead, was struck by Geo. Wright. Jan 23 Very filthy + dirty both day + night: Scratches walls slops water about: Can answer questions. Feb. 1'99 Wt. 130# Rather restless + mischievious Plays in water, scratches wall, rubs lime into face etc. Is filthy + dirty + quite thoroughly demented. Jan 29'99 Patient still very dirty + demented in habits but has quieted down somewhat. Feb 1 - July 31'99 Wt. 129# Appetite good: bowels regular: Is untidy in habits: Has habit of pulling eyebrows out. Aug 1 - Jan 31 1900 (Dr Chapple)

1900 - 30 - Aug 1 - Wt. 131# No change of importance: Is incoherent + irrational: Talks to himself a good deal. Habits very untidy. Is at times pugnacious striking other patients: Physical condition impaired

Jan 31 Feb 1 Wt 130#. P 68. Mar 15. Two days temperature, about normal. July 20. Vaccinated: Result good. —

July 30/31 July 31. No important changes to note. Is in fair physical condition. Does not complain: micturates involuntarily and is filthy. Very deluded: irrational. Well-behaved. Since June 5, has been working in the farm.

Personal and Medical History of David A. Harrison

1900

Aug 1900 - Jany 31 1901 Feb 2 1901 - Jany 31 1902 Wt 123#. Sep 10. Transferred to D'. Sep 13. To D². Jany 31. Very little change: works on farm is very dirty and filthy in habits, but very well-behaved: irrational + incoherent in conversation. Wt 128# May Wt 131" Aug 1. 134# Nov 1. 137# — Jany 31/02. No change. Mentally. During the year: Health fair: Worked on farm during summer: always well-behaved: Very demented: Talks incoherently: Habits filthy -

Aug 1902 (Dr. Chapple) 131#. Oct. 23 Still works on farm; intensely irrational; Jan. 31/03. Work on farm but is very demented + wanders about. Is filthy; physical health rather poor.

Personal and Medical History of William Davidson

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4593

Residence, Owatonna, Minn.

Date Admission, Nov. 25, 1896

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

How Sent, M. B. Chadwick, Sheriff Steele Co.

Sex, Male.

Age, 68.

Civil Condition, Married.

Children, 6.

Age Youngest Child, —

Occupation, Grocery man.

Degree Education, Academic

Profession Religion, Presbyterian.

Habits, Not intemperate.

Nativity, England, (Father England Mother Scotland)

Physicians Committing, A. B. Stewart — F. M. Smith.

Correspondents, Dr J. H. Adair, Owatonna, Minn.

No. for Year, 126.

Insane Relatives, None.

Cause Exciting, No Knowledge.

Cause Predisposing, No Knowledge.

Form, Mania senilis

Accompanying Bodily Disorder, None Mentioned

Suicidal or Not, Not.

Date of this Attack, 10 years ago.

Duration, About 10 years.

No. of Attack, 1st.

No. of Admissions, 1st

Age First Attack, 58 years

Time of Leaving, Dec. 11, 1896.

Time in Hospital, 16 dys.

Result, Died. Exhaustion in Senile Mania

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 William Davidson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION,

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT,

HEARING,

COORDINATION, Arms,

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of William Davidson.

1896

This patient was brought here by Sheriff Barnard attended by Dr Adair. with the following history - Is in feeble physical condition. No history of consanguinity, heredity or intemperance in self or parents. First symptoms manifested 6 years ago by loss of memory alternating with fits of depression. Disease seems increasing not variable, without rational intervals: Derangement manifested by an entire abolition of the mental faculties: Patient not disposed to injure others: Is not suicidal: Is filthy & destructive: No furious peculiarities shown: No severe disease or injury to head. Patient has not been confined or restrained - Has been given hypnotics which quite good effect. On personal examination patient is irrational & very excitable & disturbed. On Admission put up on Infirmary E. (Gen. Apt. Complexion dark: hair gray: Eyes gray. Condition of skin good: Scar over right eye: Large sore on right heel supposed to have been caused by burn: small sores on different parts of body; is clean Behavior very troublesome, continually getting out of bed; requires the attendance of a nurse.)

Nurses Notes. (Summary) Nov. 25 Patient came on ward at 8 P.M. Appeared weak & tired & was not given bath. Has bed sore on right heel which was dressed. Nov. 26. Was out of bed often & slept none during night. His physical condition is good. Mental condition - talks incoherently & irrationally & memory is very poor. Appears to be in a partly unconscious state. Nov. 28. Put on liquid diet. Continually trying to get out of bed & had to be held by nurse. Nov. 29 Is quite restless but appears some weaker 3.30 P.M. T. 104° Was given cold bath at 4 P.M. Dr. Herzog notes - muttering restless delirium, pulse weak & somewhat intermittent. Has slight cough but no expectoration - Impossible to make examination of limbs on account of restlessness. Temporal arteries full. Character of delirium would seem to indicate the delirium of impending death.

Dec 4 Bed sore started on left ankle - bathed in alcohol. Dec. 5 Sore on ankle was painted with Ichthyol & Glycerine. Dec. 6 Patient was very restless all last night & until 11 A.M. Today when he became quiet & appeared to be unconscious & remained in that condition until 2.30 P.M. when he revived & became restless again - Dec. 7 Sore on ankle much swollen, was lanced & considerable amount of pus discharged. Sore was afterwards dressed. Dec. 8 Patient fell asleep several times today but only for about 5 minutes & would waken suddenly. On account of patients restlessness his elbows & knees are getting sore. Physical condition is failing. Mental condition about same: Receives one glass of Wellmi food every 2 hrs. during day. Has been given powders most every night. Sore on heel dressed daily & is improving - Has slept none during last 4 nights & but very little during the day. Has had nurse in constant attendance. His habits are filthy & bowels fairly regular. Behavior restless, slightly

Personal and Medical History of Wm. Davidson

1896

noisy & has been pugnacious at times. Dec. 9 8 A.M. T. 102.6 P. 112 R 36 - Wellmis food given every 2 hrs. Heel & ankle redressed: Knees & back bathed with alcohol. Patient gradually growing weaker. 5 P.M. T. 102 P. 108 R 30. Dec. 10 8 A.M. T. 101.6 P. 108 R 36 Very weak this morning. Breathing somewhat labored - Refused nourishment at 11 A.M. & appeared to be growing weaker - Refused nourishment at 1 P.M. Is in an unconscious condition & appears to be failing rapidly - Breathing considerably labored: Has slight cough. 5 P.M. T. 104 P. 130 R. 60

Dec. 11 Patient failed gradually during night. Breathing labored & perspires freely Is still in an unconscious condition -

Died 8 A.M. December 11th 1896

Personal and Medical History of W. D. Wells.

CORBET, PIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4600

Residence, Dimison, Minn.

Date Admission, December 3rd 1896.

Admitted by Dr. H.S. Herzog Hour, 7 P.M.

How Sent, Ord Haller J. afp. Goodhue Co.

Sex, Male.

Age, -40-

Civil Condition, -Single-

Children, —

Age Youngest Child, —

Occupation, Poultry merchant.

Degree Education, highschool.

Profession Religion, Yes Methodist Episcopal.

Habits, Intemperate.

Nativity, New Jersey. (Father N.Y. mother N.J.)

Physicians Committing, N. Jull, & B. Jacking.

Correspondents, Mrs J.L. Wells. (mother)
Dimison Minn.

No. for Year, 133.

Insane Relatives, Grand father's Uncle.

Cause Exciting, Possibly Masturbation

Cause Predisposing, not known.

Form, paranoia

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, Nov. 22' 1896

Duration, Since Nov. 22' 96.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, -40-

Time of Leaving, July 8. 1897.

Time in Hospital, 7 mo. 5 d.

Result, Discharged Feb. 9. 1898
Improved.

EXAMINATION ON ADMISSION.

Exam. by Dr. R.M. Phelps 12/30/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Quick & clear but in-

Quick or Sluggish, correct.

MEMORY:

Past Events, } Fair.

Recent Events, }

Special Subjects, }

PERCEPTIVITY:

Alert or Dull, Dull on own affairs.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Fair.

Own Mental State, Poor.

Special Subjects, Poor.

GENERAL DESCRIPTIVE REMARKS: Aunt tried to make him marry Cousin.
Has been troubled by these things about 3 years.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Yes-

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of W. D. Wells.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft. 3 WEIGHT, — NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, None. Skin- good condition

TONGUE, Tremors, Normal Coatings, - Promptness Movement, Prompt-

PUPILS, Equality, Equal. Size, Dilated-

Response Light, Accommodation,

SIGHT, Good

HEARING,

COORDINATION, Arms, Normal.

Legs, "

TREMORS, Hands, None Tongue, None

Facial Muscles, " General, "

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal.

LUNGS, Normal.

Arteries "

OPHTHALMOSCOPIC EXAM.,

TAKEN,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, "until they got him so full of poison"	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Had scarlet fever when young - Dont drink Has been troubled with headaches for some time-

LENGTH OF INVASION, Probably 3 or more years. ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") No heredity he knows of-

Mother or Mat. Relations, No heredity he knows of-

Father or Pat. Relations, Living healthy

Brothers or Sisters, 1 sister sickly.

Personal and Medical History of W. D. Wells

1896

This patient was brought here by Sheriff's Deputy P. J. Lundquist attended by Mrs. Margaret Wells in fair physical condition & with the following history:- No history of consanguinity. First symptoms of this (1st) attack manifested on November 22nd by fear of personal injury: disease appears stationary not variable with irregular rational intervals. Derangement manifested by fear of poisoning: Has threatened to injure others: Is not destructive or filthy: No peculiarities previously shown: No severe disease or injury to head: No history of intemperance in parents or self: Has not been confined or restrained: Nothing known as to treatment.
On personal examination is nervous, irritable & shows fear of poisoning. On admission put upon B[3] (G.H.N. Rpt. Complexion Dark: Hair black: eyes dark brown: Condition of skin good: 2 Marks on back: Is clean: behavior good.)

Dec. 3. Nurses Notes (Summary) Received upon Ward 7:30 P.M. Given bath & put to bed. Dec. 4 Talks very irrationally this morning imagines his folks were trying to poison him. Slept none during night.

Dec. 5 Very restless during night but quiet & well behaved today: Bowels regular: appetite fair: Visited by mother today: Dec 6. Appetite good: Temperature normal today first time since admission. A little restless this a.m. but has been quiet all day. Dec. 7 Very restless all night. Before going to bed last night declared that his food had been poisoned: Sleeps very little as a rule. better last night.

Dec 16 No apparent change mentally, Complains continually that he is being poisoned: Behavior was good until 14th when he became noisy & violent while out-walking. Claiming he had been poisoned & abused since coming here. Bowels regular: Sleeps much better than formerly: Appetite good: Works some on ward.

Dec 17 Has delusions & hallucinations of taste & feeling: Is well-behaved. works on ward: Is very unreasonable in his demands: Jan 1/97 Very little change in patient; does not talk so much about being poisoned but still holds firmly to the delusion. Wt. 176 Pulse 84. Feb. 1st Makes no allusion to peculiar ideas. Feb 10th says folks have been poisoning him for 10 yrs. Has morbid sexual ideas: Delusions of persecution systematized: Mother stated at last visit that he had never been perfectly right" (Dr. Herzog.)

Mch. 2 Visited by Mother & brother-in-law. Commenced at once to upbraid mother for poisoning him: Grew excited & noisy Mar 23 Dr. Herzog notes. Delusions of poisoning. Drugs introduced into food. Very anxious to get out.

" Conduct insulting & abusive toward nurses. Continually complaining.

Apr 1 Better-natured last few days. No other change. Wt. 145½ Pulse 78

June " Visited by father. cursed him & claimed relatives sent him here in order

Personal and Medical History of W. D. Wells

to obtain his property Wt. 183 Pulse 80. July 4 Visited by Mother - July 8 Quiet & well-behaved since visited by his mother - Sent home this Morning.

Discharged.

Personal and Medical History of Charles W. Ell.

HERBERT, PIGLER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4601

Residence, Redwing, Minn.

Date Admission, December 3' 1896.

Admitted by Dr St St Stenzog Hour, 7 P.M.

How Sent, Axel Hallin, Jap't. Goodhue Co.

Sex, Male.

Age, 27.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Potter.

Degree Education, Common School.

Profession Religion, Lutheran

Habits, Very intemperate.

Nativity, Indiana.

Physicians Committing, H.R. McKinstry & J.V. Anderson

Correspondents, P. J. Lundquist. Redwing, Minn.

No. for Year, 134.

Insane Relatives, Mother died in an Insane Asylum

Cause Exciting, Onanism & excessive drinking.

Cause Predisposing, Heredity?

Form, Mania acute

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, About Nov. 17' 96.

Duration, Since November 17' 96.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 27.

Time of Leaving, Apr. 1st. 1897.

Time in Hospital, 3 mo. 29 d.

Result, Discharged Sept. 28. 1897 Recovered

EXAMINATION ON ADMISSION.

Exam by Dr R.M. Phelps. 1/4/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Fairly clear now C 1/4/97

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 says he worked in brewery 2 years ago & last year drank my hard. This he thinks the cause. Free in nose. Took cold. Got out of his head & sent here. Thinks perhaps had Tremens. Seems fairly healthy. Says was healthy aside from drink. No physical lesion is noted.

Personal and Medical History of Charles W. Ell.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7½ WEIGHT, — NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, Stiff fingers - Cut on leg. Skin - fair.

TONGUE, Tremors, Coatings, Promptness Movement, Fair now - some sluggish

PUPILS, Equality, Equal. Size, Normal.

Response Light, Normal. Accommodation,

SIGHT, Good.

HEARING,

COORDINATION, Arms, Fair.

Legs,

TREMORS, Hands, Quite marked. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal. EXAM. URINE,

Other

ARTICULATION, Slurred, Hesitating, } Good.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal.

LUNGS, Normal

Arteries

OPHTHALMOSCOPIC EXAM.,

TAKEN,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Touch of typhoid at 5 yrs. Ague in Indiana 15 yrs. ago. Drank pretty hard towards last. Worked in Brewery 2 years ago. History states he had Delirium Tremens Nov. 17 96.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Dead - Dont know - in asylum.

Father or Pat. Relations, Dead - Killed

Brothers or Sisters, 2 brothers - healthy.

Personal and Medical History of Charles W. Ell.

1896

This patient was brought here by Sheriffs deputy Adolph Grosse, in fair physical condition, with the following history: No history of consanguinity: First symptoms of attack manifested about November 17, 1896 in delirium tremens Disease appears stationary, Variable with irregular rational intervals: Patient thinks they are using Xrays on him, & that someone is trying to shoot him Fears personal injuries: Is not disposed to injure others: is not suicidal, filthy or destructive: No peculiarities previously shown: No history of intemperance in parents but patient very intemperate: No severe disease or injury to head. Patient has been under restraint & watched for five days & has been given sedatives to gain sleep & quiet. On personal examination tongue coated, pulse 80 per minute: bowels irregular: appetite good: does not urinate regularly. On Admission put upon B³ (G.H.N. Rpt. Complexion light: hair brown: Eyes brown: Condition of skin good: pimples on neck & body. Is clean: Behavior good but refused to bathe)

Dec 4 Nurses Notes (Summary) Received on ward at 10 A.M. from B³ Taken out walking & attempted to run away: When caught refused to walk & had to be taken back to hall by nurse. Was troublesome on ward striking head on window & striking nurse: Put in restraint 2 hrs. Dec 5 Taken for walk begged nurse to let him lie on R.R. track so train might kill him. Appetite poor: Bowels regular. Dec. 10 Has been very troublesome since admission. Is violent & pugnacious by spells. that restraint has been necessary: Has delusions, thinks someone is trying to kill him, Also shows evidences of being suicidal & for that reason has slept on floor: Appetite has been very poor, has occasionally refused food altogether. Has had a slight rise of temperature up to today - now 98². Dec 13 Patient improving - Since 10th behavior has been good: Goes walking with crowd: Sits quietly in bay: Complains of slight pain in stomach today: Appetite good bowels regular. Rash nearly all gone from body - Says he was a hard drinker & that was cause of his sickness. Dec. 16 Quiet & well behaved. Goes out walking with crowd: Is allowed on hall: Assists a little with work & is willing to do whatever he is told. Answers questions fairly well. Appetite good: Bowels regular. Sleep averages 4 hrs.

Dec 31 Patient trans. to B³. Jan 1/97 Remains quiet & well behaved. Also talks & acts in a rational manner. Appetite good: bowels regular: Sleeps well. Works on ward. Wt. 157. Pulse 72. Jan 4. Trans. to A¹.

Feb. 1 No delusions noticed: Physical condition good. Talks rationally. Assists with work.

Mar 1 No change of any kind. Wt. 164. Pulse 96, Mar 10 Trans. to A³.

Apr 1 Went home - Has had furlough. Physical & mental condition good.

Discharged.

Personal and Medical History of

Personal and Medical History of George Coplan

EGBERT, FUCAR & CRAMBLETT, DAVENPORT, IOWA

Whole No. 4605

Residence, St. Paul, Minn.

Date Admission, December 11th 1896

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

How Sent, Co. Milled Jap P. St. Paul Minn

Sex, Male.

Age, 23

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Labour.

Degree Education, Poor.

Profession Religion, Unknown.

Habits, Not intemperate -

Nativity, Russia

Physicians Committing,

Correspondents, M. Caplan 25 Townsend St., Pittsburgh, Pa. Jno Caplan Brook Park, Minn

No. for Year, 138

Insane Relatives, Unknown

Cause Exciting, Unknown

Cause Predisposing, Unknown

Form, Melancholia acute

Accompanying Bodily Disorder, Chronic Gastritis

Suicidal or Not, yes - propensity active.

Date of this Attack, Not Known.

Duration, Not Known.

No. of Attack, Unknown

No. of Admissions, 1st here. at C & C. Hospital St Paul

Age First Attack, —

Time of Leaving, Aug. 2. 1897

Time in Hospital, 7 mos 22 da.

Result, Discharged Feb. 2. 1898. Recovered.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

By Dr. Phelps

MENTAL ACTIVITY:

Clear or Confused, Fairly clear mind.

Quick or Sluggish, Sluggish

MEMORY:

Past Events,

Recent Events, Seems fair.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, Incorrect.

REASONING POWER:

Ordinary Subjects, Poor

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient lies in bed in a quiet & melancholy way. Somewhat pale. Thinks has consumption & is going to die. Says all family are same way. Gave directions to send remains etc. Talks in a fairly clear manner. Is a Jew.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Says brother told him to jump

Special Subjects, through window.

Transitory or Not, Thinks he is going to die etc.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of George Coplan.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7 WEIGHT, 120 NUTRITION, Poor

WOUNDS OR ABNORMALITIES, Skin pale.

TONGUE, Tremors, Coatings, Promptness Movement, Fair - Rather inactive

PUPILS, Equality, Equal Size, Some dilated.

Response Light, Accommodation,

SIGHT, Good

HEARING,

COORDINATION, Arms, Fair but

Legs, Probably fair.

TREMORS, Hands, None of note. Tongue,

Facial Muscles, General,

REFLEXES, Patellar, ? EXAM. URINE,

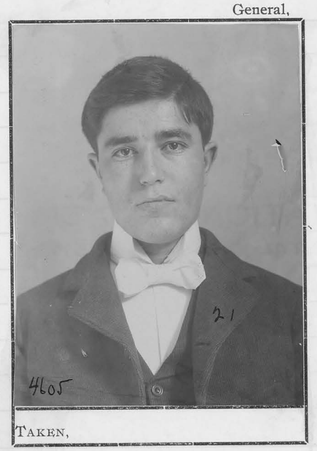
Other

ARTICULATION, Fair but talks

Slurred, low & weak.

Hesitating,

FACIAL EXPRESSION,



SENSIBILITY,

HEART,

LUNGS, Chest Symm. fair

Expansion - Slight action but seems fairly good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

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 "Sick just like I am"

Brothers or Sisters,

Personal and Medical History of George Caplan.

1896

This patient was brought here by Sheriffs Deputy P. C. Bass in a weak physical condition: with the following history:- Nothing known as to Consanguinity, heredity or as to previous attacks. Patient recently came from Fargo where he suffered from Gastritis & Melancholia: Was confined in P & C. hospital St Paul for 4 days. Disease appears stationary; not variable: no rational intervals: Has delusions of Prosecution & melancholia: Is not disposed to injure others; Is suicidal, broke window & tried to kill himself. No disposition to filthy or destructive habits: no peculiarities previously shown: Cause of disease unknown On personal examination the relatives addresses ascertained. (as per preceding page) On admission put upon infirmary (Gen'l H. Rpt. Complexion dark hair & eyes black: condition of skin poor. Old scar on left of spine: little finger two cuts on both knees & on right leg. Is clean: behavior good)

Dec 11 Nurses Notes (Summary) Patient received on ward at 7:30 P.M. Very weak & unable to walk alone. Given bath & put to bed. Skin missing from palmar surface of right hand little finger; Cut on ulnar side of right hand: Cut over both knees: Cut on upper part of right leg & two on lower third of right leg. Red spot as if from blister on pit of stomach All cuts sutured with silk worm gut. Numerous small cuts on limbs. Cuts were dressed on arrival but appeared to have been dressed 2 or more days: Were redressed at 8 P.M. Dec. 12 Lies quietly in bed with eyes closed. Talks only when spoken to & when he does speak it is hard to understand what he means. Takes but little nourishment during the day. Dec. 13 Stitches removed. Lies in bed in a partly unconscious state: Dec 15 Right cut on lower third of right leg has come open also cut on lower third of left leg: both discharge some. Redressed. Takes mostly liquid diet. Dec. 25 Appetite much improved: Habits fairly clean & behavior good. Bowels constipated, cathartics given: Sleeps well. Talks freely & quite rationally: Can notice no delusions: Cuts on limbs have been dressed daily since arrival & are improving. Patient still quite weak but appears to be improving. Dec 27 Limbs dressed with iodoform gauze daily: Thinks he is going to die. Dec 31 Is improving very much physically: walked around a good deal yesterday: Is very despondent. Jan 3 Bowels Constipated Physical condition seems rather poor: Says he will never get well: Habits clean: Jan 5. Limbs redressed daily: up on ward a little while yesterday but seemed quite weak. Appetite is poor Jan 10 Up in chair today: does not want to be up: Habits fairly clean: Appetite good: Jan 11 Wounds redressed: Lies in bed in a rather stupid condition Jan 15 Limbs redressed: Does not talk so much of dying: Jan 25 Up on ward this P.M. walks about some: appears some stronger: Jan 31 Up on ward this afternoon Walks about some & appears to be improving both mentally & physically.

Personal and Medical History of George Caplan.

1897

Feb 6 Out for a walk today: Physical condition seems to be improving:
15 Up & about ward daily since the fourth & seems to be gradually improving: Went out with other patients for a walk: At 6 P.M. Complained of severe pains in head & limbs & was put to bed. T. 102° P. 100 R. 21.
24 Kept in bed until 25th since then has been up on ward again: Bowels regular: Untidy in dress: Still thinks he is going to die at most any time Walks about ward slowly. Trans. to B³. March 1 Seems much more cheerful than formerly but is still quite despondent: Talks considerably on past events. Wt. 145½ Pulse 96. Apr. 1 Shows no despondency. Laughs & talks rationally: Appetite good: bowels regular: Wt. 156½ Pulse 72.
Apr 9 Visited by brother & friend Is again despondent: Would like to go to Pittsburgh Pa. to his brother Apr 10 Sullen & despondent: Would not get up, refused breakfast. Trans. to B³. May 1 Wt 157 P. 78. Has recovered from despondent spell & is cheerful & contented: & clean in habits Assists some with ward work. Appetite good: Bowels regular.
May 10 Trans. to C². June 30 Worked in kitchen four days last week but now refuses to go: Says he will run away. July 1 Wt. 155. Pulse 80. July 6 A false key made key was found on patient's person July 6 Visited by friend from Rochester
July 31 Patient is quite boyish in actions: Usually good-natured: Works on ward & goes out walking daily. Aug. 1 Visited by friend from town.
Aug 2 Went home at 7⁵⁵ A. M.

Discharged.

Personal and Medical History of Otto Jensen

EGBERT, PICLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 617

Residence, Freeborn, Freeborn Co, Minn.

Date Admission, Dec. 21st 1896.

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

How Sent, H. Blackmer, J. of P. Freeborn Co.

Sex, Male.

Age, 30.

Civil Condition, Married.

Children, 6

Age Youngest Child, —

Occupation, Laborer.

Degree Education, Do not know.

Profession Religion, Lutheran.

Habits, Not intemperate

Nativity, Norway.

Physicians Committing, Ab. Hodge & G.W. Barck.

Correspondents,

No. for Year, 150

Insane Relatives, Not Known.

Cause Exciting, Not known

Cause Predisposing, Not known.

Form, imbecile

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Yes. Propensity apparently active

Date of this Attack, About 3 weeks ago.

Duration, About 3 weeks.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 30.

Time of Leaving, May 2d 1901.

Time in Hospital, 4 years 4 mo 11 ds

Result, Died — Paresis.

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog. Dec 22/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Fairly quick

MEMORY:

Past Events, Fairly good

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dull.

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Poor.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Alternately exalted & depressed.

Depressed,

DELUSIONS:

Systematized or Not, None noted.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, slightly

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: At present exhibits a mild dementia - emotional - cries easily - general tone exalted. Shows no definite delusions but is silly & demented. Voice & general demeanor are very much like in general paresis but incoordination is hardly well enough marked. Says his wife was nagging at him & this is why he threatened violence. Previous mental grade probably not high.

Personal and Medical History of Otto Jensen.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fairly good.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Clear. Promptness Movement, Somewhat slow.

PUPILS, Equality, Yes. Size, Normal.

Response Light, Somewhat sluggish Accommodation, Good.

SIGHT, Good.

HEARING, "

COORDINATION, Arms, Fairly good.

Legs, Slight impairment.

TREMORS, Hands, Slight Tongue, Coarse & fine

Facial Muscles, Some about lips General, None.

REFLEXES, Patellar, 9 Equal.

Other Very slight ankle clonus.

ARTICULATION,

Slurred, yes

Hesitating, yes.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, 1st sound quite rough.

Sounds somewhat weak - Somewhat irregular

Apex beat forcible

LUNGS,

Resp. good -

Arteries good - Circulation somewhat poor, fingers blue & cold.

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Ex. Jan. 12/97 3 P.M.

Passed Jan. 12/97 2 P.M.

Color Yellow.

Sp. gr. 1026

Quan. 24 hrs. XXXIV Oz.

Character Clear.

Reaction Acid.

Albumen None.

Sugar None.

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, No claims Constipated, Irregular,

APPETITE, Good, ✓ " Medium, Poor,

SLEEP, Good, ✓ " Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Slight smoker No drinker

LENGTH OF INVASION, Probably long ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") No heredity obtainable

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Otto Jenson.

1896

This patient was brought here by sheriffs Deputy M.C. Mitchell attended by J.P. Bond in fair physical condition, with the following history: Nothing known as to consanguinity or heredity: First symptoms manifested about 3 weeks ago: disease appears stationary, usually with rational intervals: Derangement manifested by violent & quarrelsome behavior: has threatned to take his own & others lives: Is filthy & destructive: Only previous peculiarity a violent & quarrelsome disposition: No history of intemperance in self or parents: Nothing known as to severe disease or head injury: Has not been confined or restrained: has received no treatment. On personal examination appears stupid & slovenly. Commitment recommended because patient is dangerous to himself & others.

On admission put upon B.t.e. Cloth Rpt. Complexion light: hair light: eyes blue: Condition of skin good: Scars on both hands: Is clean: Behavior good.

Dec 2 Nurses Notes (Summary) Patient received upon ward: Given bath: Put to bed on floor: Slept 4 hrs. Trans. to B[3] on 2[nd] Behavior good talks fairly rationally: Habits clean. Dec. 25 Can notice no delusions: Is quiet & well behaved: Works on ward. Seems anxious to go home:

Jan 16/97 Behavior quiet & good until this Am. when patient became noisy & ugly over some trivial matter & when asked to be quiet swore at Nurses. afterward cried - Jan 3 Temperature has been normal since admission: Appetite good: bowels regular: Slept well Seems very considerate toward his family worries over their support during his stay here - usually cries when speaking of them - No delusions noticed. Has occasional ugly spells: at other times is quiet & good natured.

2/10

Apr 30/97 Summary Nurses Notes by Dr Phelps Feb 1/97 Patient seems to be about the same as on admission: Works on ward: Is neat & clean, wt. 174 lbs. Physical Health good Mch 1 Is a little irritable at times but usually good-natured: Wt. 174 lbs. Apr 1 Rather simple-minded, childish in talk & behavior: Quite tremulous & somewhat paretic in muscular state: Wt. 175 lbs. May 1/97 Wt. 173[#]

June 4 Patient talks in a rather paretic way: Has always appeared simple minded & slightly paretic - Tongue is thick; Is unsteady; General appearance that of an imbecile. Dec 6/99 Patient has gradually grown more & more demented & shown more paretic symptoms.

Feb 1 - July 31/99 (Dr. Wanous) Works in center dining room. Mch 7 Cut first & second finger on knife, while at work in dining room. Mch 17 Physical condition is failing. Face swollen on right side. Mch 21 Fell several times while out walking - had to be helped back. Trans. to Infirmary. Mch 28 Up on ward. Seems a little stupid & is unsteady in walk. Trans. to A: Again wants to go to work in dining room. Apr 30. Has some trouble keeping up with crowd while out walking: Becomes very unsteady: Speech is incoherent. May 17 Struck over eye by another patient: no injury resulted.

Personal and Medical History of Otto Jensen

1899

July 18 Gradually growing weaker: on treatment. July 21 Took sick while out walking Returned to Infirmary & put to bed: unsteady & incoherent in speech. July 26 Emesis July 31 Allowed up on ward today. Aug 1 Wt 144[lbs] Patient is up on ward, seems quite unsteady,

Aug 1/11 sluggish; speech thick & incoherent. Aug 11. Transferred to A[1]. Sept 15. Unable to walk out with other patients.

Oct 4. 1900 Oct 4 Transferred to Infirmary. Jan 17/1900 Given clothes & got up on ward - fell on heater, lacerating scalp back of head. Feb 17. Transferred to A[th]. Patient frequently takes off clothing & goes to bed during the day.

Jan 17 Is very filthy & apparently very much confused - March 20. Had to be kept in straight-suit, to keep

Feb 17 Clothing on. May 23. Patient seems somewhat improved. July 30. Patient vaccinated successfully

Mar 20 July 30 Was struck on nose by patient Olsen: is very untidy. Nov 1. Wt 175[lbs]. memory very poor: will not keep

Aug 31 clothes on. Jany 31/1901. Can see no change in patient's condition: is very filthy in habits. Mental

1901 Jan 31 condition shows no change. Feby 1. Wt 176[lbs]. P 88. Mar 31. Restless & noisy. Constantly

Feby 1 removes clothing. Apl 10. Very stupid; unstable. Transferred to TW & put to bed.

Mar 31 Shows gradual failure. Apl 30. Has steadily failed.

Apl 10/30 May 2 Died (of paresis)

Died

Personal and Medical History of John J. Gunnipson.

BARLEY, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4619
Residence, Olmstead Co. Minn.
Date Admission, December 22nd 1896.
Admitted by Dr. R. M. Phelps Hour, 2½ P.M.
How Sent, T. Fraser Jr. opP. Olmsted Co.
Sex, Male
Age, - 76 -
Civil Condition, Married.
Children, 2.
Age Youngest Child, —
Occupation, Farmer.
Degree Education, Common school.
Profession Religion, Lutheran
Habits, Not intemperate.
Nativity, Minn. (Parents Norway)
Physicians Committing, C. T. Granger. Christopher Graham
Correspondents,

No. for Year, 151
Insane Relatives, None.
Cause Exciting, Not Known
Cause Predisposing, Not Known
Form, melancholia acute
Accompanying Bodily Disorder, None stated.
Suicidal or Not, Not.
Date of this Attack, Nov. 1st 96.
Duration, Since Nov. 1 '96.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 76
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam by Dr. Herzog 12/23/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Impaired.
Recent Events, "
Special Subjects, Last few months poor.
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, In main correct
REASONING POWER:
Ordinary Subjects, Fairly accurate. but very slow
Own Mental State,
Special Subjects,

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

GENERAL DESCRIPTIVE REMARKS: Seems to present a simple melancholia. Physical health somewhat impaired. Bowels sluggish, circulation weak, digestion & appetite impaired. Has very bad dreams at night, frontal headache, sleep broken, notices loss of memory & believes there is something wrong with his mind. Previous mental grade probably four. Patient tends toward giantism very tall with large hands & feet.

Personal and Medical History of John J. Gunnipson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft 1 in WEIGHT, 195 NUTRITION, Somewhat impaired
WOUNDS OR ABNORMALITIES, 1st finger right hand deformed, accident.
TONGUE, ~~Tremors~~, large, toothmarked Coatings, Clear Promptness Movement, Slow, tends fowl.
PUPILS, Equality, Yes - of slightly irregular shape. Size, Contracted sclerotics dull.
Response Light, Yes Accommodation, Yes.
SIGHT, Good
HEARING, "
COORDINATION, Arms, Slightly impaired
Legs, "
TREMORS, Hands, Slight Tongue, None.
Facial Muscles, No General, No.
REFLEXES, Patellar, ♀ Equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating, Slow.
FACIAL EXPRESSION,
Hangs head. Eyes downcast.
SENSIBILITY,
HEART, Pulmonic sounds forcible. Strength. Sounds somewhat mak. irregular & rapid.
LUNGS, Seem good
TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Had severe attack rheumatism last winter - has not quite recovered. - Headaches & vertigo
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, No hereditary
Father or Pat. Relations, Dr. Favorable
Brothers or Sisters, Children - one child has convulsions

Personal and Medical History of John J. Gunnufson.

1896

This patient was brought here by Sheriff Charles N. Stewart. ——— in fair physical condition with the following history:- Nothing known of any consanguinity or heredity; First symptoms manifested about three weeks ago; disease appears increasing, not variable with no rational intervals: Derangement manifested by various delusions: he thinks everyone is trying to steal his wife - wanders from home & filthy & destructive; Previous peculiarities not shown; Is not disposed to injure others: is not suicidal: No severe disease or head injury: Has received no treatment: No confinement or restraint employed. — — —

On personal examination appears stupid Insists that neighbors are trying to steal his wife. On admission put upon B3 W. (9th U.P.) Pat hair brown: eyes blue; Condition of skin good; 1st finger on right hand disfigured Scar on right wrist & on right ankle. Is clean, behavior good.)

Dec. 27 Nurses Notes (Summary) Patient received on ward at 2 P.M. Talked very little & seemed stupid & melancholy: bath given:

Dec 28 Patient quite restless at night, often dressing himself & pacing the room. Had to be put to bed by force. Dec 29 Obtained specimen of urine 46 oz. 24 hrs. reddish in color. Jan 2 '97 Does not walk out with crowd being too stupid to keep up with the rest: Jan. 4 Visited by father & mother: Temp. has ranged from 99° to 100° since admission & patient has grown more despondent Talked a little when admitted but for past week has talked none: Has to be urged to eat, bathe, go to bed & to take medicine. Refused all nourishment today (Jan 4)

Jan 5 to Apr 30 '97 Summary Notes by Dr Phelps Jan 7 '97 Trans. to Infirmary: Rather dull & stupid: Jan 12 Patient needs to be fed: Is rather dull & listless: Has been receiving hot baths & massage: Jan 26 Noted that he ate without urging today: Temp. usually about normal. No special bodily disease. Feb 18 Visited several times by relatives: Kept in bed greater part of time: Receives massage & baths: Has been a little brighter of late: Feb 24 Visited by relatives Has improved somewhat: Mch 1 Wt. 174 lbs. Mch 31 Appetite poor. Has to be urged to eat. Is rather stupid. Apr 10 '97 Visited by father today Who took him home: Still rather dull & listless.. May 1 '97 Wt. 185# May 6 '97 Visited by Mother. May 16 - 20 Visited by relatives June 20 by father July 16 Taken home on trial: Has been rather quiet. Has not talked much of delusions of late but mental state is still rather that of depression & uncertainty

Jan 27 '98 Returned. Received on ward at 2 P.M. 26 Visited by mother: Is quiet & well-behaved: Seems to have changed very little: Is very despondent,

Feb 28 Attempted to escape. June 20 Visited by relatives July 7 & 10 do.

July 24 Visited by wife & mother. Occasionally attempts to escape. Oct 3 & Dec. 4, 12 & 30 Visited by relatives. Jan 31 '99 No change: Frequently tries to elope: When out with crowds: is dull & despondent Feb. July 31 '99. (Dr Manous) Wt. 193# Is irrational

Personal and Medical History of John J. Gunnufson

1899

May 16 Rather slouchy in dress: Does no work. May 26 Visited by sister. Is stubborn & surly. Incoherent in speech. June 16 Attempted to get out of door & fought nurse for preventing his exit. June 16 Had trouble with patient while out walking: Received slight bruise over cheek. June 18 & 29 Visited by relatives. Aug 1/99. Wt 189 lbs. Physical condition good.

Aug 1/31 Aug 31 Patient sits around in hall; seldom speaks; does not want to go home; does no work; physical condition continues good. Is rather depressed & inclined to be stubborn. Nov 30. Visited by relatives.

Nov 30 1900 Feb 16 Feb 18. Visited by sister - March. Patient demented, indolent and speech incoherent. June 4 - Visited by relatives - May 30. Want to go out; refuses to go home - June 11. Visited by father. July 20

May 31st Was vaccinated, unsuccessfully. July 31. Mental & physical condition continue about the same.

July 31st Aug 31 Is dull, confused: Seldom speaks: very slouchy in dress: Oct 30. No change, in any way; is still very dull. Nov 27. Visited by friends. Dec 11. Visited by relatives. Jany 4/1901. Wt 192# 8 oz.

Nov 27 1901 Jan 31 Is anxious to go home, but does not desire to return to wife. July 3. Wt 189# 8 oz.

July 31. Quiet; does not associate with other patients. March. Visited by relatives - June 20. Was visited by friends. July 31. No change in patients condition to report - Is quiet: keeps by himself a good deal. Habits cleanly. Health seems good. Receives visits from relatives

Aug 1 1902 Jan 31 Wt 191# Jany 31/02. Health good, during period. Answers many questions rationally, but is, at times, laughing & himself: silly, indifferent & slovenly. (Visited Sept 15 by mother & sister: Dec 3. by sister - Jany 8th. by his wife)

Jan 24 03 Visited by his sister; has been visited frequently during year - Is dull; indifferent; Inactive; Requests nothing; Sullen & stubborn

Personal and Medical History of Nels Foley

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4621

Residence, Manchester, Minn.

Date Admission, Dec. 23rd 1896.

Admitted by H.H. Herzog M.D. Hour, 7:30 P.M.

How Sent, Human Blackmer. Jopp. Freeborn Co.

Sex, Male.

Age, 40.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Farmer.

Degree Education, Moderate.

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Norway. (Parents Norway.)

Physicians Committing, H.H. Wilcox & G.W. Bauck.

Correspondents, J.H. Foley, Manchester, Minn.

No. for Year, 154

Insane Relatives, None.

Cause Exciting, Not Known.

Cause Predisposing, Not Known.

Form, Dementia terminal

Accompanying Bodily Disorder,

Suicidal or Not, None attempted propensity active.

Date of this Attack, ~~As~~ 12 yrs ago

Duration, 12 yrs.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 28

Time of Leaving, 11th December 1901

Time in Hospital, 4 yrs 11 mos 18 Ds

Result, Transferred to Hastings asylum

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: Patient very dull + stupid - History reaches back indefinitely Looks at floor or in a dull sort of a way at Things going on. Health fair. Does not look exactly like an imbecile but more like a chronic or terminal

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 Nels Foley.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. 5 WEIGHT, 145 NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, none Coatings, Promptness Movement, Prompt.

PUPILS, Equality, Equal Size,

Response Light, Accommodation,

SIGHT, ?

HEARING, ?

COORDINATION, Arms, Normal.

Legs,

TREMORS, Hands, None Tongue, do

Facial Muscles, do General, do

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Will not talk

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal

LUNGS, Normal.

TAKEN,

EXAM. URINE, Ex- Jan 12 '97 3 P.M.

Passed Jan. 12 '97 2 P.M.

Character - Clear.

Quan. 24 hrs. XXXII Z.

Color Yellow.

Reaction Acid

Sp. Gr. 1032.

Albumen None

Sugar None.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Nels. Foley.

1895

This patient was brought here by Sheriffs deputy N.C. Mitchell attended by A Graemer. with the following history. Patient is in fair physical condition. Nothing known as to consanguinity. Exact symptoms of attack manifested 10 to 12 yrs. ago but was not right at that time. has continued off & on since. Manifested by being ugly; wilful; melancholy etc; Disease seems increasing: variable with irregular rational intervals. Derangement manifested on no particular subject. but refuses to work with family from an old house to a new one, objects unreasonably to various affairs about the farm & work. Patient is disposed to injure others. Is somewhat filthy in habits & it is thought that he is a masturbator. No peculiarities previously known. No intemperance in self or parents. Was operated upon for hydrocele. Patient has not been confined or restrained. Has received no treatment. No further particulars learned on personal examination. On admission put upon B3 (Gt. A Rpt. Complexion dark: hair dark brown. eyes blue: skin good condition: Is dirty: behavior good)

Dec 23. Nurses Notes (Summary) Received on ward 7:45 P.M. Given bath & put to bed. very quiet & stupid: Dec. 29 Patient remains quite stupid & melancholy Bowels regular: Habits fairly good: Has had a slight rise of temperature until to day: Appetite poor: Jan 5 No improvement noticable in patient since admission: Is very stupid & sits quietly on bench all day, only moving to get a drink or go to his meals: Is very slouchy in dress: Talks very little & [illegible] only in response to questions: Appetite usually fair: bowels regular: Sleeps well. Walks out with crowd & seems quite strong. Specimen of urine obtained dark & cloudy in appearance. Summary Nurses Notes by Dr. Phelps Jan. 6'97 Patient quiet & stupid usually sits in one place all day long; Talks none; does no work.

To Apr 30/97 Feb 1 Talks none: No change: Receives massage Wt. 139 lbs. Feb. 20 Wt. 142½ Apr. 1 No special improvement - Wt. 149 lbs. May 1'97 Wt. 151 lbs July 1 Patient appears quite despondent, dull & demented. Is disinclined to talk with anyone & a little uncertain in behavior. Jan 31'99 Intervening notes show no special change. Patient now at annex. Feb 1 - July 31'99 (Dr. Manross) Wt. 147 lbs. Mch 15. Eruption over body & arms. Apr. 22 Visited by sister: July 31 Appetite good: General health good. Speech rambling. Aug - Jan 31 1900 (Dr. Chapple) Wt. 139. 1900 - To - Nov. 1. Wt. 153 lbs Is became somewhat more demented. Habits untidy. Is very active. Physical condition fairly good. Does not speak unless addressed. Feby 1 1900. Wt 139 lbs. P 70. Mar 15. Ten days temperature, has been about normal. — July 31. July 20. Vaccinated: result good. July 31. No change to note: is very demented: does not talk: habits untidy. Has hydrocele. Appetite Sleep & behavior good. Has worked some on farm during the summer. Wt 141½ lbs. Aug 1 1900. Nov 10. Transferred to D1. Sep 13. To D2. Jan 31 1901. No change. Physical condition quite good, except for double hernia. Does no work: Habits untidy: avoids Conversation: Appears very demented: never causes any trouble Feby 1 Wt 141 lbs. March 1 To TW. Mar 25 Operated on by Dr Manross for Hydrocele: operation successful. Apl 8. Up, improved. Apl 20. Was

Personal and Medical History of Nels Foley

1901 Apl 20 Dec 11. Transferred to D2. May 1. Wt 143 lbs - Aug 1. 150½ lbs: Nov 1. Wt 148 lbs. Nov 4. Visited by friends - No change in mental condition: health good. Transferred to Hastings State Asylum

Personal and Medical History of Andrew Swanson

1896

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4622	No. for Year, 155.
Residence, — —	Insane Relatives,
Date Admission, December 28, 1896.	Cause Exciting,
Admitted by H. H. Strong M.D. Hour, 7th P.M. By order District Court.	Cause Predisposing,
How Sent, W. G. Williston Judge, of Wash. Co.	Form, insanity
Sex, Male.	Accompanying Bodily Disorder,
Age,	Suicidal or Not,
Civil Condition,	Date of this Attack,
Children,	Duration,
Age Youngest Child,	No. of Attack,
Occupation, Marble cutter.	No. of Admissions, 1st
Degree Education,	Age First Attack,
Profession Religion,	Time of Leaving, Feb. 24. 1897
Habits,	Time in Hospital, 2 mos. 1 da.
Nativity,	Result, Discharged Aug. 11th. 1897 Improved.
Physicians Committing,	
Correspondents,	

EXAMINATION ON ADMISSION.

Examined 12/96 by Dr. H. H. Strong. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Fairly good.

Recent Events, Of very recent events, good.

Special Subjects, Does not remember about the shooting

PERCEPTIVITY:

Alert or Dull, Somewhat dull.

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Fair.

Own Mental State, Claims to be all right.

Special Subjects, Not as to the time of shooting.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not, None now

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent, on some subjects

GENERAL DESCRIPTIVE REMARKS:

Fair physical condition - has scar in centre of forehead. right leg short + somewhat stiff - caused by cutting knee with hatchet in youth. Talks fairly well about past events + about very recent events. Went to Sweden 3½ yrs. ago. staid 3 mo. While there married his wife. Left her there + returned to this country. Sent for her last fall (96) She stays with him 3½ days, then left him later going to Fargo for a divorce. He alleges infidelity. When subject of the shooting is discussed he hangs his head + says "I don't know what I do." It is impossible to get him to discuss the subject or to get an expression of regret from him. He will only repeat this formula.

Personal and Medical History of Andrew Swanson.

COMMITTED TO THE ASYLUM.

Judge Williston Orders the Confinement of Andrew Swanson at Rochester.

Judge Williston has made an order directing Sheriff Smith to convey Andrew Swanson to the insane asylum at Rochester. The law provides that when a person, accused of a crime, shall be acquitted by the jury by reason of his insanity, the judge may commit him to the insane asylum, the state prison or may give him into the custody of his friends providing they give bonds that he shall not commit further depredations upon society.

Sheriff Smith according lett this afternoon with his prisoner for Rochest- but we understand that Attorney Nethaway will immediately make application for the release of his client, through a writ of habeas corpus. The jury, in its verdict, acquitted Swanson on the ground that he was insane at the time, but Nethaway claims that there is nothing to show that the man is insane at present.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

4. WEIGHT, 150. NUTRITION, Fairly good.

MALITIES, 2nd finger left hand missing - scar recent - powder marks.

Coatings, whitish coat Promptness Movement, Prompt.

qual. Size, Normal.

t, Normal Accommodation, Normal.

s, Good

" "

Slight. Tongue, Slight

les, " General,

REFLEXES, Patellar, 9-10 Equal - EXAM. URINE,

Other Slight ankle clonus.

ARTICULATION,

Slurred,

Hesitating, Yes.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries pulse full.

HEART, No murmurs. regular

Strength sounds good. rapid

LUNGS,

Good

Skin, condition of. Some acne rosacea

OPHTHALMOSCOPIC EXAM., TAKEN,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Had severe illness 15 yrs ago. Nature unknown - Very Moderate drinker - No smoker.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Heredity unknown by patient.

Mother or Mat. Relations, Died - unknown

Father or Pat. Relations, Died inflammation of lungs.

Brothers or Sisters,

1896 Personal and Medical History of Andrew Svanwood.

EGGERT, FIGLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4622

Residence, — —

Date Admission, December 23 1896.

Admitted by H. H. Herzog M.D. Hour, 7th P.M.

How Sent, By order District Court, W. G. Mullinton Judge, of Wash. Co.

Sex, Male.

Age,

Civil Condition,

Children,

Age Youngest Child,

Occupation, Marble cutter.

Degree Education,

Profession Religion,

Habits,

Nativity,

Physicians Committing,

Correspondents,

No. for Year,

Insane Relatives,

Cause Exciting,

Cause Predisposing,

Form,

Accompanying Bodily Disorder,

Suicidal or Not,

Date of this Attack,

Duration,

No. of Attack,

No. of Admissions, 1st

Age First Attack,

Time of Leaving, Feb. 24. 1897

Time in Hospital, 2 mos. 1 da.

Result, Discharged Aug. 11th. 1897 Improved.

EXAMINATION ON ADMISSION.

Examined 12/24/96 by Dr. H. Herzog. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Fairly good.

Recent Events, Of my recent events, good.

Special Subjects, Does not remember about the shooting

PERCEPTIVITY:

Alert or Dull, Somewhat dull.

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Fair.

Own Mental State, Claims to be all right.

Special Subjects, Not as to the time of shooting.

GENERAL DESCRIPTIVE REMARKS:

Fair physical condition - has rear in center of forehead. right leg short & somewhat stiff - caused by cutting knee with hatchet in youth. Talks fairly well about past events & about my recent events. Went to Sweden 3½ yrs. ago. staid 3 mo. While there married his wife. Left her there & returned to this country. Went for her last fall (96) She stays with him 3½ days, then left him later going to Fargo for a divorce. He alleges infidelity. When subject of the shooting is discussed he hangs his head & says "I don't know what I do." It is impossible to get him to discuss the subject or to get an expression of regret from him. He will only repeat his formula.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not, None noted

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent, on some subjects

PAN
pale.
s sale. To procure
ristmas gifts is no
ow you will agree
small amount of
f you are in doubt
we are prepared
Hints.
RESS GOODS!

ersonal and Medical History of Andrew Svanwood.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4. WEIGHT, 150. NUTRITION, Fairly good.

WOUNDS OR ABNORMALITIES, 2nd finger left hand missing - scar recent - powder marks.

TONGUE, Tremors, Coatings, whitish coat Promptness Movement, Prompt.

PUPILS, Equality, Equal. Size, Normal.

Response Light, Normal Accommodation, Normal.

SIGHT, Good.

HEARING,

COORDINATION, Arms, Good

Legs, "

TREMORS, Hands, Slight. Tongue, Slight

Facial Muscles, " General,

REFLEXES, Patellar, 9-10 Equal - EXAM. URINE,

Other slight ankle clonus.

ARTICULATION,

Slurred,

Hesitating, Yes.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries pulse full.

HEART, No murmurs. regular

Strength sounds good - rapid

LUNGS,

Good

Skin, condition of. Some acne present

OPHTHALMOSCOPIC EXAM.,

TAKEN,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Had acute illness 15 yrs ago. Nature unknown - Yes Moderate drinker - No excess.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Heredity unknown by patient.

Mother or Mat. Relations, Died - unknown

Father or Pat. Relations, Died inflammation of lungs.

Brothers or Sisters,

Personal and Medical History of Andrew Swanson

1896

This patient was brought here by sheriff Gw. Smith attended by A. Gu. Peterson with the following history:- Patient was committed by order of District Court of Washington County, Judge Williston, Judge. Orde accompanying paper Order of Court. which states that on Aug. 1896 the patient shot at & wounded a woman in Stillwater - with intent to kill her: That on December 18 1896 he was arranged & entered a plea of not guilty, at which time jury decided him to be insane. That said patient was dangerous to the peace & safety of the community & for that reason was committed to this institution. No further information given concerning patient.

On admission put upon B 3 (Gth Rpt. Complexion dark: hair brown: eyes gray: skin good: 2nd finger of left hand off. Is clean: behavior good.)

Dec 23 Nurses Notes (Summary) Patient came on ward at 8 PM. Quiet & well-behaved: talked rationally: Seems to be in good health but is rather weak from want of exercise. Dec. 29 No change in patient: Is quiet & good-natured & seems contented: Can notice no delusions: Appetite remains good: Bowels regular: Works on ward:

Dec 30 Behavior good: Is very weak: While out walking lost his wind & forced to walk very slowly: Jan. 5 Has continued quiet & well behaved since admission: Still works on ward: Have noticed no delusions or peculiar behavior. Appetite good: Bowels regular: Sleeps well.

Jan 6 Patient quiet & well behaved: Works on ward: Talks rationally & writes a great deal: Appetite good: Bowels regular: Sleeps well.

Feb 1 No delusions noted as yet. Is quiet & good-natured- Neat & clean in habits & dress. Assists very willingly with work. Wt. 162 P. 96.

Feb 14 Note by Dr. Herzog. Sent home today as his employer had work for him & as in the opinion of the judge committing him he was not insane but judge felt that he should be committed because he was acquitted on grounds of insanity. He appears somewhat feeble-minded with a considerable constant tremor somewhat intention in type. Exhibits no marked delusions

Discharged.

Personal and Medical History of

Personal and Medical History of Simon Sumberg.

EBERT, PICKAR & CRANDERS, DAVENPORT, IOWA.

Whole No. 4624

Residence, St. Paul, Minn.

Date Admission, December 7th 96.

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

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

Sex, Male.

Age, - 34 -

Civil Condition, - Married -

Children, - Three.

Age Youngest Child, —

Occupation, Pedlar

Degree Education, Can read & write.

Profession Religion, Not a church member.

Habits, Not intemperate -

Nativity, - Germany -

Physicians Committing, J. Chase - Archur Sweeney.

Correspondents, M. L. Finkelstein - 116 E. 7th St. St Paul, Minn (Brother-in-law)

No. for Year, 157

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form, mania acuta

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, One week ago.

Duration, a week.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 34

Time of Leaving, Sept. 29. 1897

Time in Hospital, 9 mo. 1 da.

Result, Discharged Dec. 9. 1898 Much Improved

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by H.S. Herzog 12/9/96.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Impaired -

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Poor.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Physical health impaired but no definite disease seems present. probably from lack of sleep & nourishment. Has hallucinations of hearing - Hears voice of the Lord. Heard people cutting up his father. Delusions of persecution, believes he is being

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Unsystematized -

Special Subjects, of poisoning & of grandeur.

Transitory or Not,

HALLUCINATIONS: of hearing.

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, ✓

Voluble ✓ or Reticent,

poisoned.

Delusions of grandeur, believes that he is the Savior. Nearest type is sub-acute mania.

Every spoonful of Price's Special Flavors Powder will do perfect work.

SAFE, INDEED.

Sumberg's Signs Land Him in an Insane Asylum.

Simon Sumberg was committed to the insane asylum at Rochester by Judge Willrich, of the probate court, yesterday. Sumberg is thirty-four years of age and has a wife and three children and was born in Germany. He said that all the world was against him and people were trying to kill him. He wore a sign hung around his neck on which was printed "Sumberg of Jerusalem." He told the judge that an angel appeared to him and told him he was all right. He said he fooled the angel into thinking he was from Jerusalem, when in fact he came from Germany.

He also wore a flag bearing the words, "McKinley and Protection," which he said protected him from all danger. As long as he wore that flag no one could harm him. His enemies had tried to shoot him and poison him, but his two signs saved him from all harm.

Personal and Medical History of Simon Sumberg.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 130½ lbs. NUTRITION, Impaired.

TIES, — Skin pigmented yellow.

Coatings, heavy whitish - dry Promptness Movement, prompt.

lightly larger Size, dilated.

Excession Accommodation, Excession

HEARING, Good.

COORDINATION, Arms, fairly good.

Legs, "

TREMORS, Hands, Slight Tongue, No.

Facial Muscles, No. General, No.

REFLEXES, Patellar, 8-9 equal EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No. murmurs. Slightly irregular.

LUNGS, Expansion good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Nothing Ascertainable 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 Simon Sunberg

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4624

Residence, St. Paul, Minn.

Date Admission, December 28 '96.

Admitted by R.M. Phelps M.D. Hour,

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

Sex, Male.

Age, - 34 -

Civil Condition, - Married -

Children, - Three.

Age Youngest Child, —

Occupation, Pedlar

Degree Education, Can read & write.

Profession Religion, Not a church member.

Habits, Not intemperate -

Nativity, - Germany -

Physicians Committing, J. Ohage - Archie Sweney -

Correspondents, M. L. Finkleston - 116 E. 7th St, St Paul, Minn. (Brother-in-law)

No. for Year, 157

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, Unknown

Form, mania acu

Accompanying Bodily Disorder, None recent

Suicidal or Not, Not.

Date of this Attack, One week ago.

Duration, a week.

No. of Attack, 1st

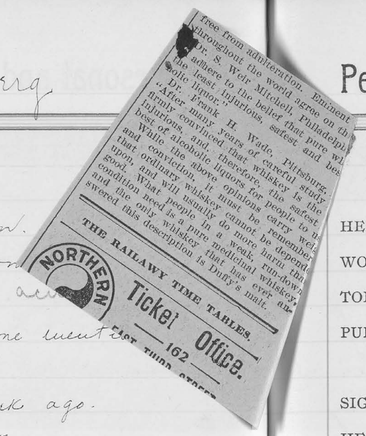
No. of Admissions, 1st

Age First Attack, 34.

Time of Leaving, Sept. 29. 1897

Time in Hospital, 9 mo. 1 da.

Result, Discharged Feb. 9. 1898 Much Improved



EXAMINATION ON ADMISSION.

Exam. by H. Herzog 1/29/98.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Impaired -

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Poor.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Physical health impaired but no definite disease seems present - probably from lack of sleep & nourishment. Has hallucinations of hearing - Hears voice of the Lord - Heard people cutting up his father - Delusions of persecution, believes he is being poisoned - Delusions of grandeur, believes that he is the Savior. Nearest type is sub-acute mania.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Unsystematized -

Special Subjects, of poisoning & of grandeur.

Transitory or Not,

HALLUCINATIONS: of hearing.

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, ✓

Voluble ✓ or Reticent,

Personal and Medical History of Simon Sunberg.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 6 in. WEIGHT, 130½ lbs. NUTRITION, Impaired.

WOUNDS OR ABNORMALITIES, — Skin pigmented yellow.

TONGUE, Tremors, Coatings, heavy whitish - dry Promptness Movement, prompt.

PUPILS, Equality, left slightly larger Size, dilated.

Response Light, excessive Accommodation, excessive

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms, fairly good.

Legs, "

TREMORS, Hands, Slight Tongue, No.

Facial Muscles, No. General, No.

REFLEXES, Patellar, 8-9 Equal EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No. murmurs. Slightly irregular.

LUNGS, Expansion Good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Nothing Ascertainable 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 Simon Sunberg.

1896

This patient was brought here by Sheriffs deputy Pl. Haas in fair physical condition with the following history:- No history of consanguinity - First symptoms of (1st) attack manifested about a week ago when patient suddenly became maniacal: disease appears stationary: not variable: with no rational intervals: believes that people are poisoning & shooting at him: Is not disposed to injure others: is not suicidal filthy or destructive: no peculiarities previously shown: No history of intemperance in self or parents: no severe disease or head injury. Patient has not been confined or restrained: no treatment given beyond hypnotics. On personal examination is very excited, talks irrationally & refuses at times to eat or drinks. ——— ———

Dec 28 On admission put on B 3 C (Cotton Apt. Complexion dark: hair & eyes black: Scar on right side of face: small pimples on back: has body lice: Behavior good.) Nurses Notes (Summary) Came on ward at 7:20 PM. Had body lice, was given bath & put to bed. Dec. 29 Restless most of last night: Slept 3 hrs. Takes no nourishment during day: Bowels constipated: Has delusions; thinks that people are trying to poison him & will not eat. Slept none during night Dec. 30 Very restless & talkative all day: Takes no nourishment: Transferred to Infirmary at 5 PM. After much persuasion on part of Physician & nurses consented to take bath. Temp. 100° time 10 min. Put to bed. Very restless: Talks incoherently & irrationally: Physical condition good: Fair supper: Says he feels good: Restless most of night: bowels constipated. Dec 31 Patient Taken out for walk today: Behavior good. Jan 1st Since Jan 1st has been very restless most of time & at times very noisy & pugnacious & has had to be held in bed at times: Bowels constipated & has taken cathartics: Has many delusions, thinks that he is God & nothing can hurt him. Has been given baths at 100° which appear to quiet him some. Memory is good. Appetite good. Behavior noisy: at times has refused medicine: Seems to realize where he is & wants to go home: Habits fairly clean.

Feb 1 Restless & maniacal: Talks loudly & irrationally: Appetite voracious: Given milk between meals: Feb 3 Noisy at times during night Restless & troublesome: Upon ward & out for walk this afternoon. Feb 20 Noisy & pugnacious: Attacked Nurse Robinson. Feb 24 Physical conditions good: Has delusions of various kinds: Behavior changeable: Is stupid, stubborn, restless noisy & pugnacious. Feb 27 No change for the better noticeable. Trans. to C. March 3 Behavior fair tho he pretends not to understand what is said to him. Shows no signs of violence & maintains an independent air: Talks to himself in an undertone a great deal. March 11 Says someone appeared to him during night & told him not to eat - So he refused breakfast. March 14 Noisy on hall & troublesome while out walking. Apr 1 Wt. 186 Pulse 96 Apr. 6 Engaged in fight with

Personal and Medical History of Simon Sunberg.

1897

J. Munger - was quite violent. Apr 9 Would not walk with crowd; this PM. & had to be carried in. Apr 22 Refused to put on shoes & when requested to do so by physician grew pugnacious & had to be held - Apr 30 Seems to be improving in behavior: Sometimes gets noisy & talks & sings loudly. May 3 Wt. 155 Pulse 84. May 5 Has been improving until this afternoon when he had a long crying spell. May 6 Refused supper. May 7 Refused food of any kind also medicine: has been noisy singing & crying; 8 Still refuses meals & medicine - very noisy running up & down hall. Taken to bay. May 9 Taken to Infirmary to be fed but decided to eat without. May 11 Has improved some: goes to d.r. & will eat. June 1 Is more quiet & has improved in behavior in last few weeks: Is very stubborn at times Trans. to B 3. June 13-14 Has been stubborn & troublesome during last two days. Trans. to C. June 30 Refused all meals today. July 1 Ate good dinner & tea. July 21 Has been quiet & well-behaved: Talks quite rationally: Does not seem to care about working. Physical condition good: Sleeps well. Trans. to B 3. July 30 Has been very well behaved since on ward. Aug 1 Wt. 160 Pulse 90. Patient is very quiet & good-natured. Does a little work if asked but is not very willing. Habits & dress tidy. Seems perfectly rational of late. Physical condition seems excellent. Aug 4 Began working in laundry today. Aug 8 Trans. to A 3. Sept 1 Is very quiet: Habits & dress neat & clean: Appetite good. Sleeps well. Bowels regular. Works on ward & is on parole. Sept 29 Taken home today by friend

Discharged.

Personal and Medical History of John F. Drake.

ROBERT, FIELAB & CHAMBERS, DAVENPORT, IOWA

Whole No. 4625

Residence, Byron, Minn.

Date Admission, December 29' 1896.

Admitted by Dr. C.B. Eby. Hour,

How Sent, Thomas Fraser, Jo. P. Olmsted Co.

Sex, Male.

Age, 41.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Laborer.

Degree Education, Common school.

Profession Religion, Not a church member.

Habits, not intemperate

Nativity, New York.

Physicians Committing, Chas. T. Granger + A.S. Baker.

Correspondents, —

Mother - Eliz. Brady, Byron Minn.

No. for Year, 158

Insane Relatives, None (mother intemperate)

Cause Exciting, Masturbation.

Cause Predisposing, Unknown.

Form, Imbecile

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, 2 years ago.

Duration, About 2 years.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 39.

Time of Leaving, Dec. 16. 1897

Time in Hospital, 1 mo. 18 da.

Result, Discharged Aug. 11-1897.
Unimproved

EXAMINATION ON ADMISSION.

Exam. Jan. 4'97 by R.M. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Talks willingly + with apparent

Quick or Sluggish, clearness, yet feeble-mindedly.

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS: Did not note talk of any.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Thinks he is not crazy - In a feeble-minded way thinks he was sent here to gratify neighbors. Don't know anything he did or said out of the way. Says he would rather stay at home + work - Says his heart has troubled some for 8 years.

Personal and Medical History of John F. Drake.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 6½ in. WEIGHT, 120 NUTRITION, Seems poor

WOUNDS OR ABNORMALITIES, one on foot. Condition of skin - some pale.

TONGUE, Tremors, Coatings, Promptness Movement, Fair.

PUPILS, Equality, Equal Size, Normal.

Response Light, Respond. Accommodation,

SIGHT, Normal.

HEARING, "

COORDINATION, Arms, Good

Legs, "

TREMORS, Hands, None of note. Tongue, None of note.

Facial Muscles, " General, "

REFLEXES, Patellar, Normal.

Other

ARTICULATION, Slurred, Hesitating, } Normal.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Strong murmur following 1st sound heard at base - Sounds fair. Regular

LUNGS, Normal

TAKEN,

EXAM. URINE, Ex. Jan. 12'97 3 Pm.
Passed Jan. 12' 2 Pm.
Color yellow.
Sp. gr. 1032
Quan. - 24 hrs. XXVIII Z.
Character Clear.
Reaction Acid.
Albumen None.
Sugar None.

Arteries - no notable change.

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 typhoid fever 13 years ago. Drinks only a little - Occupation gardening.

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

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") None that he knows of.

Mother, or Mat. Relations, living - Age 70 - (mother said in history to be intemperate)

Father, or Pat. Relations, died of kidney complaint

Brothers or Sisters,

Personal and Medical History of John F. Drake.

1896

This patient was brought here by Sheriff C. N. Stewart, in fair physical condition, with the following history - Nothing known as to consanguinity. First symptoms of attack (1st) manifested about 2 years ago by religious delusions: disease appears increasing: is variable with irregular rational intervals: derangement manifested by religious mania: Patient is disposed to injure others: is not suicidal, filthy or destructive: No heredity known. Patient manifested previous peculiarities: Mother was intemperate: no severe disease or head injuries - Has not been confined or restrained: has received no treatment. On personal examination believes himself to be the Christ.

On admission put on B^{s} (Blue Flannel Robe) Complexion light - hair brown, eyes blue, skin good - is clean - behavior good)

Dec 29 Nurses Notes (Summary) Patient received on ward: Quiet & well behaved. Answered a few questions rationally Temp. slightly above normal.

Jan 1 Appetite good. bowels regular: Seems contented, makes no complaints: Is very simple-minded & talks very little: Sits quietly, doing nothing, most of time.

Jan 4 No change in patient: Is at times quite slow of comprehension; when spoken to stops to think before he is able to answer. Is not very strong & is unable to walk out with crowds. Jan 7 Seems very uncertain when asked questions, does not make direct answer: No delusions noticed but is weak & simple minded: Very quiet, rarely speaking except to answer questions.

Jan 11 Can notice no change since admission, Bowels regular: appetite good: sleeps well: Complained of headache last night. Feb. 1 A simple-minded patient but is quiet & well-behaved: Habits neat & clean: Works on ward Appetite fair: bowels regular: Wt. 121½ Pulse 70.

Feb 16 Patient appears the same as on admission.
Went Home.

Discharged.

Personal and Medical History of

Personal and Medical History of Frederick Klees

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4626

Residence, Iowa Grove, Minn.

Date Admission, December 29th 1896.

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

How Sent, Thos. P. Moran Jopt. Dakota Co.

Sex, Male.

Age, 36.

Civil Condition, Married

Children, Four.

Age Youngest Child,

Occupation, Farmer

Degree Education, Common School

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Prussia (Parents Prussia)

Physicians Committing, H. VanBeek + P.M. Asst.

Correspondents,

No. for Year, 159

Insane Relatives, None.

Cause Exciting, Possibly business reverses.

Cause Predisposing, Unknown.

Form, Acute delirious mania

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Dec. 23' 96.

Duration, 6 days

No. of Attack, 2nd

No. of Admissions, 1st

Age First Attack, 36.

Time of Leaving, Jan. 22 1897

Time in Hospital, 25 da.

Result, Died. Exhaustion in Acute Delirious Mania

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by H.H. Herzog 12/29/96

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Examination conducted with extreme difficulty on account of delirium of patient. Has retention of urine. Heart + lung sounds could not be made out on account of struggles of patient. Form Acute delirious mania.

Personal and Medical History of Frederick Klees.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, —— WEIGHT, —— NUTRITION, Very much impaired.

WOUNDS OR ABNORMALITIES, Wrists bruised + swollen by wristlets.

TONGUE, ~~Tremors~~, Sores on tongue + lips Coatings, heavy brown coat Promptness Movement,

PUPILS, Equality, Yes Size, dilated

Response Light, yes Accommodation, yes.

SIGHT,

HEARING,

COORDINATION, Arms, Much impaired

Legs, "

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE, stiff + small.	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 Frederick Klein.

1896

This patient was brought here by Sheriff's Deputy Highley, in fair physical & condition, with the following history. No history of consanguinity; first attack occurred last summer lasting but one day. First symptoms of present attack manifested by aberration of thought on Dec. 23/96 & by violence on Dec. 25th. Disease appears increasing: is variable with rational intervals at irregular intervals: derangement manifested by violence & on religion. Patient is disposed to injure others: is not suicidal, filthy or destructive: No previous peculiarities shown: no history of intemperance in parents or self. At age of 14 patient received injury to head; following the blow it is reported he became religious; Has been confined & shackled. & has been given bromides & chloral, laxatives. Bromide of Hyoscine 1/10 gr. most effective, quieting him for one hour. On personal examination in an active maniacal condition. On admission put on W. & E. (U.S.N. Pipt. Complexion light; hair light; eyes brown; Condition of skin good: mark over left eye. So clean: violent, put in protection sheet.)

Dec. 29 Nurses Notes 7 P.M. received on E. Emaciated: refused to walk; had to be carried. was held by 2 nurses until bed-time. 8 P.M. T. 102° P. 114 R. 31 Given both wrists bruised & swollen also bruise on left elbow, cut over left eye, slight bruise on nose. Put to bed. required being watched constantly. Put in restraint sheet at 9:30

Dec. 30 8 A.M. T. 101' P. 130 R. 36 Took two glasses of milk 8:15 Taken out of restraint watched by special nurse until 10:30 Trans. to Infirmary. Very nervous & restless. Inclined to be pugnacious at times. Catheterized at 11:40 - about 2 pts. urine. 2:30 Urinated in bed. Has to be held by two or more nurses. Put in restraint sheet at 3 P.M. Noisy all afternoon. Given eggnog with wine as often as he will take it. Dec. 30 Patient very restless first part of night. Perspired freely. Very noisy from 10:00 to 17:00 became quiet at 2:20 & perspiration stopped. Slept 1 hr. Quiet & talked quite rationally at 5 A.M. Given 1 qt. eggnog during night. Protection sheet removed at 5:30 A.M.

Dec. 31 8 A.M. T. 101 P. 90 R. 21. 3 qts eggnog given during day. 8:30 A.M. Very restless & noisy had to be held by 2 or more nurses. Inclined to be pugnacious. 5 P.M. T. 103 1/5 P. 108. R. 28 Again put in protection sheet. 1 P.M. Has not been so noisy since morning. & mental condition appears some better. Very restless & noisy first part of night, perspired freely. Coughs some & expectorates thick mucus. Will take no nourishment. Jan. 1/1897 8 A.M. T. 104.2° P. 120 R. 40. 10 A.M. Very restless all last night but seems a little quieter this morning. Was taken out of sheet & not replaced. Takes considerable eggnog with wine during day. Talks quite rationally. Has had to be watched by nurse during day. Quite restless at times but appears quite weak. Perspires freely, coughs some & expectorates thick mucus. Sponge bath given at 7:30 (alcohol & water) Very weak. Talks quite rationally. 8:45 P.M. out of bed but very weak 10. P.M. Complains of pain in stomach & talks rationally

Personal and Medical History of Frederick Klein.

11. P.M. Light B.M. Appears to be growing weaker. Jan. 2nd Has been failing rapidly since 11 P.M. was given eggnog frequently in small quantities - Appeared to be conscious

Died. 5:05 A.M. Jan. 2' 1897.

Personal and Medical History of Anny Davis.

1896

BERART, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4627
Residence, Spring Valley, Minn.
Date Admission, December 30 1896.
Admitted by A. F. Kilbourne M.D. Hour, 11 A.M.
How Sent, E.W. Farrington, Jop. P. Fillmore Co.
Sex, male.
Age, 17
Civil Condition, Single.
Children, -
Age Youngest Child, -
Occupation, None (father Carpenter)
Degree Education, moderate.
Profession Religion, Not a church member.
Habits, Not intemperate.
Nativity, Minnesota. (Father Minn. Mother Indiana)
Physicians Committing, J.H. Phillips & Bro. A. Lovs.
Correspondents,

No. for Year, 160.
Insane Relatives, None.
Cause Exciting, Masturbation
Cause Predisposing, Epilepsy.
Form, Demential epileptic
Accompanying Bodily Disorder, Epilepsy.
Suicidal or Not, yes - propensity active.
Date of this Attack, September 1895
Duration, About 15 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 16
Time of Leaving, June 13. 1897
Time in Hospital, 05 mos. 12 d.
Result, Unimproved

EXAMINATION ON ADMISSION.

Exam by H.S. Herzog M.D 12/31/96.

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Is fairly intelligent. Has what he calls "spells" at night. Is note in history for description. Has also what he calls "symptoms" or a sort of momentary mental confusion which he is unable to describe. His spells came on a year ago. Sometimes has spells during day. They come whether anyone is with him or not & seems to be petit mal. Shows some hysteria. Uncle used to correct him & he determined to pretend to take poison & excite sympathy. Quarrelled frequently with uncle. Confesses masturbation.

Personal and Medical History of Anny Davis.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 9½ WEIGHT, 133. NUTRITION, Somewhat thin & anaemic
WOUNDS OR ABNORMALITIES, Is tall & slight. puffy undereyelids & dark circles.
TONGUE, Tremors, Coatings, Grayish coat. Red tip & lip Promptness Movement,
PUPILS, Equality, Yes. Size, normal.
Response Light, Yes Accommodation, Yes.
SIGHT, Good.
HEARING, "
COORDINATION, Arms, Good.
Legs, "
TREMORS, Hands, None. Tongue, Slight.
Facial Muscles, " General, None.
REFLEXES, Patellar, 5 equal.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs, impulse forcible. Sig. Hypertrophied - somewhat rapid & irregular.
LUNGS, Seem good.

EXAM. URINE, Jan. 14 97 3 P.M.
Passed Jan. 14 1 P.M.
Color yellow.
Sp. Gr. 1027
Quan. 24 hrs. XXVIII Z.
Character Clear.
Reaction Acid.
Albumen None.
Sugar None.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Had diphtheria when about 11 years of age
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, died when patient was young - Uncle had Chorea - Grandparents do not stay long in one place
Father or Pat. Relations, living - does not stay long in one place, does not provide for family.
Brothers or Sisters,

Personal and Medical History of Arry Davis.

1896

This patient was brought here by F. M. Davis, in poor physical condition, with the following history: No history of consanguinity, heredity or intemperance. Disease appears increasing; variable with irregular rational intervals: Disarrangement manifested by threats to take his own life & the life of others. Is disposed to injure others: is suicidal: is not filthy or destructive: No peculiarities previously shown: Is epileptic, no head injury - Has not been confined or restrained. Has been treated for epilepsy with some benefit but the vicious propensities seem to increase. No further information gained on personal examination. — — —
On admission put on B³ C (U.S.N. Rpt. Complexion light; hair & eyes brown: Condition Tattoo marks on left fore arm in form of star: is clean: behavior good: Says he is a contortionist.

Dec 30 Nurses Notes (Summary) Patient came on ward at 11 A.M., was given bath - Talked rationally & was quiet & well behaved:
Dec 31 Slept 5 hrs. during night but sleep was broken as if by bad dreams: Patient would start up, talking loudly then turn over & lie quietly until next spell: not waking at all. Jan 2 Patients still troubled by restlessness at night: Appetite good: Bowels regular: Jan 3 Had fainting spell at noon; fell forward on face & remained unconscious 5 or 6 seconds: Was very weak during rest of day.
Jan 4 Has been on extra diet since Dec. 31 & on medicine since Jan. 1st. Has been at times mischievous & troublesome but on the whole quiet & fairly well behaved: Very childish in actions. Apparently no change since admission: Appetite good: bowels regular: Sleep still broken by spells of restlessness.
Feb 1 Patient remains irritable & mischievous, continually doing something whereby he gets into trouble: Appetite good: bowels regular: Pulse 88. Wt. 136 Pulse 96. on bromide 3 x day. Sleep is still broken each night by the "spells" Feb. 27 Sleep still broken at night but not quite so frequently. Today had spell resembling epileptic fit, face - Contortion of face, stiffening of body. Duration 15 sec. Reasoned Consciousness immediately afterward: When spell came on was standing with back to wall & slid rather than fell to floor.
Mar 1 Still remains irritable & mischievous Continually annoying
X nurses & patients: Does no work: Appetite good: Bowels regular Wt. 138½
11 Very ugly & troublesome: Keeps ward in continual tumult.
Apr 8 Trans. to B'. Adm. 15 Noisy, Dancy & abusive all day: Finally Taken to Bay.
16 Complained of not feeling well. Did not go walking. Had 10 spells during P.M. Apr 17 Complained of headache, powders given.
Apr 28 Troublesome all day, picking on other patients & constantly getting into trouble Table knife lost - patient searched - Found several pieces of wire in pockets.

Personal and Medical History of Arry Davis.

Very angry because searched: Slept in room by himself. Had 19 spells during month. May 3 Appetite good: Bowels regular: Is mischievous & troublesome - Always making trouble May 11 Had trouble with patient Fait. Farted by nurses. May 13 Locked room door - searched but nothing found: May 18 Again had trouble with Fait while out May 30 Says he does not have any more spells: Wants to go home: June 8. Had two spells each night since 7th
Escaped from ward this evening: Evidently picked lock in door.

Discharged.

Personal and Medical History of Frank Helmer.

EGBERT, FIDLAR & BRAMBERG, DAVENPORT, IOWA

Whole No. 4632
Residence, Rochester, Minn.
Date Admission, January 4th 1896.
Admitted by P. M. Phelps M.D. Hour, 11 A. M.
How Sent, Thos. Fraser, Jailor Olmsted Co.,
Sex, Male.
Age, 24
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Laborer.
Degree Education, Common.
Profession Religion, Not a church member.
Habits, Uses tobacco excessively.
Nativity, Rochester Minn. (Father U.S. Mother N. York)
Physicians Committing, Drs. Adams + Granger.
Correspondents, —

No. for Year, 165.
Insane Relatives, None. (Mother very weak mentally)
Cause Exciting, Excessive use of tobacco.
Cause Predisposing, Heredity.
Form, inebriate
Accompanying Bodily Disorder, None.
Suicidal or Not, Has threatened to injure himself.
Date of this Attack, May '96.
Duration, about 7 months.
No. of Attack, 1st
No. of Admissions, 1st (In '92 was confined in State Reform School for forgery.
Age First Attack, 24
Time of Leaving, March 8. 1897
Time in Hospital, 2 mos. 4 da.
Result, Discharged Aug. 11. 1897 Improved.

EXAMINATION ON ADMISSION.

Exam. Jan. 5'97 by Dr. Herzog. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Clear.
Quick or Sluggish, Somewhat Sluggish.
MEMORY:
Past Events, Fair.
Recent Events, "
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly alert.
Correct or Illusive, Correct.
REASONING POWER:
Ordinary Subjects, Fair
Own Mental State, Realizes there is something wrong
Special Subjects, Fair

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

GENERAL DESCRIPTIVE REMARKS: Patient somewhat ill nourished - Has been living at home under unfavorable conditions. Poverty, quarrelling etc. Has spent much of his time with the volunteers of late + became somewhat excited. Says he always has been quick tempered + got mad but knew what he was doing. Now feels sleepy + heavy, tenderness in bowels, no ambition. Confesses masturbation. Is feeble-minded + has misbehaved while at home under imperfect control. Feels unable to work steadily.

Personal and Medical History of Frank Helmer.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Somewhat under weight
WOUNDS OR ABNORMALITIES, Right foot crippled from accident at 10 years of age
TONGUE, ~~Tremors~~, Red, glazed. Coatings, Promptness Movement, Somewhat slow.
PUPILS, Equality, Yes. Size, Small.
Response Light, Excessive Accommodation, Excessive.
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms, Fair.
Legs,
TREMORS, Hands, Some. Tongue, Yes.
Facial Muscles, No. General, No.
REFLEXES, Patellar, 8-9 Equal.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Impulse forcible - slight irregularity.
LUNGS, Expansion good.

TAKEN,

EXAM. URINE, Jan. 12'97 4 P.m.
Passed Jan. 12'97 3:30 P.m.
Color yellow.
Sp. gr. 1030.
Quan. in hrs. XXVIII ¾
Character Clear.
Reaction Acid.
Albumen None.
Sugar None.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Has some headache - occasional vertigo.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Feeble minded
Father or Pat. Relations, dead. Had no regular employment - inebriate
Brothers or Sisters,

Personal and Medical History of Frank Helmer.

1897

This patient was brought here by Sheriff Stewart, in fair physical condition - with the following history: No history of consanguinity: First symptoms of attack manifested in May '96 by threats of violence & religious mania. Disease seems increasing: not variable & with no rational intervals. Derangement manifested by threatening relatives with violence: prays constantly. Beats drum for American Volunteers & forgets to stop beating. Is disposed to injure others: Has never attempted suicide but threatens to injure himself: Is filthy & destructive: No history of insanity: In 1892 was confined in State Reform School for forgery: Uses tobacco excessively: No severe disease or head injury: Has not been confined or restrained & has received no treatment On personal examination Heart is very irritable: pulse 120, irregular, cannot sleep. Pain in head. On admission put upon B3E (G.N.N.P.pt. Complexion light: hair black: Eyes gray: Right leg above ankle disfigured. Is clean: behavior good.)

Jan 14 Nurses Notes (Summary) Patient received on ward this A.M. Given bath. Answered a few questions rationally: Behavior good:

Jan 15 No hallucinations or delusions noticed. Works on ward: Continues to be quiet & well behaved. Appetite good: bowels regular: sleeps well.

Jan 17 Went to bed after breakfast: Complained of soreness & stiffness joints & headache - with rise of temperature. Received 2# powders - took three & refused fourth & while trying to make him take it he struggled & cried: Afterward said we were trying to poison him Jan 17 Temp. subsided after 14th. Has behaved very well Appetite has been good. Bowels regular & has slept well.

Jan 19 Patient quiet & well behaved: works on ward: Appetite good: Bowels regular: sleeps well: Makes no complaint. Feb 1 Very quick tempered & ugly at times: No change mentally: Appetite good: Bowels regular & sleeps well. Mar 1 No improvement. Inclined to be stubborn & set in his ways: Slouchy in habits but neat in dress.

Mar 8 Home this afternoon -

Dr. Herzog notes. Patient still feeble-minded - was allowed to go home on request of Mother, principally because he lives in town & his return would be easy if necessary, & because he has been in this condition for a long time & does no serious harm

Discharged

Personal and Medical History of

Personal and Medical History of Garwood B. Rice

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4635
Residence, Canton, Minn.
Date Admission, January 5' 1897.
Admitted by A. F. Kilbourne, M.D. Hour, -
How Sent, E.V. Farrington, Jo. of P. Fillmore Co.
Sex, - Male.
Age, - 19 yrs.
Civil Condition, Single.
Children, -
Age Youngest Child, -
Occupation, Farm Laborer.
Degree Education, Common School.
Profession Religion, Not a church member.
Habits, Not intemperate.
Nativity, Minnesota (Parents Canada)
Physicians Committing, J.H. Phillips + Henry Jones M.D.
Correspondents,

No. for Year, 168
Insane Relatives, (Father's brother also) 2 uncles of father's mother
Cause Exciting, Not known,
Cause Predisposing, Heredity ?
Form, Confusion in acute
Accompanying Bodily Disorder, None noted.
Suicidal or Not, Not.
Date of this Attack, 4 mos ago.
Duration, about 4 mos.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, -
Time of Leaving, June 3. 1897
Time in Hospital, 4 mo. 29 da.
Result, Discharged Dec. 3. 1897 Recovered.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

By Dr. Phelps 7/6/97.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient in fair physical condition. Did some odd things during Summer. 4 wks ago left home in an unprepared, purposeless way in night. Was found 2 wks later hunting corn for a man. Did not talk very crazy until last Saturday. Is now incoherent with rambling delusions.

Personal and Medical History of Garwood B. Rice.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, — WEIGHT, — NUTRITION, Fair
WOUNDS OR ABNORMALITIES, — Skin fair condition
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal Size, Rather dilated.
Response Light, Accommodation,
SIGHT, Normal
HEARING, Good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Probably none of Note. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred, Good.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
No active exam will test.
LUNGS,
Good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Never drank - was always quietly at home on farm
LENGTH OF INVASION, 1 - 2 mo. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations, Living Had one attack of insanity. Father's Mother + 2 brothers insane
Brothers or Sisters,

Personal and Medical History of Garwood B. Rice.

1897

This patient was brought here by father J.C. Rice: attended by D.L. Rice, in fair physical condition, with the following history. No history of consanguinity: First symptoms of (1st) attack manifested about 4 weeks ago by wandering away from home, not seeming to know where he was going*. After 2 weeks was brought home; has failed a great deal since. Last Thursday he had delusions imagined he was a cowboy &c. Disease seems increasing: not variable, with no rational intervals. Derangement manifested by fear of being murdered by cowboys & indians. Not disposed to injure others: not suicidal, filthy & destructive. History of heredity as stated. No previous peculiarities; severe disease; injury to head: No history of intemperance in parents or self: has not been confined, restrained or received any treatment. On personal examination has all the appearance of acute mania. On admission put upon Infirmary E. (G. H.N. Rpt. Complexion dark: hair black: eyes brown: small scar on 3rd finger of right hand, & 3 bruises on right leg. Is clean: behavior noisy.)

*Note Wandered from home. Found after 2 weeks husking corn for a man in another town - age 19. Learned well - Uncle has had 5 attacks. In Iowa Hospital - Uncle had first attack at 25 yrs. now 56.)

Jan 5 Nurses Notes (Summary) Patient received on ward at 3:15 P.M. Very nervous & maniacal: Was given bath 100° & put to bed. Talks very incoherently & is irrational. Has delusions: thinks that he is going to be shot. Given hypodermic at 5:15 Dose of medicine at 6:45. Held by nurse until 8:45 When he became quiet & went to sleep: Jan 6 Slept until 12:30 when he became maniacal & unmanageable & was put into protection sheet. Slept until 5:30 A.M. when he awoke & became noisy again. Was taken from sheet at 10. A.M. On liquid diet. Has been very restless & noisy all day & had to be held in bed by nurse. Hypo at 8 P.M. Was put in P. sheet at 10:45 P.M. on account of maniacal behavior.

Jan. 7 Slept none until 2 this morning when he went to sleep & slept until 5:40 A.M. Was taken out of sheet at 9. Cool bath given @ 10. Very restless all day. Talks incoherently: Bowels constipated & was given cathartic. Jan 8 Slept 6 hrs. last night. More quiet today. Hypodermic at 7:30 Jan. 9 Very melancholy today. Says he does not know how he came here or where he is. Jan. 13 Patient put on regular diet with eggs substituted for meat. Appears to be improving some.

Jan 14 Great change has come over patient since yesterday. Mental improvement marked & patient converses intelligently. Up & out for walk this afternoon. Behavior good. Jan 18 Patient up on ward. helps some with work. Behavior good. Habits clean: Bowels regular: Appears to be in good physical condition. Talks freely & rationally. No delusions noticeable.

Personal and Medical History of Garwood B. Rice

1897

Jan 19 Patient up on ward: Behavior good: Bowels regular: Sleeps & eats well. Occasionally helps with work on ward. Talks rationally: Jan 22 Trans. to B3.

25 Behavior suddenly became very peculiar: Stood quietly wherever placed. Would talk none. Continually rolls eyes about & makes peculiar faces. 6 P.M. Put to bed. Given sleeping dose but slept none during night. Jan 27 Put on liquid diet. Hot bath with cold application to head at 1 P.M. Appears same as yesterday excepting that cataleptic tendency is not shown today. Jan 29 Same treatment continued: No improvement. Sleeps none: Visited by parents. Feb 1. On liquid diet: Habits filthy. Very restless & often out of bed: Slept 5 hrs. Trans to Infirmary at 4 P.M. Temp. 101°.

Feb 7 No change in patient: Restless & out of bed often: Sleeps fairly well: Habits filthy. On diet of toast & milk: Feb 8 Up & out for short walk today. Feb 10 Much quieter in bed: Put on regular diet: Taken for short walk each afternoon.

13 Patient up on ward: No change since last note. Feb 20 Is very quiet & rather stupid. Continually standing near door as if waiting to get out. Feb 28 Is very stupid: Talks very little: Is filthy in habits: Sleeps on B3 - Behavior good: Bowels regular. Eats & sleeps well. Mar 16 Visited by relative today. Mar 24 Visited by sister:

31 Appetite good: Bowels regular: Sleeps well. Clean in habits: Talks quite intelligently: Is variable being brighter at some times than at others: At times has delusions that some one is going to kill him - Sometimes is quite mischievous & will take anything he sees: Assists with ward work.

Apr 1st Wt. 135 Pulse 70. Visited by sister. Apr. 13 Is improving physically & mentally. Takes an interest in surroundings & converses intelligently & pleasantly.

30 Is somewhat silly at times, laughing to himself. May 2 Is more flighty than usual today. May 4 Visited by friend. June 1 Wt. 150 Pulse 90. Appetite is good: Bowels regular: Sleeps well. Neat & clean in habits: Assists with ward work: Goes walking: Attends chapel: Is quiet & well behaved.

June 3. Visited by parents & taken home.

Discharged.

Personal and Medical History of John Vertini.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4638
Residence, St. Paul, Minn.
Date Admission, January 6' 1896.
Admitted by R. W. Phelps M.D. Hour, 7 P.M.
How Sent, C. Millrich Jr. of P. Ramsey Co.
Sex, Male.
Age, 35.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Harness-maker.
Degree Education, Common school.
Profession Religion, Catholic.
Habits, Intemperate.
Nativity, Austria (Parents Austria.)
Physicians Committing, O.A. Beal + Olof Dahlberg.
Correspondents,

No. for Year, 171
Insane Relatives, None.
Cause Exciting, Alcoholism (?)
Cause Predisposing, Previous attack.
Form, mania a potu
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, About 1 mo. ago.
Duration, 1 mo.
No. of Attack, 2nd
No. of Admissions, 1st
Age First Attack, 35
Time of Leaving, Mar. 16. 1897
Time in Hospital, 2 mo. 10 da.
Result, Discharged Sept. 28. 1897 Recovered.

EXAMINATION ON ADMISSION.

Exam. by H.H. Herzog. 1/7/97.

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Yes.
Special Subjects, of persecution.
Transitory or Not, Fixed.
HALLUCINATIONS: of hearing.
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Coherent.
Voluble or Reticent, Fairly voluble.

GENERAL DESCRIPTIVE REMARKS: Physical condition suggests kidney trouble - exam. urine not yet made. Has hallucinations of hearing. Says that man with whom he boarded has been troubling him + that he heard him upstairs last night. Some man troubled him while in jail. Had some delusions of persecution at New years time + got the two men who troubled him arrested + was arrested himself. Drinks + after 4 or 5 glasses of beer becomes very sick. Has to take to his bed vomits + is ill for 3 or 4 days. Some weeks ago was in city hospital for this drinking. Has about the average intelligence of the Bohemian laborer. Mental condition is nearest paranoia.

Personal and Medical History of John Vertini.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, —
WEIGHT, —
NUTRITION, Somewhat anaemic
WOUNDS OR ABNORMALITIES, Puffiness of hands. extremities cold.
TONGUE, Tremors, clean, large tooth marked Coatings, pale.
Promptness Movement, prompt.
PUPILS, Equality, Equal.
Size, Normal.
Response Light, Normal
Accommodation, Normal.
SIGHT, Good.
HEARING, "
COORDINATION, Arms, Fairly good.
Legs, "
TREMORS, Hands, Slight.
Tongue, Slight
Facial Muscles, None
General, None.
REFLEXES, Patellar, Equal. 7-8
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,

EXAM. URINE, Ex Jan 12 97 3 P.M.
Passed Jan. 12/97 2 P.M.
Character Clear.
Sp. Gr. 1018.
Quan. 24 hrs. XXXVIII 3.
Color Light Yellow.
Reaction Slightly acid.
Albumen None.
Sugar None.

HEART Roughness 1st Aortic Sound - Sounds weak - Size enlarged - Apex beat feeble, displaced + left - Slightly Irregular
TAKEN,
LUNGS, Good.
OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of John Vertin.

1897

This patient was brought here by Sheriffs deputy J.P. Haudrates, in fair physical condition with the following history:- No history of heredity: first attack occurred about 3 months ago + lasted about four weeks, during part of which time patient was in City Hospital, St Paul + left improved: First symptoms of present attack manifested about a week ago by delusions + hearing voices: Disease appears increasing: is variable with rational intervals – only hears voices whispering, sometimes. Derangement manifested by thinking someone wants to disturb him in his sleep. Not disposed to injure others: Not suicidal, filthy or destructive: No history of consanguinity Previous peculiarity Periodical intemperance: No severe disease or head injury Was confined in City Hospital as above stated + has been in Jail now for one week. Nothing known as to treatment. On personal examination appears rational on all subjects except as stated. On admission put on B.C.E. G.H.N.S.Pt. Complexion dark hair black: eyes gray: Condition of skin good: first finger of left hand bruised. Is dirty: behavior good.)

Jan. 6 Nurses Notes (Summary) Recd on ward at 1:30 P.M. Was given bath Talked fairly rationally + was quiet + well behaved: Jan 7 Complains that someone kept him awake while at his boarding place + at jail in St Paul + that he had not slept for a week before coming here. Temp. was 99.6 on admission but subsided to normal on following day + has remained so since. Jan. 16 Works on ward, is good natured, + well behaved + makes himself generally agreeable: Appetite is good: Bowels regular: Sleeps well: Has improved physically but no apparent change mentally. Shows no delusions except concerning being disturbed at night. but says his tormentors have not troubled him since he came here.

Jan 20 Is quiet + well-behaved + very good-natured. Goes out daily for exercise + seems to be gaining in flesh rapidly. Works on ward: Appetite good: Bowels regular: Sleeps well. Feb 9 Complained last night of being sick. Remained in bed this morning. Took scarcely any nourishment

Feb 10 Still in bed but feeling better. Temp. slightly elevated. On liquid diet

" Up + dressed on ward.

Mar 1 Patient remains good-natured + quiet. Continues to work: Makes no allusions to his former delusions + hallucinations. Appetite good: Bowels regular: sleeps well. Wt. 154 Pulse. 84

Mar 11 Dr. Hargrave writes - Is desirous of going home + shows letter from his former employer offering work. Is in good flesh + talks very rationally considering his comparative unfamiliarity with the language. He has no hallucinations at present + is willing to take our statement that his former ones really were such. He attributes all his trouble to drink + says he has previously been arrested for drunkenness + is very susceptible to liquor a few

Personal and Medical History of John Vertin.

glasses of beer overcoming him.

Mar 16 Went Home.

Discharged.

Personal and Medical History of Mads. Nelson

EUGERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. #639
Residence, Blooming Prairie Minn.
Date Admission, Jan. 7' 1897.
Admitted by H.H. Herzog M.D. Hour, 10:30 A.M.
How Sent, W. A. Eggleston J. of P. Steele Co.
Sex, male.
Age, 29
Civil Condition, Single -
Children, -
Age Youngest Child, -
Occupation, Stone mason.
Degree Education, Slight -
Profession Religion, Lutheran.
Habits, Intemperate
Nativity, Denmark.
Physicians Committing, B.M.J. Conlin + J. Palmer Johnson.
Correspondents,

No. for Year, 172.
Insane Relatives, Mother.
Cause Exciting, Intemperance + masturbation.
Cause Predisposing, Heredity
Form, Melancholia Atonic
Accompanying Bodily Disorder, None ascertained.
Suicidal or Not, Not.
Date of this Attack, - (1st attack. June '95.)
Duration,
No. of Attack, 2nd
No. of Admissions, 1st
Age First Attack, 23
Time of Leaving, Nov. 22. 1897
Time in Hospital, 10 mo. 15 da.
Result, Discharged May 4. 1898 Much Improved.

EXAMINATION ON ADMISSION.

Exam. 1/8/97 by H.H. Herzog.

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, Seems correct.

REASONING POWER:
Ordinary Subjects, Very slow
Own Mental State,
Special Subjects,

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

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

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent, Fairly coherent.
Voluble or Reticent, Reticent

GENERAL DESCRIPTIVE REMARKS: Now is dull + depressed. Answers are very slow in coming. Physical condition impaired - digestion + appetite poor. Now shows a melancholia added to considerable feeble-mindedness.

Personal and Medical History of Mads. Nelson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Considerably impaired.
WOUNDS OR ABNORMALITIES, Condition of skin - Greasy.
TONGUE, Tremors, Coatings, Pale-white coat on dorsum, Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Excessive Accommodation, Excessive.
SIGHT, Fairly good.
HEARING, "
COORDINATION, Arms, Slightly impaired
Legs,
TREMORS, Hands, Some Tongue, Quite marked
Facial Muscles, None General, None
REFLEXES, Patellar, 8-9 Equal.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, 2nd aortic sound sharp. 1st mitral sounds fairly strong - Regular - some what slow.
LUNGS, Fairly good.

EXAM. URINE,
TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, No history obtainable
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Mads Nelson. (or Matts)

1897

This patient was brought here by Sheriff J.J. Barnard in fair physical condition with the following history:- No history of consanguinity: First attack of insanity occurred 18 months ago (June 1895) & lasted six months: Was melancholy - crying & feeling bad. Disease appears increasing & is variable: Derangement manifested by dullness of intellect, incoordination & inability to concentrate thoughts. Not disposed to injure others: not suicidal, filthy or destructive: No previous peculiarities: Never diseased or injury to head: Has not been restrained or confined: Nothing known as to treatment. On personal examination is sleepy, dull, sluggish, tongue is coated. On admission put on B.3 (Gr 1/4 Rpt. Complexion Light: hair brown: Eyes blue: Condition skin good. So dirty: Behavior good.)

Jan 7. Nurses Notes (Summary.) Patient received on ward on morning of 7th. Talked some: Was given bath: Seemed restless & despondent, Continually walking up & down the hall & speaking to no one.

Jan 10 Has very offensive breath: Eyes are at times inflamed as if from crying: Still restless & nervous: Talks very little: asks to see a minister: Jan. 13 Continues restless & nervous also seems quite weak being unable to keep up with the crowd when out walking: Talks a little more, having answered a few questions in a slow uncertain manner. Can ascertain nothing concerning condition of bowels.

Jan 16 Appetite poor: Shows no improvement since admission: Still very melancholy: Nutrition impaired: Says he wants to see a minister before he dies Jan. 20 No improvement mentally & has evidently declined physically since admission. Has been on medicine 3 x day since Jan 8th. Jan. 21 Has slight rise of Temperature today: Appetite poor: Bowels constipated. Jan 22 No change. Trans. to Infirmary ward.

23 Lies quietly in bed & talks but little: Bowels constipated: Jan 25 Visited by Prof. Johnson: Thinks he is going to die: Talks some. Out of bed often Appetite fair: bowels irregular. Jan 27 Up on ward this PM. - Moves about slowly. Wants to go home. Jan 30 Patient up on ward daily since last note.

31 Is bad today: Lies very quietly Talks but little. Feb 1 Patient has been up on

Feb - ward daily since last note: Is upon massage treatment. Medicine 3 x day.

" 8 Trans to B.3. Mch. 1 Patient continues despondent. Very restless: Is always trying to escape. Lies a great deal of the time. Has to be coaxed to take his medicine Appetite is very poor & bowels slightly constipated: Wt. 123 lbs. Pulse 78.

20 Patient's behavior changed suddenly about a week ago. Laughs continually to himself: Walks floor constantly, acts very silly. Habits have become very slouchy & dirty. Massage given 3 x per week: Is upon medicine & extra diet.

21 Became suddenly violent today. Trans. to B. Still attempts constantly to escape.

Apr 6 Has been more quiet of late. Apr 7 Wt. 126 lbs. Apr. 15 Appetite fairly good. Bowels regular: Got out of door today, was caught at foot of stairs.

Personal and Medical History of Mads Nelson.

1897

Apr 28 Patient very melancholy & has crying spells at times: Will not talk but understands what is wanted of him. Is untidy in dress but habits are clean.

May 3 Is very troublesome at times - is mischievous & has to be kept in bay. Is at times destructive, breaking anything within reach. Eats in hall June 1 Wt. 126. Pulse 83. June 11 Eloped while out walking today, brought back about three hours later June 14 Visited by friends

18 A slight improvement in behavior noticable. Sits quietly in bay most of time: Does not talk: Minds fairly well: When out requires constant watching: Does no work.

July 3 Wt. 131 lbs. July 8 Refused breakfast. July 17. Is restless & discontented: Appetite fairly good. Bowels regular - July 22 While out on road with crowd today patient eloped. July 23 Returned to ward by Nurse Semrson. Aug 15 Patients behavior does not change: Has to be kept in bay. Habits clean: does no work. Sept 2 Wt. 148 lbs. Pulse 92. Sept 9 Has improved very markedly: Talks & acts rationally: Is working in Dining room. Sept 13 Visited by friends Sept 26 Very restless & mischievous: Talks a great deal. Appetite good: Bowels regular. Eyes look weak & inflamed. Oct. Wt. 133 P. 118. Oct 5 Attempted to elope today.

Nov 1 Behavior good. Talks & acts rationally. Talks freely about his past life. Thinks he has never been insane. Nov 9 Visited by friends. Nov 21 Is gaining in flesh Goes out with crowd for daily exercise. Visited by friends who took him home

Discharged.

Personal and Medical History of Herman Sievers

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4640

Residence, Winona, Minn.

Date Admission, January 8 1897.

Admitted by Dr P.M. Phelps. Hour, 4 P.M.

How Sent, H.L. Buck Dep. Winona Co.

Sex, Male.

Age, 26.

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, None.

Degree Education, Can read & write.

Profession Religion, German Methodist.

Habits, Not intemperate.

Nativity, Born (Parents Germany)

Physicians Committing, W.P. English & H Lichtenstein.

Correspondents, Claus Sievers. 402 E. 5th St, Winona, Minn.

No. for Year, 173.

Insane Relatives, Cousin in Germany.

Cause Exciting,

Cause Predisposing, Always mentally weak.

Form, imbecile

Accompanying Bodily Disorder, -

Suicidal or Not, Not.

Date of this Attack, Mine during last 2 years.

Duration, Long.

No. of Attack, Always weak minded.

No. of Admissions, 1st

Age First Attack, -

Time of Leaving, Apr. 26. 1900

Time in Hospital,

Result, Transferred to Hastings. OK PMP

EXAMINATION ON ADMISSION.

P.M. Phelps - 1/23/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish,

MEMORY:

Past Events, Uncertain.

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, Cross & irritable at times

Exalted,

Depressed,

DELUSIONS: Primal dullness & incoherence - Vague delusions

Systematized or Not,

Special Subjects, -ideas of being imposed upon.

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient a young man. Probably feebleminded. Said when he came here his Father got him mad - "Was going to rule my lady & I gave him a going over" Has delusions about being married.

Personal and Medical History of Herman Sievers.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8 in. WEIGHT, 143 NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, None

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Some dilated

Response Light, Accommodation,

SIGHT, Good

HEARING,

COORDINATION, Arms,

Legs,

TREMORS, Hands, No special tremors Tongue,

Facial Muscles, Has nervous ticky movements General,

REFLEXES, Patellar, Q. exag.

Other

ARTICULATION,

Slurred,

Hesitating, Some sluggishness

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal.

LUNGS, Normal

TAKEN,

EXAM. URINE, Jan. 14th 97 Rm.

Passed Jan 14' 13th Rm.

Color Pale yellow.

Sp. gr. 1003

Quan. 24 hrs. XLVI

Reaction Slightly Acid.

Character Clear.

Albumen None.

Sugar None.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Denies any severe illness - Says when 6 or 8 yrs. old fell & struck head. Denies drinking & smoking

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 Herman Sievers.

1897

This patient was brought here by Sheriff's deputy A.W. Fehrmann in fair physical condition with the following history: No history of Consanguinity: Patient has always been feebleminded but has been worse & had illusions during last two years. Disease seems increasing, not variable & with no rational intervals. Derangement manifested in thinking parties are after him to do him bodily harm - Carries a revolver for protection. Thinks he is a detective for appears: Is disposed to injure others: Is not filthy or destructive: No previous peculiarities shown. No history of intemperance in self or parents: Was sickly when a child: No injury to head. Has not been confined or restrained & has received no treatment. On personal examination is restless, irritable: has illusions & is partially incoherent. On admission but upon B³ E (5 Ft 4 In. Rpt. Complexion light hair light: Eyes gray: Condition of skin good: Is clean: Behavior good.)

Jan 8 Nurses Notes (Summary) Put on ward at 4 P.M. Was very much excited & talked quite irrationally: While removing things from his pockets he became violent & required several nurses to hold him. - 2 101.4 P. 136 Jan 10 Restless & nervous today: Still talks irrationally & with effort as if uncertain what to say. Jan 16 Seems to have twitching of eyelids & corners of mouth when speaking.

Jan 13 Has taken exercise daily & seems quite strong but temperature has ranged from 99 to 101.4 since admission.

Jan 18 Works on ward: Is disagreeable in many ways: Temperature still remains high; has not been normal since admission. Appetite good: bowels regular & sleeps well: At times talks & gesticulates foolishly to himself: Seemingly very little improvement since admission.

Summary Nurses Notes by Dr. Phelps Jan 22 Seems rather drowsy & dull: Temperature at times above normal. Says, however, that he feels alright: Feb 1 Talks to himself at times: Wt. 147 lbs. Mch 1 Wt. 145 lbs. Mch 11 Noisy & restless during night. Trans. to B³ Apr. 30 '97 untidy: Has various delusions Still dull & listless. May 2 '97 Wt. 150.# July 1 '97 149.# Patient rather demented & dull. Talks to himself: Occasionally appears to get angry with himself or some imaginary person. June 4 '98 Visited by father:

Jan 3 '99. At annex. Does not seem to be improving in any way. Goes through exceedingly foolish motions. Works at present on farm.

Feb 1 - July 31 '99. (Dr. Wanous) Wt. 135.# Visited by friends: Is untidy. Incoherent in speech.

Aug 1 - Jan 31 1900. (Dr. Chapple) Wt. 141.# Aug. 20 Visited by cousin. Mch. 6 Visited by friend. Not much change during period. Is demented: Talks in a rambling manner & works on ward & in kitchen. Habits cleanly: Appetite & behavior good: Apr 26 1900 - No change in patient mentally or physically.

Apr 26 '900 Transferred to Hastings Asylum.

Transferred.

Personal and Medical History of

Personal and Medical History of H. P. Nelson

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4647

Residence, Shell Rock. Minn.

Date Admission, January 10' 1897

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

How Sent, Herman Blackmer - Freeborn Co.

Sex, - Male.

Age, 37.

Civil Condition, - Single -

Children, -

Age Youngest Child, -

Occupation, Laborer.

Degree Education, Moderate.

Profession Religion, Lutheran

Habits, Drinks + smokes.

Nativity, Denmark.

Physicians Committing, F.A. Blackmer. G.W. Bancr.

Correspondents,

No. for Year, 175

Insane Relatives, Not Known.

Cause Exciting, Unknown

Cause Predisposing, Previous attack.

Form, Mania Simplex

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not - Homocidal?

Date of this Attack, About Christmas

Duration, Since Christmas.

No. of Attack, 2nd

No. of Admissions, 2nd

Age First Attack, about 32.

Time of Leaving, Nov. 1. 1897

Time in Hospital, 9 mo. 22 d.

Result, Discharged May 4. 1898

Much Improved.

EXAMINATION ON ADMISSION.

Exam. by H.H. Stryker M.D. 1/12/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Clear.

Quick or Sluggish, Somewhat sluggish.

MEMORY:

Past Events, Fairly good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Fairly Alert.

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State,

Special Subjects, Fair.

GENERAL DESCRIPTIVE REMARKS: Patient is in fair physical health. Seems feeble minded but not markedly so. Threatened to kill his employer but says he meant nothing by it "Got a little excited."

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS: None noted.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent.

Voluble or Reticent, Somewhat voluble

Personal and Medical History of H. P. Nelson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fairly good.

WOUNDS OR ABNORMALITIES, Low narrow forehead - droop of eyelids.

TONGUE, Tremors, Coatings, Yellowish coat in base Promptness Movement, Fairly prompt.

PUPILS, Equality, Equal. Size, Contracted.

Response Light, Yes Accommodation, Yes.

SIGHT, Fairly good.

HEARING, Good.

COORDINATION, Arms, Some incoordination

Legs, "

TREMORS, Hands, Slight Tongue, Some

Facial Muscles, None - General, None.

REFLEXES, Patellar, 8 Equal.

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs.

Sounds fairly good - Regular.

LUNGS,

Good,

TAKEN,

EXAM. URINE, Jan 14 '97 2 P.M.

Passed Jan 14 '97 1st P.M.

Color Opleom.

Sp. gr. 1023

Quan. 24 hrs. L. ½.

Acid -

Sediment Clear.

Albumen None.

Sugar None.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Drinks + smokes.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Is an illegitimate child — Mother had 5 illegitimate Children

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of H. P. Nelson

1897

This patient was brought here by Sheriffs deputy Ed. Ellickson in fair physical condition with the following history:- No history of consanguinity:- Patient was confined in this (Rochester) [x] hospital from Sept. 25'91 to Oct. 29'91. First symptoms of present attack shown about Christmas, when patient threatened to kill people. disease appears increasing: is variable: Is disposed to injure others: not suicidal, filthy or destructive: No history of insanity known. No previous peculiarities: Nothing known as to intemperance in parents or Rel: No severe disease or head injury: Patient was confined as above stated: has received no other treatment. On personal examination. has masturbated but says habit is not active now. Commitment recommended because he is not safe to be at large at present. ——— ———

[x] Note - for further particulars see Vol. 17 Page 345 No. 7826. ——— ———

On admission put upon D[3] E (Std N. Hyt. Complexion light: hair brown: eyes blue: Condition of skin good: Is clean: behavior good.)

Jan. 10 Nurses Notes (Summary) Patient received on ward: given bath: was quiet & well behaved answering a few questions rationally: is a little simple minded Jan 13 Appetite good: bowels regular: Have noticed no delusions or hallucinations. Still remains quiet & good natured

Jan 14 Seems anxious to get out & is constantly asking when we will let him go. Jan. 16 Can see no change in patient since admission

Jan 17 When not working generally sits quietly in chair, does not read or employ his time intelligently. Jan 18 Trans to A. quiet & well behaved

Jan 23 Works on hall but spends most of time sitting quietly - doing nothing, reads very little: Is anxious to go home: Talks rationally but is a little simple minded: Have noticed no delusions:

Physical condition apparently good: Bowels regular: appetite good: sleeps well. [2]61 Patient quiet & well-behaved: Works very willingly: Is anxious to go home: Appetite good: Bowels regular: Sleeps well.

Apr. 1 Wt. 178 lbs. Pulse 68. Apr 5 Works in dining room: Talks rationally: Habits clean: Does neat: Health good. May 4 Still works in dining room: Behavior continues good. Physical condition good. July 5 Wt. 174 lbs. Aug 30 No change.

Sept 1 Wt. 173 Pulse 80. Asks to be allowed to go home. Oct 31 No change Either mentally or physically since last note. Nov. 1 Allowed to go home today.

Discharged.

Personal and Medical History of

Personal and Medical History of Charles M. Curtis

HERBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4650

Residence, Faribault, Minn.

Date Admission, January 18th 1897.

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

How Sent, G.A. Mott, J. of P. Rice Co.

Sex, Male.

Age, -36-

Civil Condition, Married

Children, None.

Age Youngest Child, —

Occupation, Telephone Lineman.

Degree Education, Common.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, Iowa.

Physicians Committing, L.L. Wagner & J.S. Seeley.

Correspondents,

No. for Year, 183

Insane Relatives, Father's sister.

Cause Exciting, Domestic trouble & worry.

Cause Predisposing, Heredity.

Form, melancholia with

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, Jan. 5th or 6th 1897

Duration, 1 to 2 weeks

No. of Attack, Not known.

No. of Admissions, 1st here.

Age First Attack, Not known.

Time of Leaving, Mar. 16. 1897.

Time in Hospital, 1 mo. 26 da.

Result, Discharged Sept. 28. 1897 Recovered.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: —

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY: —

Alert or Dull,

Correct or Illusive,

REASONING POWER: —

Ordinary Subjects,

Own Mental State,

Special Subjects,

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 thinks there is a plot against him. Wife left him - followed her up. His papers disappeared (suspected wife took them) A girl working for his wife, whom he had previously spoken about to his wife as suspicious followed him into a room, talked suggestively to him of an elopement. The wife came in & a charge of attempt at rape lodged him in jail. Thinks a Justice of Peace (staying in same house) & others are in the plot.

Personal and Medical History of Charles M. Curtis.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft. WEIGHT, 151 lbs. NUTRITION, Rather poor.

WOUNDS OR ABNORMALITIES, None noted. Skin fair condition but pale.

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Accommodation,

SIGHT, Good

HEARING, "

COORDINATION, Arms,

Legs,

TREMORS, Hands, None Tongue,

Facial Muscles, " General,

REFLEXES, Patellar, 4 - Equal.

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries hard & nervously palpitating

HEART,

LUNGS, Fair.

TAKEN,

EXAM. URINE, Ex. Jan 25 97 5 Bx.

Taken Jan. 25th 2 P.M.

Color Light yellow

Spg. 102-1

Quan. 24 hrs. XXVIII Oz.

Character Clear.

Reaction Acid.

Albumen None.

Sugar None -

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Sick in jail - Gets headaches & worrying. Thinks was out of head once. Don't drink. Smokes a good deal. Had bad headaches for 2 weeks now.

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, Father's sister insane once - Father living - healthy.

Brothers or Sisters, No children Married 2½ yrs.

Personal and Medical History of Charles M. Curtis.

1897

This patient was brought here by Sheriffs Deputy Maguire(?) in fair physical condition with the following history:- No history of consanguinity - Nothing known as to number of attacks:- Sheriff says, on oath, that about the 5th or 6th inst he found him acting strangely with symptoms of insanity. Disease appears increasing: Variable, with irregular rational intervals. Domestic & personal trouble (real delusions) have driven him wild - He is not able to control himself: Has shown no disposition to injure others- No information given concerning habits:- Nothing known as to previous peculiarities as patient has been in Faribault only about three months- No history of intemperance in parents or self: Patient hurt head at Minneapolis by falling, about 4 years ago. Has been confined in a room with a watch: Sedatives have been administered. On personal examination no facts other than those stated above, were learned. Note facial expression. On admission put upon B3 (G.S.H. Rpt Complexion & hair dark: eyes blue: Condition of skin good: has tattoo marks on right forearm - a flags & a shield: Has scar on inside of left thigh just above the knee. Is clean: back covered with small brown moles. Behavior good: Talks very rationally)

Jan. 18 Nurses Notes (Summary) Reid on ward at 4 PM. Given bath. Quiet & well behaved also talked rationally Jan. 24 Had slight elevation of temperature during first few days, but said he felt first rate. Appetite is good: bowels regular & sleeps well. Works on ward & does whatever is asked of him Jan 31. Has remained quiet & well behaved since admission. Has taken no medicine. Nothing strange noted in behavior since admission; has taken no medicine. Rational in conversation. Has improved physically since admittion.

Feb 1 Quiet & well behaved. Also works on ward & does whatever is asked of him. Can notice nothing wrong in conversation or actions: Appetite good. Bowels regular: Sleeps well. Wt. 159. Pulse 94.

Mar. 1 Seems perfectly rational in every way. Works with painter: W 164 P. 72 No change in patient. Trans. to A 3. Mar 10.

Mar 10 Patient behaves well: Habits neat & clean: Works around center Physical condition good.

Mar 16. Eloped today & could not be found.

Discharged.

Personal and Medical History of

Personal and Medical History of Hans Bille.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4651

Residence, Alden, Freeborn Co. Minn.

Date Admission, January 19' 1897.

Admitted by Dr H.H. Herzog Hour, 7 P.M.

How Sent, Herman Blackmer, Jo's Freeborn Co.

Sex, Male.

Age, 25.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Farm hand - Laborer.

Degree Education, "Fairly good for business"

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Denmark - (Parents Denmark)

Physicians Committing, J.P. Bro + A.L. Midge.

Correspondents, N. Larson (Brother) 225 E 4½ St. Waterloo, Iowa.

No. for Year, 184.

Insane Relatives, None

Cause Exciting, Unknown but there is evidence that he masturbated

Cause Predisposing, Previous attack

Form, mania acute

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, Jan. 3'97.

Duration, 16 days.

No. of Attack, ~~2nd~~ 1 (to P)

No. of Admissions, 1st here.

Age First Attack, 25

Time of Leaving, Aug. 5. 1897

Time in Hospital, 6 mo. 17 d.

Result, Discharged Feb. 9. 1898

EXAMINATION ON ADMISSION.

Exam Jan 25 by Dr H.H. Herzog.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Impaired.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dull

Correct or Illusive, Correct in the main.

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Slightly,

Depressed,

DELUSIONS:

Systematized or Not, Unsystematized.

Special Subjects, Hypnotism. Vague.

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, somewhat.

Voluble or Reticent, Fairly voluble.

GENERAL DESCRIPTIVE REMARKS: Patient has slight rise of temperature, breath is somewhat foul. Seems to have been of fair intelligence. About 2 weeks ago was taken to St Elizabeth's Hospital Chicago while there was kept in bed, restraint at night. Seems from description to have been in a mildly maniacal condition, somewhat more marked than at present. He now talks somewhat vaguely of hypnotism + of "exercising" in the night. Makes purposeless movements with arms — says it is to drive out rheumatism.

Personal and Medical History of Hans Bille

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8¾ in. WEIGHT, 131½ lbs. NUTRITION, Slightly impaired.

WOUNDS OR ABNORMALITIES, Abrasions on wrists from restraint.

TONGUE, ~~Tremors,~~ Red centre, Gray edges ~~Coatings,~~ papillae prominent Promptness Movement, Fairly prompt.

PUPILS, Equality, Yes. Size, Normal.

Response Light, Yes - c Accommodation, Yes -

SIGHT, Good. Very slight double ptosis.

HEARING, Good.

COORDINATION, Arms, Slight impairment

Legs, "

TREMORS, Hands, Slight Tongue, Very slight

Facial Muscles, None General, None.

REFLEXES, Patellar, 9 Equal.

Other

ARTICULATION,

Slurred,

Hesitating, Somewhat slow.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No Murmurs noted. Sounds fair - somewhat rapid.

LUNGS,

Seem good.

TAKEN,

EXAM. URINE, Jan 25 '97 2 P.M.

Passed Jan. 25 — 2 P.M.

Color Yellow.

Sp. gr. 1025

Quan. 24 hrs. XXXIV — 34.

Character Cloudy.

Reaction Slightly acid.

Albumen None.

Sugar None.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Claims to have hurt head in youth: moderate drinker + smoker. Said by friend to have had an attack 3 months ago from which he recovered. It is questionable whether he fully recovered or not as he left Alden + went to Pipestone LENGTH OF INVASION, from which place he soon after went to Sioux City. ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations, } Friend states that an uncle became insane at age of 60

Brothers or Sisters,

Personal and Medical History of Hans Bille.

1897

This patient was brought here by Sheriffs deputy. A.P. Hanson attended by N. Larson, in fair physical condition, with the following history:- No history of consanguinity. First attack occurred about 3 months ago & lasted about 3 weeks - was not confined in hospital during that time but has just now returned from Elizabeth Hospital, Chicago where he has been treated for 2 mos., resulting in some improvement: First symptoms of present attack were manifested about 16 days ago. When he went to bed. appeared stupid listless & sullen, would not answer questions; he did not appear sick but did not seem to know anything: Disease seems to be decreasing is variable with irregular rational intervals: Derangement manifested on no particular subject but patient has delusions, is suspicious of friends, listless & indifferent. Is feeling all over his person for some annoying trouble or disease. Not disposed to injure others: not filthy or destructive to any extent: No previous peculiarities shown: No history of intemperance in parents or self: No severe disease or head injury: Has received Hospital treatment as above stated. On personal examination appears restless but indifferent: pulse 120. is feeling or pressing on various parts of his body. Commitment recommended because patient requires treatment.

Jan 19 On admission put on B^3 (Y.M.C.A. Cpt. Complexion light: hair light: Eyes blue: has scratches on hands: Eruption on back: Is clean; behavior good)

Nurses Notes (Summary) Came on ward at 9:15 P.M. Given bath & put to bed. Quiet & well behaved. Jan. 20 Slept 7 hrs. last night. Appears weak & was kept in bed all day. Answers questions fairly well. quiet. Jan. 21 Appetite fair: Talks & sings to himself most of day. Jan. 22 Restless, noisy & destructive during day. Bowels constipated. Jan 24 Continues maniacal & noisy. Jan. 25 Bowels moved by an enema: Still in bed: No change in behavior. Jan. 26 Patient slept 6 hrs. last night but has been extremely noisy & maniacal Thos P.M. Became violent & required three nurses to hold him. Jan 27 Slept 6 hrs. last night. Somewhat queer this morning. Trans. to Infirmary at 12:30 Put to bed. Ate dinner. Seemed to be in an elevated state of mind. Conversation irrational. Quiet most of afternoon Says that he feels good. On medicine 1 tsp. Bromide after meals.

Jan 28 Talks irrationally to himself much of time. Out of bed after at night. Put on liquid diet. Jan 29 Stubborn in behavior & irrational in conversation. Refused medicine this morning. Struggled violently when compelled to take it. Jan. 30 Slept 8 hrs. last night: refused salts & could not be made to take them: Was given an enema: Quiet most of day. Feb. 1 Soft food added to diet. Ate a fair supper. Patient is somewhat restless at times but quiet: Bowels constipated. Habits clean: Stubborn. Physical condition appears good. Feb. 2 Quiet in bed today. Habits clean. Talks incoherently. Physical

Personal and Medical History of Hans Bille.

1897

Feb. 5 Has been up & out for a walk twice of late. Seemed exhausted after coming in & was put to bed. Feb 13 Physical condition appears fair: Goes out every day. Habits occasionally filthy: Talks irrationally: Bowels fairly regular.

Feb 28 Seems quite restless, walks around a good deal. Appetite good. Sleeps & eat well. Sleeps on B^2. March 10 Appetite Good. Habits filthy: Is on bromide mixture.

March 25 Fairly well behaved since on ward: altho occasionally troublesome. Talks very little & sleeps a great deal. April 1 Wt. 136½ P. 72. April 25 Masturbates excessively of late. Is becoming more slouchy in habits is also mischievious & requires continual watching. May 1 Evidently no improvement. Sits quietly on a bench in a stupid manner & talks none. Appetite very poor. May 5 Wt. 134 P. 72. Has refused nourishment for a couple of meals. May 16 Has been eating - but not very well - bowels constipated. May 19 Appetite fairly good. May 25 For last few days has shown great mental improvement - Is much neater in habits & dress: Talks quite rationally. May 30 Has relapsed into former state - restless, destructive, habits filthy. Seems to have a mania for destroying gas fixtures. June 1 Wt. 134 Pulse 100.

June 3 Has refused all nourishment for past few meals - remains restless nights Trans. to Infirmary Ward & put to bed - stupid - refuses to talk - habits filthy.

6 Restless & out of bed a number of times last night - Has been up most of day. Bowels fairly regular. June 7 Visited by brother & friend - Talked freely & apparently quite rationally to them. Went out with crowd for a walk. June 30 Has been up & about ward since 7th Can notice no marked change: Seldom speaks. Pulls at curtains & draperies & at times watches for chance to escape - Untidy in dress & appearance. July 1 Wt. 106 July 8 Trans to B^3.

July 21 Has seemed perfectly rational since on ward - Has worked in Center for last few days - Has improved both physically & mentally. Trans to A^3.

22 Behavior good: is of a quiet disposition - Physical condition good. Habits neat & clean. Sleeps well: Bowels regular. Is on parole: Works in center - Went home today

Aug 5

Discharged.

Personal and Medical History of William W. Adams

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4653

Residence, Faribault Minn.

Date Admission, January 20 1897.

Admitted by Dr. A.M. Phelps Hour, 4 P.M.

How Sent, R.A. Nott, Dep. Sh. Rice Co.

Sex, - Male -

Age, - 23 -

Civil Condition, - Single.

Children, —

Age Youngest Child, —

Occupation, Has none -

Degree Education, High School graduate.

Profession Religion, Not a Church member.

Habits, - Not intemperate.

Nativity, Rochester, Minn. (Father Mich. Mother Vt.)

Physicians Committing, C.H. Wagner + D.M. Cool.

Correspondents,

No. for Year, 186.

Insane Relatives, None.

Cause Exciting, Onanism.

Cause Predisposing, -

Form, Paranoia

Accompanying Bodily Disorder, Spinal Curvature

Suicidal or Not, Not.

Date of this Attack, A growing condition

Duration, —

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, —

Time of Leaving, June 20. 1897

Time in Hospital, 5 mo -

Result, Discharged Nov. 3. 1897 Improved.

EXAMINATION ON ADMISSION.

Exam. by H. Herzog M.D. Jan 21/97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Clear.

Quick or Sluggish, Quick

MEMORY:

Past Events, Quite good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Fair.

Own Mental State, Evasive

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Somewhat.

DELUSIONS:

Systematized or Not, Yes.

Special Subjects,

Transitory or Not, Fixed.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, Voluble.

GENERAL DESCRIPTIVE REMARKS: Patient is not very well nourished in addition to his deformity. Is egotistical - imagines himself better than his family. Has a high school education + plumes himself on his mental ability. Says his elder sister is quite dull. Has systematized delusions that his stomach is incapable of digesting + that his bowels are loaded with undigested food: that his blood is mostly salt + water. Considers his case as absolutely unique. Condition does not seem purely hypochondriacal as he talks calmly about his condition — rather paranoiac adolescent.

Personal and Medical History of William W. Adams.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, —

WOUNDS OR ABNORMALITIES, Lunch-back - hands blue + cold. Curvature of spine, first to right later to left.

TONGUE, Tremors, Coatings, Yellow coat. Promptness Movement, Quite prompt.

PUPILS, Equality, Yes Size, Normal.

Response Light, Yes Accommodation, Yes

SIGHT, Good.

HEARING, "

COORDINATION, Arms, Fair

Legs, Fairly good -

TREMORS, Hands, Quite marked Tongue, None

Facial Muscles, None. General, None

REFLEXES, Patellar, 9 Equal. EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs noted - Apex beat forcible - fairly regular.

LUNGS, The hypocondriasis so contracts the capacity of the chest that the breathing is almost purely abdominal.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of William W. Adams.

1897

This patient was brought here by Sheriffs Deputy Moshier in fair physical condition with the following history:- No history of consanguinity, heredity, or intemperance in parents or self: Condition is a growing one: Patient demands money & support without work & claims the reason for his ill-health is an inability to digest food: He has threatened to injure others: Goes to bed with clothing on & has destroyed documents, credentials &c: Has always been incorrigible: Has spinal curvature: Has not been confinedly restrained & has received no treatment. On personal examination claims absolutely no digestion—that his blood is simply salt & water. On admission put upon B3C

Jan 20 (5 ft 8 in Apt Complexion & hair light: Eyes blue: Condition of skin good: Scar on left instep: Is clean: behavior good: Talks rationally.)

Nurses Notes (Dunn-ay) Patient received on ward at 4 P.M. on 20 inst. was given bath: Quiet & well-behaved also talked rationally.

When doing anything which requires exertion complains of shortness of breath. Jan 22 While out for walk became exhausted & required assistance of nurse to walk to house: In ordinary conversation can notice nothing out of place but has one peculiar idea,- thinks his bowels are full of undigested food, which has been there for months. Has been quiet & well behaved since day of admission. Is unable to do any work: Employs the time reading. Had slight elevation of temperature when admitted which has continued with tendency to rise up to date of record. Was put on medicine on 23rd & continued up to date.

Feb 3. Patient quiet & well-behaved: appetite fair: bowels regular: sleeps well. Is unable to work: complains of difficulty in breathing when exerting himself: Reads most of time: Always has slight rise of temperature: Wt. 121½ Pulse 106. March Still complains of shortness of breath: Has not been for walk since last note: On medicine 3 x day. Appears same mentally & physically. March 29 Temp. subsided to normal. April Goes for walk occasionally note that weather is warmer. Does not talk about his delusions Appetite good: Bowels regular: Wt. 115 Pulse 90. May 1 Can see no change in patient either physical or mental: In ordinary conversation talks rationally but when alluding to his health shows delusions very plainly:

June 1 Neat in habits & dress: Has made no allusion to delusions since above
To note: Physical condition seems quite good: Wt. 110 P. 120.
June 16 No change in patient. Went Home today.

Discharged.

Personal and Medical History of

Personal and Medical History of Mathew Daly.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4654
Residence, Wilton, Minn.
Date Admission, Jan. 21 1897.
Admitted by Dr B. Eby M.D. Hour, 4 P.M.
How Sent, H. L. Buck. J. of P. Winona Co.
Sex, - Male -
Age, - 20 -
Civil Condition, - Single -
Children, —
Age Youngest Child, —
Occupation, Farmer.
Degree Education, County school.
Profession Religion, Catholic.
Habits, Not intemperate.
Nativity, Stockton, (Parents Ireland.)
Physicians Committing, W. F. English + J. S. Tracy.
Correspondents, Dennis Daly Sr. (Father)

No. for Year, 187.
Insane Relatives, Brother was in this Institution in '95
Cause Exciting, Not Known.
Cause Predisposing, "
Form, Melancholia acute Stuporous
Accompanying Bodily Disorder, Headaches + sleeplessness
Suicidal or Not, Suspected. Propensity active.
Date of this Attack, About a week ago.
Duration, About one week.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 20 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

T. M. Phelps. 8/25/97.

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,
GENERAL DESCRIPTIVE REMARKS: Patient young. Has been a Stupid, resistive Stuporous Melancholiac ever since coming. No bodily ailment has been noted. Health otherwise good.

EMOTIONAL STATE: A stuporous melan-
Normal, Calm, cholia ever since his admission
Indifferent, Now a distressed expression
Exalted, with a set askward attitude.
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Mathew Daly.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, 122 lbs. NUTRITION, Some impairment.
WOUNDS OR ABNORMALITIES, —
TONGUE, Tremors, Want show Coatings, Promptness Movement,
PUPILS, Equality, Equal. Size,
Response Light, Accommodation,
SIGHT, Normal
HEARING,
COORDINATION, Arms, Normal
Legs,
TREMORS, Hands, None. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
Resists Cannot Test
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Won't Talk ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters, Brother was insane.

Personal and Medical History of Mathew Daly.

1897

This patient was brought here by Sheriffs deputy George Jacobs in fair physical health with the following history: No history of Consanguinity: First symptoms manifested within a week, is melancholy & depressed, morose & listless - Complains of head ache & sleeplessness: Disease appears increasing; variable with irregular rational intervals: Derangement manifested on no particular subject but is melancholy & wants to be alone: Is not disposed to injure others but is suspected of attempting suicide by trying to eat all the Doctors pills at once; standing at 3rd story window in night clothes & speaking of places he visited as last time he would ever see them: Is not filthy or destructive: Dennis Daly Jr. brother of patient was in this institution from Feby 3'95 to Aug 14'95. No previous peculiarities shown: No severe disease or head injury: Has been watched by friends for 2 or 3 days. no treatment. On personal examination is indifferent, morose, listless, answers questions reluctantly. On admission put on B 3 6.
(Gen. Rpt - Complexion light: hair black: eyes brown: skin good: Is clean: behavior good: will not talk)

Jan 21 Nurses Notes (Summary) Patient was received on ward at 4 PM - Refused to take bath. Very stubborn & will not talk. Jan 22 Slept 4 hrs. last night: Refused breakfast: Trans. to Infirmary at 11:30 A.M. Given shower bath 80° & put to bed: Lies very quiet & does not talk: Physical condition appears good: Refused dinner: Habits clean: Took 2 glasses of milk for supper. Fed by nurse. Jan 23 Slept 7 hrs. last night. Was given shower bath at 80° & put on liquid diet Jan 26 Condition about the same. Ate breakfast & dinner of his own accord: Is still very stubborn but at times will speak when asked a question: Lies quietly in one position most of the time.

Feb. 1 No change in patient: Given electrical treatment 3 times a week, general Faradigation. Feb. 3 Patients physical or mental condition does not seem to change. Bowels constipated: Habits clean: Has been on liquid diet part of time. Will answer a question at times when spoken to. Appetite fair of late. Can notice no marked symptoms of any change.
Summary Nurses Notes by Dr. Phelps Mch 1 Patient has been upon ward quietly Is dull & stupid with appearance of stuporous melancholia. Habits dirty. Has to be seen to with regard to everything. Has to be fed by tube at times. Apr 1 Has to be fed with tube regularly: Is dull, listless & demented. May 1 Has to be fed with tube but drinks a little occasionally. Is thoroughly melancholy & somewhat demented.
May 10 Patient on Infirmary. Very quiet, rather stuporous in manner. June 1 98 lbs
June 6 Visited by brother: Very stupid & demented in every way July 1 Wt. 115 lbs
Aug 1 106 lbs Sits in a very dull demented & stupid way. Sept 1. Wt. 99 lbs Refuses to walk. Is carried around. Oct 1 Wt 89 lbs Now lying quietly in bed. Nov 6 96 lbs Has

Personal and Medical History of Mathew Daly

recently been a little less stupid Jan 1 '98 106 lbs Mch 2 Wt. 122 lbs June 4 Visited by friends. Aug 1 Wt. 128 lbs Jan 3 '99 Wt. 127 lbs Has gaite stupid & stuporous yet picks restlessly at face. Very stubborn, dull & quiet.

Feb 1 - July 31 '99 (Dr Wanous) Wt. 131 lbs Is demented: restless: simple in actions. Patients face is marked from scratching with finger nails: patient abuses himself. Receives treatment. Visited by father Feb 25th Aug 1 - Jan 31 1900 (Dr Chapple) Wt. 139 lbs
Aug 30 1900 Visited by relatives. Speech very irrational: Is stubborn & at times pugnacious: Very untidy in dress: Wears straight suit part of time. Does nothing: Physical condition fairly good. Feby 1900. Wt 134 lbs. Pbs.
Jany 31 Visited by friends. Mayst. Transferred to Annex. May 27. Eloped homewards. Was Caught near Chester.
Febr Transferred to V8. June 23. Visited by friends. July 4. Visited by friends. July 20. Vaccinated. July 31
Mar 23 no change during period. Is much demented & very stubborn in behavior. At times, pugnacious, without provocation. Requires coaxing to go out for exercise & to take his food. Habits filthy. Talks very seldom. Destructive to clothing and wears a straight-suit. Physical condition is fairly good.
June 23 Wt 115 lbs. Aug 29 Visited by friends Nov 19. Visited by friends. Jany 31/901. very slouchy & inactive:
July 4 will not speak: constantly watching for an opportunity to escape: is very stubborn: Physical
20 Condition fairly good. Feby. Wt 123 lbs - Feby 4. visited by friend. June 25. Eloped, while
Aug 1 outside: was brought back, the same day. Augs. Wt 123 lbs: no change noted. Nov 1 Wt 136 lbs
1900 Physical condition not so good of late: otherwise, no change. Is very demented. Is active.
Jan 31 habits dirty.

May 10/02 (Dr. Chapple) visited by father. Apr. 4. Visited by brother.
June 3 Trans. to D.W.; has slight fever; refuses to eat; is stupid -
Same day visited by father. June 11 Visited by father and mother.
June 13. to C; Seems as well as usual. Jan. 31 - Condition about the
same. Habits very dirty & filthy. Does no work.

Personal and Medical History of Frank Labarge.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4657
Residence, St. John, N. D.
Date Admission, January 26' 1897.
Admitted by Dr. A. F. Kilbourne Hour,
How Sent, G. Millrich, J. of P. Ramsey Co.
Sex, - male -
Age, - 53 -
Civil Condition, - married.
Children, - 4 -
Age Youngest Child, -
Occupation, - Labarer.
Degree Education, - none -
Profession Religion, - Catholic -
Habits, - Not Intemperate -
Nativity, - Canada -
Physicians Committing, O Martel, - St Hahn, N. D.
Correspondents,

No. for Year, 190.
Insane Relatives, - None -
Cause Exciting, Unknown.
Cause Predisposing, Unknown.
Form, paranoia
Accompanying Bodily Disorder, None mentioned -
Suicidal or Not, Not.
Date of this Attack, 4 months ago.
Duration, about 4 mo.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 53.
Time of Leaving, May 29 - 1900
Time in Hospital, 3 yr. 4 mo. 3 Xd
Result, Discharged Aug - 8. 1900 Improved

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

By Dr. R.M. Phelps 8/31/97.

MENTAL ACTIVITY:
Clear or Confused, Quick - probably inaccurate
Quick or Sluggish, on some subjects

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

PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Probably incorrect on subjects of examination

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

GENERAL DESCRIPTIVE REMARKS: Talks willingly & gives his statements clearly - or fairly so says entrusted a man with his money, found out he was not straight & in the dispute was sent here.

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 Frank Labarge.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 3/4 WEIGHT, 140 1/2 NUTRITION, Fair
WOUNDS OR ABNORMALITIES, Skin fair condition for age.
TONGUE, Tremors, None Coatings, Promptness Movement, Prompt
PUPILS, Equality, Equal Size, Normal.
Response Light, Accommodation,
SIGHT, Fair
HEARING, "
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, Fairly steady Tongue,
Facial Muscles, General,
REFLEXES, Patellar, & Equal
Other
ARTICULATION,
Slurred, Normal.
Hesitating,
FACIAL EXPRESSION,

SENSIBILITY,
Arteries - Perhaps slight atheroma
HEART,

LUNGS,

TAKEN,

EXAM. URINE, Feb 12'97 3 P.M.
Passed Feb. 12' 11 30 A.M.
Color yellow.
Sp. gr. 1021
Quan. 24 hrs. XXVIII Oz.
Character Clear.
Reaction Slightly acid.
Albumen None.
Sugar None.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Had typhoid fever long ago. Never in hospital before
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies
Mother or Mat. Relations, Died 3 yrs ago } Rather ignorant concerning parents.
Father or Pat. Relations, Don't know
Brothers ~~or Sisters.~~ Don't know where - 4 sisters don't know where -
4 Children

Personal and Medical History of Frank Labarge.

1897

This patient was brought here by Sheriffs deputy, J.P. Hardiake, in good physical condition, with the following history - Nothing known as to consanguinity: For last four months patient has manifested symptoms of the disease - is thinking people wanted to rob his farm. Disease appears increasing, is variable with rational intervals. Derangement manifested by thinking people are about to injure him; thinks the Indians are after him to kill him - says his son was killed last night by Indians in St. Paul. Is not disposed to injure others, or to filthy or destructive habits: Nothing known as to previous peculiarities: No history of intemperance in parents or self: no severe disease or head injury: Has not been confined or restrained: No information concerning treatment. On personal examination no further particulars noted.

On admission put upon B[3] E. Q.4.16 Rpt. Complexion dark: Eyes brown: hair brown & gray: Skin good condition: Scratch on back of head: Small mole back of left ear. Is clean: behavior good: Talks rationally)

Jan 24 Nurses Notes (Summary) Patient received on ward on 21st: was quiet & well behaved: Given bath: Talked rationally - Was quiet until morning of 25th refused to go to dining room - had to be forced. Had hallucinations of hearing, imagines someone is calling him at night. Feb. 7 Became noisy & violent during night & night watch was obliged to call up one of day nurses to assist him. Appetite has been good, bowels regular, but has not slept well. Slight elevation of temperature during greater part of two weeks. Has taken no medicine.

Summary Nurses Notes by Dr. Phelps. Patient some times stubborn & ugly: imagines someone is watching him: Works on ward. Health good: Has hallucinations of hearing. Mch 1 Wt. 157 Is at times obstinate on account of delusions Apr. 1 Seems to be growing worse. Is, however, quite intelligent & does some work. May 1 Wt. 156[3] Is quiet: Has tried to elope several times: Is usually in fair health. Has some eczema. Has appearance of fair intelligence

Jan 7 '99 Patient remains about same in every way: Is said at times to to speak more freely of delusions of late & is noisy & nervous.

Feb 1900 - Jan 31 Feby 1 May 29 July 31 '99 (Dr. Wanamaker) Wt. 158[3] Very excitable: Easily disturbed: No change in general condition. Aug. Jan 31 1900. (Dr. Chapple) Physical condition good: Behavior fairly good. Is at times very noisy & excitable: Has delusions of persecution. Ordinary conversation rational: Habits tidy: Sits in room most of time. Does little work. Has a very suspicious manner. Feby 1 1900. Wt 167[3] Pulse 80 No change to note: has been in good health; quite well-behaved but of stubborn disposition. Converses quite well. At times, becomes somewhat excited & expresses ideas of a persecutory nature. Will not talk about certain business matters, as "he thinks authorities are trying to "do" him". Stays in his own room, most of time. "Thinks he is held here without cause." Works on ward.

Was, today, visited by a friend, who removed him from the Institution to Canada, with him.

— Discharged —

Personal and Medical History of

Personal and Medical History of Henry S. Stone

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4663

Residence, White Bear, Minn.

Date Admission, February 6' 1897.

Admitted by Dr. R. M. Phelps Hour, 6⁴⁵ P.M.

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

Sex, Male

Age, -59-

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, Farmer.

Degree Education, very good.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, Massachusetts.

Physicians Committing, J. C. Farmer & J. Chase.

Correspondents,

No. for Year, 197

Insane Relatives, Unknown

Cause Exciting, Senility.

Cause Predisposing, Not given.

Form, Paranoia

Accompanying Bodily Disorder, Sleeplessness.

Suicidal or Not, Not.

Date of this Attack, Several years ago - Came on gradually

Duration, Several years

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, -

Time of Leaving, October 11 - 1902

Time in Hospital, 5 Yrs 8 mos 5 ds

Result, Died: Carcinoma (last illness 3 wks)

EXAMINATION ON ADMISSION.

Exam. by Dr Herzog 2/8/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Clear

Quick or Sluggish, Quick.

MEMORY:

Past Events, Very good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Fairly good.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Somewhat.

Special Subjects,

Transitory or Not, Fixed.

HALLUCINATIONS: of hearing

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient is a New Englander with an extraordinary memory for unimportant dates & fond of airing his acquirements. Talks of the pedigree of various families like the new England villager of stories. Is very voluble & demonstrative. Says living in poor quarters on coming West 12 yrs. ago - is the cause of his trouble. Was in St Paul hospital 3 months 95-96, says no benefit. Hears voice say "Mr. Wilkinson" once every second. realizes it is hallucination. Thinks his nerves in his head move up & down causing variations in his hallucinations - knows they do not because he feels them. Thinks his nephew persecutes him & wants his property. Condition like senile paranoia.

Personal and Medical History of Henry S. Stone.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT,

NUTRITION, Good. Skin somewhat yellow

ALITIES, Undersloped helix of ear. - High arched narrow palate.

Coatings, Clean.

Promptness Movement, Prompt.

Size, Somewhat contracted

Accommodation, yes.

yes

yes

Arcus senilis

HEARING, Good

COORDINATION, Arms, Good.

Legs, Slight incoordination.

TREMORS, Hands, Slight

Facial Muscles, None.

Tongue, None

General, None

REFLEXES, Patellar, 9-10 equal.

Other Slight ankle clonus.

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries - quite stiff.

HEART, No murmurs noted. Sounds strong; eye somewhat enlarged: Impulse Apex beat downward & left.

LUNGS,

TAKEN,

EXAM. URINE, Feb. 12th 97 Dr Mc

Passed Feb. 12 '97 11 AM

Color Yellow

Sp. gr. 1024

Quan 24 hrs. 317

Character Clear

Reaction Acid

Albumen None

Sugar None.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, for 12 yrs past.	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Does not drink - smokes & chews some.

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

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

Mother or Mat. Relations, Cancer of breast.

Father or Pat. Relations,

Brothers or Sisters, one sister had cancer.

WILL IS INVALID.

Judge Bazille Sets Aside Documents in $8,000 Estate.

The will of the late Henry S. Stone of Bald Eagle, who died at the hospital for the insane at Rochester, Oct. 11, 1902, was declared invalid yesterday by Judge Bazille in the probate court after he had heard the objections of George E. Snell, a nephew, and Grace L. Carrier, a niece of the deceased.

Stone bequeathed his property to an old schoolmate, Joseph E. C. Farnham, in Providence, Rhode Island. The estate amounts to $8,000. The will was made in 1891 soon before Stone was sent to the hospital and his relatives set up the claim that the will was made while he was insane and under undue influence. The objectors want an administrator appointed to look after the division of the estate.

Farnham served notice that an appeal would be taken.

Personal and Medical History of Henry S. Stone

BRIGET, PIOLAR & CHANDLER, DAVENPORT, IOWA

Whole No. 4663

Residence, White Bear, Minn.

Date Admission, February 6' 1897.

Admitted by Dr. R. M. Phelps Hour, 6.45 PM.

How Sent, G. Millrick & of P. Ramsey Co..

Sex, Male

Age, -59-

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, Farmer.

Degree Education, very good.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, Massachusetts.

Physicians Committing, J.C. Farmer & J. Chase.

Correspondents,

No. for Year, 197.

Insane Relatives, Unknown

Cause Exciting, Senility.

Cause Predisposing, Not given.

Form, Paranoia

Accompanying Bodily Disorder, Sleeplessness.

Suicidal or Not, Not.

Date of this Attack, Several years ago - Came on gradually

Duration, Several years

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, -

Time of Leaving, October 11 - 1902

Time in Hospital, 5 Yrs 8 mos 5 days

Result, Died: Carcinoma (Constitutional Cause)

Chicago & Florida Limited
New equipment and more luxurious than ever. This year an exclusively Pull...
...Easter tour... ing by leaving... one o'clock this... —only thirty hr... Summer on the nor...

EXAMINATION ON ADMISSION.

Exam. by Dr Herzog 2/8/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Clear

Quick or Sluggish, Quick.

MEMORY:

Past Events, Very good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Fairly good.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not, Somewhat.

Special Subjects,

Transitory or Not, Fixed.

HALLUCINATIONS: of hearing

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient is a New Englander with an extraordinary memory for unimportant dates & fond of airing his acquirements. Talks of the pedigree of various families like the new England villager of stories. Is very voluble & demonstrative. Says living in poor quarters on coming West 12 yrs. ago - is the cause of his trouble. Was in St Paul Hospital 3 months 95-96, says no benefit. Hears voice say "Mr. Wilkinson" once every second. realizes it is hallucination. Thinks his nerves in his head move up & down causing variations in his hallucinations - knows they do not because he feels them. Thinks his nephew persecutes him & wants his property. Condition like senile paranoia.

Personal and Medical History of Henry S. Stone.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good. Skin somewhat yellow

WOUNDS OR ABNORMALITIES, Undeveloped helix of ear. - high arched narrow palate.

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

PUPILS, Equality, Yes Size, Somewhat contracted

Response Light, Yes Accommodation, Yes.

SIGHT, Fair - arcus senilis

HEARING, Good

COORDINATION, Arms, Good.

Legs, Slight incoordination.

TREMORS, Hands, Slight Tongue, None

Facial Muscles, None. General, None

REFLEXES, Patellar, 9-10 equal.

Other Slight ankle clonus.

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries - quite stiff.

HEART, No murmurs noted. Sounds strong: apex somewhat enlarged: beyond Apex Beat downward & left.

LUNGS,

EXAM. URINE, Feb. 12th 97 PM

Passed Feb. 12 '97 11 AM.

Color Yellow.

Sp. gr. 1024

Quan 24 hrs. 517.

Character Clear

Reaction Acid -

Albumen None -

Sugar None.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, for 12 yrs past.	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Does not drink - smokes & chews some.

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

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

Mother or Mat. Relations, Cancer of breast.

Father or Pat. Relations,

Brothers or Sisters, one sister had cancer.

Personal and Medical History of Henry S. Stone.

1897

This patient was brought here by sheriffs deputy P.E. McDonald in fair physical condition with the following history:- No history of consanguinity, This is first attack Patient has been confined in City Hospital St Paul, result of treatment, no improvement: First symptoms of attack manifested several years ago has increased in severity: Disease appears stationary: not variable + with no rational intervals: Derangement manifested by sleeplessness + a feeling of rising + falling of the brain: Is disposed to injure others: Is not suicidal, filthy or destructive: Previous peculiarity a very violent temper: No history of intemperance in parents or self: No severe disease or head injury, but an "epileptic tendency": Has not been confined or restrained + has received no treatment of late. On personal examination claims not to have slept for 12 years; cant sleep. On admission put on B³E. (Gen. Rpt. Complexion light. Hair gray: eyes brown: Condition of skin good: Is clean: behavior good)

Feb 1897 Nurses Notes (Summary) Patient received on ward at 7:30 PM. Feby 6 Talked a great deal + irrationally: Said he had slept none for a number of years: Has hallucinations of hearing: While talking would suddenly exclaim "Shut up" "Shut up- up-there" Refused to go to bed, was given Sleeping dose + put to bed: Slept 3 hrs. Feb. 17 Talks incessantly when ever he can find a listener: Can talk rationally on different subjects - seems to be a man of some education - Talks French + German: but behavior + continual stream of talk show that his mind is not right Feb 19 Has slept well every night except the first: Appetite has been good: Bowels regular: Does not think he is insane: Habits + dress neat + clean.

Summary Nurses Notes by Dr. Phelps March 97 Usually good-natured: Talks a good deal: Is irrational but at times answers questions fairly well. Appetite is voracious. March 30 Wt. 193 lbs. Has hallucinations. May 1 '97 Wt. 202 lbs. Talks rather rapidly + incoherently: is foolish in manner. Complains of a voice in his head. Jan 1 '98 Wt. 203 lbs. Complains very bitterly of noise in his head: Of late will frequently sit all day in on place: Is at present at ease: Very quiet + demented Jan 1 '99 No change.

Feb 1900 - July 31 '99. Wt. 217 lbs. Appetite good: General behavior quiet. Has hallucinations + delusions. Physical condition good. Aug 1 + Jan 31 1900 (Dr. Chapple) Wt. 223 lbs. Sept 11 - Visited by friends. Nov 22. Ear badly bruised by patient Mieman - Very little change during period: Health fairly good but is easily exhausted by exercise. While on ward sits in chair constantly tapping floor with feet. Says he hears voices in his head + that brain is moving. Behavior good. Is rather untidy: Does nothing. Feby 1 Wt. 229 lbs. Feby 21/22 Transferred to IW. (Became very much exhausted, while at walking; unable to stand). Feb 29. was May 15/19 transferred to Annex. Is as well as usual. May 18. Transferred to IW. May 19. Abscess on neck

Personal and Medical History of Henry S. Stone

1900

June 3 opened. June 3. Transferred to Annex: wound healed. July 20. Vaccinated. Result was negative.
July 20 / 31 No apparent change, mentally, or physically. Is very fat + unable to stand much exertion. Takes but little exercise: sits in one place on ward, most of time: never talks unless spoken to. Does not like to be disturbed: says "it bothers his head, which is constantly in motion" - Speaks very quietly. Untidy in habits: has a large appetite + eats very rapidly. Aug 1. Wt 220½ lbs. Sept 20. Transferred to D⁴. Jany 31/1901. No change. Very slovenly in habits: Stays in one place most of time: Has Constant hallucinations: Eats ravenously: will answer questions, but does not like to be disturbed. Wt 226 lbs. No change to note - Augt. Wt 218 lbs. - Nov. Wt 214 lbs. Jany 31/02 No change of importance: Sits in a corner all day long, never speaking to anyone unless addressed. Very slovenly. Complains of head, as usual. Troubled with frequent micturation, but otherwise in good health.

Aug 1/02 - 175 lbs. (Dr. Chapple) Has lost flesh of late + seems to be failing. Mentally remains as before. Sept. 20 To I W. One leg is much swollen + he is scarcely able to support himself upon it. Persists that there is nothing the matter with him - probably cancerous. Oct. 10/02 Has been gradually failing. To day was seized with severe attack of Diarrhoea. Oct 11 Died of Exhaustion at 2.05 P.M. Post mortem examination disclosed cancerous growth invading lymphatic nodes of groin + abdomen.

Personal and Medical History of J. W. Percy Mulholland

FOREST, FISHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4666

Residence, Olmsted County, Minn.

Date Admission, February 9th 1897.

Admitted by H H Herzog M.D. Hour, 11 Am.

How Sent, J.A. Leonard J. of P. Olmsted Co.

Sex, Male.

Age, 40.

Civil Condition, Married.

Children, one.

Age Youngest Child, –

Occupation, Clerk.

Degree Education, Toronto University.

Profession Religion, Yes Episcopalian.

Habits, Good.

Nativity, England.

Physicians Committing, Drs. J.G. Groves & C.T. Granger.

Correspondents, –

No. for Year, 199

Insane Relatives, None.

Cause Exciting, Overwork & insufficient exercise.

Cause Predisposing, Previous attack.

Form, melancholia acute

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, July. 1896.

Duration, Since July 1896.

No. of Attack, 2nd

No. of Admissions, 2nd

Age First Attack, about 33

Time of Leaving, Dec 11 — 1900

Time in Hospital, 3 years 10 mo 2 ds

Result, Recovered: Discfd Dec 11/1900 and remains as clinical-clerk

EXAMINATION ON ADMISSION.

Dr. P.M. Phelps 9/1/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Clear - not confused on general topics

Quick or Sluggish,

MEMORY:

Past Events, Good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert & correct - At least knows

Correct or Illusive, accurately his own perversion.

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State, Accurate

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not,

Special Subjects, } None were defined

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Has melancholia without delusions & a perversion by which he continually worries about every bit of dirt or lint about. Mind also rambles along on one topic - worries him tho he knows the lack of reason for it.

Patient was ~~Employed at~~ clinical clerk in the Hospital as worry & gave up work 8/1/96 - Later was committed - wished to be. Began gradually to

Personal and Medical History of J. W. Percy Mulholland.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ WEIGHT, 161½ NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Coatings, None. Promptness Movement, Prompt.

PUPILS, Equality, Equal Size,

Response Light, Accommodation,

SIGHT, Good

HEARING, As.

COORDINATION, Arms, Normal

Legs,

TREMORS, Hands, None Tongue, None

Facial Muscles, General,

REFLEXES, Patellar, Normal EXAM. URINE,

Other

ARTICULATION, Good.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY, Normal

HEART,

LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Has had Rheumatism quite severely. Some headaches. Does not drink or smoke

LENGTH OF INVASION, 6 mo. 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 J. W. Percy Mulholland.

1897

This patient was received at hands of Chas. N. Stewart Sheriff in fair physical condition: No history of consanguinity: First attack occurred in 1889 when patient was confined in this hospital & remained until fall of 1891 when he was discharged recovered: First symptoms of present attack manifested in July 1896 by worrying over unimportant objects: Disease appears increasing: not variable: no rational intervals: Is not disposed 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: Has been confined at this 2nd Minnesota Hospital: Has received hygienic treatment: On personal examination - picks up trivial objects & worries over their nature.

On admission put upon Infirmary East (G.H.A. Pt. Complexion dark: hair brown: Eyes brown: Condition of skin good: Name "Percy" Tattooed.

Feb. 9 Nurses Notes (Summary) Patient came on ward at 11.30 Am. Appears quite weak: was put to bed: Physical condition appears fairly good. Talks rationally in conversation: Skin in good condition: Behavior good:

Feb. 27 Quite restless & nervous at times: will stop in the middle of a conversation & ask irrational questions about small articles which he picks from the floor or bed: Can notice no delusions: Appetite is good: Bowels regular: Habits clean: Behavior good. Has been on medicine of different kinds: Massage given 3 x week. also electrical treatments 3 x week. Does not appear to be quite so weak & restless as on admission: Has been visited several times by friends.

Summary Nurses Notes by Dr. Phelps. Mch. Patient receiving massage: Very quiet during day: Has to be careful about diet, but genral bodily condition is about normal. Apr. During month patient received baths & massage treatment: Is usually rather quiet: Is very much disturbed by his own mental state as he realizes his condition. Complains of noise at night. May. No special change in patients physical or mental state: Lies in bed a good deal: Is quite melancholy altho he can answer questions accurately.

July 31 Wt 172# Manner in which he is troubled this time is the same as in the past. Worries about little things & doubts if things are right: picks up small objects & worries about them: Is quite melancholy. Nov 15 Trans. to A3. Talks quite freely at times: Some feebleness of mind noted, in general, however, there is very little change apparent. Aug 1st '98 Went out camping at Oronoco. Oct 22 '98 Return in St. Paul. Jan 1 '99 Not very much change noted during past year except that he is perhaps a little more cheerful in his ways. Feb 1 - July 31 '99 (Dr Mawson.) Wt. 167. Patient quiet, neat, but inclined to be melancholy. Has parole. Genral physical health good Aug 1 - 99 to Aug 1 1900. Patient quiet: Habits neat & cleanly: Appetite good: Has parole: goes rowing daily: Oct. Wt. 168# Dec 26 Went home on trial. May 21 1900 Returned to hospital. Quiet & generally cheerful.

Personal and Medical History of

1900

Physical condition good. July 7. Went to Camp at Oronoco. Remained there several weeks. Nov. 1 1900 Patient very well both mentally & physically -

Dec. 11 1900. Discharged to take up work as clinical clerk.

Discharged

Personal and Medical History of Patrick Cassidy

BEGLEY, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4667
Residence, Fairbault, Minn.
Date Admission, February 9th 1899.
Admitted by Dr. A. F. Kilbourne Hour, 3 P.M.
How Sent, R. A. Mott, J. of P. Rice Co.,
Sex, - male -
Age, - about 80 -
Civil Condition, - widower -
Children, - none -
Age Youngest Child, -
Occupation, Laborer
Degree Education, none.
Profession Religion, Yes - Catholic -
Habits, not intemperate.
Nativity, Ireland (Parents Ireland)
Physicians Committing, Drs. C. T. Wagner & J. D. Perley
Correspondents, none given in papers
Edward Haley Fairbault Minn.

No. for Year, 700
Insane Relatives, Not known
Cause Exciting, old age & environments
Cause Predisposing, Not given.
Form, Dementia senilis
Accompanying Bodily Disorder, None mentioned -
Suicidal or Not, Not.
Date of this Attack, About 2 months ago
Duration, About 2 months.
No. of Attack, 1st.
No. of Admissions, 1st
Age First Attack, About 80.
Time of Leaving, August 31 — 1902
Time in Hospital, 3 yrs 6 mo 22 ds
Result, Died; Catarrhal Enteritis — 4 ds

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog 2/10/99

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient is an old man: Has been living alone for past 3 months, for some time has received aid from city. While his wife was living had to care for her. Probably never was extremely bright. Says neighbors took false keys & entered his premises & took various articles. Senile.

4667
Copy of Notice of hearing petition for appointment of guardian for Patrick Cassidy served upon Dr. Kilbourne January 19 1900
Paper filed with Commitment Papers.

...ick Cassidy.

...N, CONTINUED.

...ISTICS.

NUTRITION, Fair.
Promptness Movement, Prompt.
...odation,
... Double Pterygium
HEARING, Impaired
COORDINATION, Arms, None impairment
Legs, "
TREMORS, Hands, None.
Facial Muscles, None
Tongue, Slight
General, on standing
REFLEXES, Patellar, 5 Equal.
EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs noted. Sounds weak.
LUNGS,
Large moist rales.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Smokes.
LENGTH OF INVASION, ONSET GRADUAL OR 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 Patrick Ca

HERBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4667
Residence, Fairbault, Minn.
Date Admission, February 9th 1897.
Admitted by Dr. A. F. Kilbourne. Hour, 3 P.M.
How Sent, R. A. Mott. J. of P. Rice Co.
Sex, - male -
Age, - about 80 -
Civil Condition, - widower -
Children, - none -
Age Youngest Child, -
Occupation, Laborer
Degree Education, none.
Profession Religion, yes - Catholic.
Habits, not intemperate.
Nativity, Ireland (Parents Ireland)
Physicians Committing, Drs. C. F. Wagner & J. A. Perley.
Correspondents, none given in papers
Edward Haley Fairbault, Minn.

No. for Year, 700
Insane Relatives, Not known
Cause Exciting, old age & exp
Cause Predisposing, Not given.
Form, Dementia senil
Accompanying Bodily Disorder, None mentioned -
Suicidal or Not, Not.
Date of this Attack, About 2 months ago
Duration, About 2 months.
No. of Attack, 1st.
No. of Admissions, 1st
Age First Attack, About 80.
Time of Leaving, August 31 — 1902
Time in Hospital, 5 yrs 6 mo 22 ds
Result, Died; Catarrhal Enteritis - Hyp.

EXAMINATION ON ADMISSION.

Exam. by Dr Herzog 2/10/97

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient is an old man: Has been living alone for past 3 months, for some time has received aid from city. While his wife was living had to care for her. Probably never was extremely bright. Says neighbors took false keys & entered his premises & took various articles. Senile.

Copy of Notice of hearing petition for appointment of Jeremiah Cassidy as Guardian of Patrick Cassidy filed October 20, 1898.

Patrick Cassidy.

ON, CONTINUED.

ISTICS.

NUTRITION, Fair.
Promptness Movement, Prompt.
odation,
Double pterygium
HEARING, Impaired
COORDINATION, Arms, None impairment
Legs, "
TREMORS, Hands, None.
Facial Muscles, None
REFLEXES, Patellar, 5 equal.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs noted
Sounds weak.
LUNGS,
Large moist rales.

Tongue, Slight
General, on standing
EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Smotes.
LENGTH OF INVASION, ONSET GRADUAL OR 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 Patrick [illegible]

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4667
Residence, Fairbault, Minn.
Date Admission, February 9th 1897.
Admitted by Dr. A. F. Kilbourne. Hour, 3 P.M.
How Sent, R. A. Mott, J. of P. Rice Co.,
Sex, - Male -
Age, - About 80 -
Civil Condition, - Widower -
Children, - None -
Age Youngest Child, -
Occupation, Laborer
Degree Education, None.
Profession Religion, Yes - Catholic -
Habits, not intemperate.
Nativity, Ireland (Parents Inland)
Physicians Committing, Drs. C. H. Wagner & J. D. Decley
Correspondents, none given in papers
Edward Haley Fairbault Minn.

No. for Year, 700
Insane Relatives, Not [illegible]
Cause Exciting, old age + [illegible]
Cause Predisposing, Not given
Form, Dementia senilis
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, About 2 months ago
Duration, About 2 months.
No. of Attack, 1st.
No. of Admissions, 1st
Age First Attack, About 80.
Time of Leaving, August 31 — 1902
Time in Hospital, 5 yrs 6 mo 22 ds
Result, Died: Catarrhal Enteritis - 4 ds.

EXAMINATION ON ADMISSION.

Exam. by Dr Herzog 2/10/97

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient is an old man: has been living alone for past 3 months, for some time has received aid from city. While his wife was living had to care for her. Probably never was extremely bright. Says neighbors took false keys & entered his premises & took various articles. Senile.

Personal and Medical History of Patrick Cassidy.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 Ft. 4 3/4 WEIGHT, 112 1/2 NUTRITION, Fair.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Grayish coat Promptness Movement, Prompt.
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT, Impaired Much - Double pterygium
HEARING, Impaired
COORDINATION, Arms, None impairment
Legs, "
TREMORS, Hands, None. Tongue, Slight
Facial Muscles, None General, on standing
REFLEXES, Patellar, 5 Equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs noted
Sounds weak.
LUNGS,
Large moist rales.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Smokes.
LENGTH OF INVASION, ONSET GRADUAL OR 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 Patrick Cassidy.

1897

This patient was brought here by Sheriffs deputy J.B Thompson, in a feeble condition with the following history: No history of consanguinity: This first attack came on about 2 months ago - is suspicious & accuses the neighbors of robbing him: Disease appears increasing: not variable: no rational intervals: Derangement manifested by ideas of persecution: Is not disposed to inspire others: Is not suicidal, filthy or destructive: No previous peculiarities shown: No severe disease or head injury: No history of intemperance in parents or self: Has not been confined or restrained: Has received no treatment: On personal examination [illegible] says he has been troubled by boys & hoodlums. Lost his wife about 2 months ago & lives alone & has broken down under the trouble. ——————

On admission put upon B³ E (Ost16. Rpt Complexion light: hair gray: Eyes blue: Hernia on right side: Is clean: behavior good.)

Feb 22 Physicians notes. Has shown no improvement since admission. Is senile, demented. Fairly tidy but wears hat in house. Stands about ward, seldom speaks unless spoken to. Drag & partially blind. Unable to keep up while out walking. Marked loss of memory for recent events. (HHS)

Summary Nurses Notes by Dr Phelps Mch 1 Patient appears about same as during preceding month: does not care to work on account of physical state: Habits fairly clean: Wt. 119 lbs. Apr 30 Trans. to A⁴: Is senile & feeble-minded, no special change in condition:

May 99 Wt. 114ᵗˢ Is quiet, rather senile in manner, eyesight & hearing rather poor: seems partially demented. July 6 98 Visited by brother Dec. 18 98 Transferred to infirmary on account of diarrhoea. Jan 1 99 Is lying quietly in bed: does not seem to be troubled very much, still homm, has some diarrhoea at times. Jan 31 99 At present up on ward & out walking: Behavior very quiet in every way Feb 1. July 31 99. (Dr. Wanous) Patients sight & hearing very poor: memory good Does no work. Has delusions. Thinks he is being burned with a torch. April 21 Refused dinner and supper Taken to dining room by force, broke several dishes. July 31 No change in patient either mentally or physically. Aug 23 Transferred to T.W., as he complains of being sick: no definite symptoms - Aug 30. Transfered to A⁴ Oct 1. Wt 112 lbs. Oct 31 appetite good: bowels regular: habits neat & clean. Is quite feeble & somewhat irritable: Has hallucinations also delusions of persecution. Dec 9. Caught foot in carpet and stumbled; afterwards Complained of pain in ankle: upon examination, nothing found, except slight swelling; bandaged and condition improved. Dec 16. Again transfed to T.W. Dec 27. Transferred to A⁴. Feb 1900. Patient is well-behaved. Is easily excited: Still has delusions of persecution. Apl 15. Fell on steps and bruised left hand. Apl 30. Complains of sore eyes. May 1 1900. Wt 121 lbs p 68. May 6. Complained of pain in right side; Gave liniment to rub on. July 1 1900. Wt 119 lbs - July 21. Patient vaccinated successfully -

1899 Jan 31 Feby 1 July 31 Aug 23 - 30 Oct 1/31 Dec 9 - 16/1900 Feby 1 Apl 15/30 May 6 July 10

Personal and Medical History of Patrick Cassidy

1901

Aug 30 Dec 1 1901 Jan 31 Feb 1/27 May 6 31 Apl 1 15/26 July 31 Aug 31 Nov 18 Dec 2 1902 Jan 31

Stubborn & has delusions of persecution: Eye-sight impaired: Oct 1. Wt 110ᵗˢ. P 72. Oct 30. Is quite feeble, from age. Dec 1 Refuses to retire; frequently must be put to bed. Jany 31/1901. Patient pretty: Still feeble & holds delusions. Feby 1. Wt 121ᵗˢ 176. seems very restless, at times. Is delusional - Also hard of hearing. Feby 27. Patient Coughs & expectorates: Seems very unsteady. Feby 28. Refused breakfast. T 100°. Refused medicine - March 1. Transfered to T.W: Given bath & put to bed. Mar 6. Patient has Diarrhoea - Stools Watery - Seems quite weak, physically - Mar 31. Patient seems much improved and is stronger & able to be around. Apl 1. Transferred to T.W - Put to bed, to rest. Apl 15 Given Clothes & got up - Apl 26. Transferred to A⁴. July 31. Patient is troubled with obstipation. seems somewhat stronger, of late. Augt 1/01. 112ᵗˢ. Aug 31. Was noted, during month as feeling somewhat: & also feeble: has aged appearance - Nov 1. Wt 119ᵗˢ. Nov 18. Noted as showing fallen down, quite frequently, from weakness. Dec 2. Still weaker. Transferred to T.W. and put to bed. Dec 17. Up and dressed. - Dec 31. During his whole Stay, no prominent Symptoms noted - Lying quietly in bed Jany 31/02 - Seemed to get along well on T.W. and, recently, was moved back to his old ward (A⁴). Feb 1/02 Wt. 115ᵗˢ; Apr. 1/02 Wt. 108ᵗˢ Apr. 21/02 Complains of being lame. Apr. 26/02 Still quite lame, one leg seems to bother him and he was today transfered to D.W. Temperature & pulse; condition about normal; Is very old and feeble; is very deaf & cannot see very well; May 1 Patient is still in bed, scolds & is irritable - Very weak. June 1/02 Wt. 107ᵗˢ Remains quietly in bed; coughs some at times. June 17/02 Seems somewhat stronger and was today gotten out of bed. July 12. Wt. 112ᵗˢ Still lame and unsteady His lameness mentioned was a very peculiar swaying of the foot and seemed to have no well understood cause. Aug. 27. Has been particularly untidy and dull. Today seemed unable to stand alone and was put to bed. In P.M. temperature went up to 102°. Seemed to have abdominal pains. Aug. 31, Died at 4 P.M. Had been troubled somewhat with Dysentery and with slight rises of temperature.

Personal and Medical History of J. C. Brennan.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4670

Residence, 287 Grove St. St Paul, Minn.

Date Admission, February 10th 1897.

Admitted by Le Eby M.D. Hour, 6th P.M.

How Sent, Sheriff Millrich Co. of P. Ramsey Co.

Sex, Male.

Age, 47.

Civil Condition, Married.

Children, 2.

Age Youngest Child, -

Occupation, Ry yard master.

Degree Education, Common school.

Profession Religion, Not a church member.

Habits, Drinks some.

Nativity, Newyork (Parents Ireland)

Physicians Committing, H. J. O'Brien - B. F. Paxton.

Correspondents, None given in papers.

No. for Year, 207

Insane Relatives, None.

Cause Exciting, Progressive paresis

Cause Predisposing, Not stated.

Form, Dementia paralytic

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Over a year ago.

Duration, Over one year

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 47.

Time of Leaving, June 13. 1898

Time in Hospital, 1 yr 4 mo. 3d

Result, Died General Paresis

EXAMINATION ON ADMISSION.

Exam by Dr Herzog 2/11/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Fairly clear.

Quick or Sluggish, Somewhat sluggish

MEMORY:

Past Events, Somewhat impaired

Recent Events, More marked impairment.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Fairly correct.

REASONING POWER:

Ordinary Subjects, Slow.

Own Mental State, Realizes something wrong

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Previous mental state fairly intelligent - General paresis 1st stage. No history of syphilis obtainable - Dementia slight. Incoordination considerable. Facial expression fairly typical. Feeling of him-self rather than any definite delusions.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Slightly

Depressed,

DELUSIONS:

Systematized or Not, None noted.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, Fairly voluble

Be it Enacted by the Senate and House of Representatives of the United States

Specimen of handwriting of J. C. Brennan 2/11/97.

Personal and Medical History of J. C. Brennan.

TION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 155 NUTRITION, Fair

ight Coatings, White coat over entire dorsum Promptness Movement,

w Size, Irregular outline

Accommodation, Excessive

Tongue, Coarse + fine

General, None.

EXAM. URINE, Feb. 12 '97 3 P.M.

Passed Feb. 12th 11 A.M.

Color yellow.

Sp. gr. 1025

Quan. 24 hrs. 77 Z.

Character Clear.

Reaction Slightly acid.

Albumen None

Sugar None.

TAKEN,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs noted. 2nd aortic somewhat sharp. Bounds mak. rapid on standing - Circulation not very good.

LUNGS, Chest sym. good.

Some Bronchitis.

Arteries pulse slightly harder + firmer than 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, September '95 noticed "giving way of right limb" says temporary paralysis - Attack here up to 7 mo. ago.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Post position Dec. 26 last.

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters, lost 1st child at 1 week; 2nd + 3rd living 4th child died at 1 month 5th a miscarriage.

Personal and Medical History of J. C. Bre

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4674

Residence, 287 Grove St. St Paul, Minn.

Date Admission, February 10th 1897.

Admitted by LeBoy M.D. Hour, 6:45 P.M.

How Sent, G. Willich Dep. Sh. Ramsey Co.

Sex, Male.

Age, 47.

Civil Condition, Married.

Children, 2.

Age Youngest Child, -

Occupation, Ry yard master.

Degree Education, Common school.

Profession Religion, Not a church member.

Habits, Drinks some.

Nativity, Newfoundland (Parents Ireland)

Physicians Committing, H. J. O'Brien + B. F. Paxton.

Correspondents, None given in papers.

No. for Year, 207

Insane Relatives,

Cause Exciting,

Cause Predisposi

Form,

Accompany

Suicidal

Date

Du

T

Time in Ho

Result, Dis Recovered.

EXAMINATION ON ADMISSION.

Exam by Dr Herzog 2/11/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Fairly clear.

Quick or Sluggish, Somewhat sluggish

MEMORY:

Past Events, Somewhat impaired

Recent Events, More marked impairment.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Fairly correct.

REASONING POWER:

Ordinary Subjects, Slow.

Own Mental State, Realizes something wrong

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Previous mental state fairly intelligent - Grimal facies 1st stage. No history of syphilis obtainable. Dementia slight. Incoordination considerable. Facial expression fairly typical. Feeling of loss etc rather than any definite delusions.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Slightly

Depressed,

DELUSIONS:

Systematized or Not, None noted.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, Fairly voluble

Personal and Medical History of J. C. Brennan

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, 155 NUTRITION, Fair

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Large protrudes straight Coatings, White coat over entire dorsum Promptness Movement,

PUPILS, Equality, left slightly larger Size, irregular outline.

Response Light, Excessive Accommodation, Excessive

SIGHT, Says good.

HEARING, "

COORDINATION, Arms, Impaired

Legs, "

TREMORS, Hands, Slight Tongue, Coarse + fine

Facial Muscles, Slight about lips General, None.

REFLEXES, Patellar, 9 - 10

Other

ARTICULATION,

Slurred, yes

Hesitating, yes.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs noted. 2nd aortic somewhat sharp. Bounds max. rapid on standing - Circulation not very good.

LUNGS, Chest sym. good.

Bone bronchitis.

Arteries pulse slightly harder + firmer than normal.

OPHTHALMOSCOPIC EXAM.,

EXAM. URINE, Feb. 12/97 3 P.M.

Passed Feb. 12th 11 A.M.

Color yellow.

Sp. gr. 1025

Quan 24 hrs. 77 Oz.

Character Clear.

Reaction Slightly acid.

Albumen None

Sugar None.

TAKEN,

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

CRANIAL MEASUREMENTS,

HISTORICAL, September '95 noticed "giving way of right limb" says temporary paralysis. Drank born up to 7 mo. ago.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Lost position Dec. 26 last.

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters, lost 1st child at 1 week; 2nd + 3rd living 4th child died at 1 month 5th a miscarriage.

Personal and Medical History of J. C. Brennan.

1897

This patient was brought here by Deputy Sheriff Geo L Rochet in fair physical condition, with the following history: No history of consanguinity: First symptoms of attack manifested over a year ago: disease appears increasing: not variable no rational intervals: Manifests no delusions: Is not disposed to injure others: Is not filthy or destructive: No previous peculiarities: Injury to head or severe disease: Has not been restrained or confined: Received treatment from Dr Charles Greene St. Paul. On personal Examination:- history of defect in memory, hesitation in speech, defects in writing and spelling, great irritability of temper, loss of power in legs, lack of judgment in estimating events & values. On admission put on B[3] E (Gate. Rept. Complexion light: hair gray: eyes blue: Condition of skin good: Anchor tattooed on right arm. Is clean: behavior good.)

Feb 23 Physicians Note: Practically no change since admission. General paretic, no marked delusions, feeling of brain-storm, considerable incoordination of legs, some of hands, more marked in his handwriting. Has not been able to take exercise partly because of incoordination of legs, partly because of an inflamed sore. No treatment except occasional cathartics.

Summary Nurses Notes. Feb 26 General Paretic: Habits & dress neat & clean: Voice tremulous & unsteady: Unsteady on feet: Appetite good: Bowels regular: Sleeps well. Walk & Out for walk, seemed to have great difficulty in keeping erect. Bowels regular of late: Sleeps well. Wt. 159½ lbs. Pulse 90. Feb 27 More unsteady of late: Apr 1 Has rheumatism: Wt. 165 P. 72. May 1 Unable to dress without assistance is stiff in shoulders: Speech more tangled & unintelligable. Is on regular diet: Appetite good: Bowels regular: June 1 Wt. 169# Is declining quite rapidly: Talks irrationally & Writes confused letters. June 20th Attempted to elope July 1 Wt. 162 P. 116. Patient has a mania for stealing everything he can lay his hands on. Nurse found 3 handkerchiefs & 15 Neckties in his pockets: Writes obscene letters to wife & friends. Has a voracious appetite. Seems to be declining physically.

Aug 1 Summary Notes by Dr Herzog. Incoordination & other paretic symptoms becoming more marked: Dementia more marked: Has discontinued writing letters to wife & friends: Continually tries to escape, but shows very little ingenuity in his attempts - hides behind doors & in stairways going to & from meals &c & is never successful: Has acquired the habit of hoarding articles of no value & will steal small articles from other patients. Sept 1 Attempted to escape: Appetite voracious. Sept 8 Trans to B[3]. Oct 27 98 Is growing more demented & not bed for first time. Oct 16 Struck in face with spoon by patient Thos Brennan witness Wm. Brown. Nov. 1 Becoming more unsteady in walk: Has to be led. Loss of memory more marked: Kleptomaniac habit still Nov 6 Refused breakfast, Is stupid & unable to help himself or dress himself: Has little use of left arm: Apparently had apoplectic seizure during night. Trans. to Infirmary

Personal and Medical History of

1897

Temp 96. Convulsive tremors of left arm & leg: Is in semi comatose condition. Hot sand bags applied Temp. 101½. Nov 7 Temp. 101 P. 120. in Aw. In Bx. Temp 102[4] P. 128. Liquid diet. one convulsion during day. & 2 during night: Vomited twice, slept some.

Nov. 8 Liquid diet. 8 oz. milk & 8 oz. malted milk alternately every two hrs. Temp. 101[6]-101[8]. Stupid: Does not realize anything. Nov 9 Temp. & diet about same: Enema of salts, glycerine, turpentine & castor oil given: Very stupid & restless: 2 convulsions during day. Nov 10 Still in a semi comatose condition - No convulsions. Nov. 11 Temp. has returned to normal: Visited by wife & daughter: Bowels constipated: Sleeps little 1-2 hrs. a night - Dr Nov 17 Visited by Father Riordan: Still stupid & confused: & occasionally restless: Bowels constipated & require to be moved by enema:

Nov 23 Solid diet resumed, meats ordered cut fine. Sleeps somewhat better: Is slovenly - more quiet - Temp normal. Nov 27-30 Is restless; frequently out of bed: Inclined to be destructive of bedding. Asks for his clothes. Dec 1 Wt. 105[#] Still in bed: On regular diet: Bowels constipated, requires enema: Is stupid: confused Temp. normal. Appetite good. Habits filthy. During month gained in strength. Difficult to keep in bed: Temp. about normal: Bowels constipated: Sleeps some nights - on others rotates well up & out of bed frequently - Carries off everything he can get hold of & hides same in his room.

Jan 98 Wt. 140½ lbs. Very filthy in habits: Remained about during month: Rather more inclined to be restless & out of bed during night. Feb 26 Had apoplectic attack: Very stupid: urine scant. Bowels moved by enema: on liquid diet. Has to be coaxed to take nourishment. Mch 13 Temp. 103 - P. 114. Jan 14 Temp. 103-102. Mch 1 Stupid & badly confused: Picks bedding: Temp. again down: Very filthy in habits. On liquid diet - Up to 16th Temp. remained sub-normal. Mch 15 Still on liquid diet: Bed-sores forming on heels:

Mch 15 to End of month Temp. as a rule normal: Bedsores improving slightly: on solid food Still stupid & confused: Apr 15 Remains about same: still demented but gaining in strength. Apr 26 Gotten up: Filthy in habits: Confused, demented, Careless in appearance.

May. Remained about same up to 26th became more excited in evening. Pulling button off clothes more than usual. 27th Put to bed. Visited by Father Riordan. Refused to take No nourishment. 29th Right side partly paralyzed. Temp. 103[2]-103[5]. Took 3 glasses milk during day. 30th Took no nourishment. 31st Cannot talk. Took 4 glasses milk: Bowels constipated. June 1 Took 8 glasses milk: No control over right side: Does not realize surroundings: Unable to speak. June 12 More stupid: Took 3 glasses milk during day. Temp A.M. 99. P. 106. P.M. T. 105 P. 120. Rise of temperature due to hypostatic pneumonia.

June 15 Temp. 104[8]-106[5]. Pulseless in evening. Gradually failed & died. Cause of death exhaustion in General Paresis.

Died.

Personal and Medical History of Erbrik (or Engbret) Sander.

BERGET, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4695
Residence, Newry Minn.
Date Admission, February 11th 1897.
Admitted by Dr. P.M. Phelps Hour, 6 45 P.M.
How Sent, Herman Blackmer Jopt. Freeborn Co.
Sex, Male.
Age, 38.
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Farmer
Degree Education, Fair.
Profession Religion, Lutheran
Habits, Not intemperate.
Nativity, Norway.
Physicians Committing, P. A. Blackmer & G.W. Bauck.
Correspondents, Peter Sander, Blooming Prairie Minn (brother)

No. for Year, 208
Insane Relatives, None.
Cause Exciting, Not known
Cause Predisposing, Not known.
Form, Melancholia acute inclined toward stuporous
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not.
Date of this Attack, About 3 months ago.
Duration, 3 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 38.
Time of Leaving, Apr. 26. 1900
Time in Hospital,
Result, Transferred to Hastings

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam by Dr. Herzog 2/12/97

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Seems fair
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Correct
REASONING POWER:
Ordinary Subjects, Slow
Own Mental State, Realizes something is wrong
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS:
Systematized or Not, No.
Special Subjects, of sin.
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patients previous mental grade probably average of lower class Scandinavian. Has disordered digestion, exaggerated reflexes, masturbator. Thinks his bad habits are extremely sinful. Says that at times he is worse. Speaks no English. Says he has been "nervous" & sleep poor during past 3 months. Melancholia acute - inclined toward stuporous.

Personal and Medical History of Erbrik Sander.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8½ WEIGHT, — NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, Condition of skin greasy & has acne.
TONGUE, Tremors, — Coatings, White coat. fair breath Promptness Movement, Slow
PUPILS, Equality, Yes Size, Normal
Response Light, Excessive Accommodation, Excessive
SIGHT, Seems good
HEARING, "
COORDINATION, Arms, Slightly impaired
Legs, "
TREMORS, Hands, None Tongue, Quite marked
Facial Muscles, None General, None.
REFLEXES, Patellar, 10 Equal
Other
ARTICULATION,
Slurred,
Hesitating, Yes.
FACIAL EXPRESSION,

TAKEN,

SENSIBILITY,

HEART, No murmurs. Sounds weak. Rapid - slightly irregular.
LUNGS,

EXAM. URINE, Exam. Feb. 12 '97 3 P.M.
Passed Feb. 12th 11 A.M.
Color Reddish yellow
Character Cloudy.
Quan. 24 hrs XXXVI ℥
Reaction Acid.
Sp. Gr 1031.
Albumen by Heat + Nitric Acid
Sugar None.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Moderate drinker + smoker.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, No history obtainable.
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Emrick Sander.

1897

This patient was brought here by Sheriffs deputy W. C. Mitchell attended by Peter Sander in fair physical condition, with the following history:- No history of consanguinity: First symptoms of attack manifested three months ago; talked irrationally: Disease appears stationary; is variable. Derangement manifested on no particular subject: Patient not disposed to injure others: not filthy or destructive: No previous peculiarities, severe disease or injury to head: No history of intemperance in parents or self: Has been watched to keep him from straying away & has been given patent medicines. On personal examination pulse 110: Temperature 99. but do not know what ails the man.
On admission put upon B³ W. (G.S.H. Rpt. Complexion & hair light: eyes gray: Condition skin good: Is clean: behavior good)

Feby 9 Physicians note. On admission patient was a stuporous melancholiac. Skin greasy with some acne. Had a slight rise of temperature which disappeared after cathartic. Bowels are still inclined to be costive. A mixture of mag. sulph. Acid Nitr. Dil. & Tr. Nux Vom. was prescribed but patient refused same after a few doses. Brother states that patient was all right & as bright as anyone up to 3 months ago but possibly Leap may overrate his abilities. Patient has shown some improvement since admission. Skin is clearer, sleep & appetite much improved, facial expression brighter, nutrition improved. Speaks a little but does not volunteer anything. Has not yet done any work.
On 14th day commenced course of central galvanism.
Summary Nurses Notes by Dr. Phelps. Patient during month of February rather despondent. received electrical treatment & massage. Seems to have improved a little. Apr 30 Patients condition varies somewhat as he is brighter at some times than at others. Is very stupid & confused in mental state at times; acts as if in a dream. hesitates when spoken to as if it were an effort for him to answer. May 1'98 Wt. 148#
July 30 In fairly good health: Tries to get away frequently: Is rather sluggish & peculiar in behavior. Jan 31'98 Looks a little brighter during December, but is again very stupid. Tries frequently to elope. Jan 31'99 Now at annex Visited on Second by Sister, is very dull & quiet Feb 1 - July 31'99 (Dr Wamons) Wt. 146#
March 15. Commenced working in Kitchen. June 10 Visited by brother. General condition good: Is demented. Aug. Jan 31'1900 (Dr Chapple) Wt. 146# No change during period either mentally or physically: Habits cleanly: Health & behavior good. Is quite demented: silly in manner: Works in Kitchen: Is
Apr. 26'1900 Trans. to Hastings Asylum. no change in condition,

Personal and Medical History of

Personal and Medical History of James Mc Andrews.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4676
Residence, Fountain, Minn.
Date Admission, February 12th 1897.
Admitted by Dr. D. L. Phelps Hour, 3 P.M.
How Sent, Ex. Farrington, J. of P. Fillmore Co.
Sex, - Male -
Age, - 60 -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, Farm Laborer.
Degree Education, None.
Profession Religion, - Catholic -
Habits, Not intemperate.
Nativity, - Ireland -
Physicians Committing, J.S. Phillips + Geo. A. Low.
Correspondents, Patrick Gillespie (nephew) Fountain. Fillmore Co. Minn.

No. for Year, 209
Insane Relatives, None.
Cause Exciting, Not known.
Cause Predisposing, Not known.
Form, Senile Melancholia
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not. Fears
Date of this Attack, 2 months ago.
Duration, 2 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 60
Time of Leaving, Aug. 3. 1899
Time in Hospital, 2 yrs. 5 m. 21 d.
Result, Died. Tuberculosis Pulmonalis.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by Dr. Herzog 2/13/97

MENTAL ACTIVITY:
Clear or Confused, Somewhat confused.
Quick or Sluggish, Sluggish

MEMORY:
Past Events, Slightly impaired.
Recent Events, More marked impairment.
Special Subjects,

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

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

GENERAL DESCRIPTIVE REMARKS: Senile melancholia - fear of suicide - Liver dullness increased abdominal veins enlarged + tortuous. suggesting cirrhosis of liver - Has lost in flesh - Complains of pain in bladder region extending into pelvis. Says has no relation to micturition - Probably was never of very high mental grade

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

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

HALLUCINATIONS:

ILLUSIONS:

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

Personal and Medical History of James Mc Andrews.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 9½ WEIGHT, Usually 140 NUTRITION, Poor.
WOUNDS OR ABNORMALITIES, Length of ears. Asymmetry of ears. Lobules long + deformed. Skin connective tissue
TONGUE, Tremors, Coatings, Whitish Promptness Movement, deviates to right.
PUPILS, Equality, Yes Size, Normal
Response Light, Slow Accommodation, Slow.
SIGHT, Impaired
HEARING, "
COORDINATION, Arms, Some impairment
Legs, "
TREMORS, Hands, Slight Tongue, None
Facial Muscles, None General, On standing
REFLEXES, Patellar, 2 Equal EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating, Yes.
FACIAL EXPRESSION,

SENSIBILITY,
Arteries - Marked atheroma
HEART, 1st Mitral Roned Sough. 2nd
Pulmonic Roned Clicking - Rapid + irregular
LUNGS, Chest symmetry normal
Expansion 1½ in Circum 32½ in.
Breath Sounds -
Left apex slightly consolidated
OPHTHALMOSCOPIC EXAM.,

TAKEN,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Says digestion has been disordered for years. Was at St. Marys 6 days in June 1896 Headaches + vertigo - Drinks + smokes some.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, No history obtainable
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of James Mc Andrews

1897

This patient was brought here by Sheriff's Deputy Patrick Gillespie 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 2 months ago, became melancholy & despondent, fearful that he might take his own life or injure someone else: Disease appears increasing: Variable with rational intervals: Patient fears that in his despondency he may commit suicide or destroy someone else. Lately he has had delusions in regard to evil spirits: Is not filthy or destructive: No previous peculiarities shown: No history of intemperance in parents or self: No severe disease or head injury: Has not been confined or restrained: Has received no treatment for present trouble: Was at St Marys for some disease of stomach. On personal examination put upon is my melancholy & despondent: Fears that he may commit suicide: Has delusions in regard to evil spirits: On admission put upon B³ E (1 Khk Rpt Complexion light: hair gray: eyes blue: wart on right side of nose: scar on lower side of jaw: Is clean: Small black mark on right side surrounded by several small scars: Behavior good.)

Feby 12 Nurses Notes (Summary) Patient came on ward at 4 PM. Given bath: Talks but little: Not capable of making himself understood: Ate but little supper. Given 2 C. pills. Feby 13 Slept but little last night: Appetite light Bowels constipated Walks aimlessly about ward: Given salts Feby 14 Refuses medicine today: Visited by relatives: Feby 15 Thinks that he is going to die. Despondent: Out for a walk this PM. Feby 16 No change Feby 19 Still despondent & depressed. Appetite light. bowels constipated: Refuses medicine. Trans. to Infirmary 11¹⁵ A.M. Put to bed. Talks irrationally: Put on liquid diet. Feby 20 Requires some force to make patient take medicine: Is given liquids between meals. Asks for poison. Does not appear to know where he is. " 22 Medicine given in milk instead of water: No change in patients. " 24 Visited by a friend: Expectorates some: Bowels constipated, moved by enema only. Groans at times as if in severe pain but says that he feels good. Feb. 25 Patient very restless last night. out of bed often. Complains none: Still on liquid diet: Bowels: Constipated: Physical condition appears poor. Mental state weak: Talks irrationally & incoherently. Quiet most of time during day.

March to Apr 30 Summary Notes by Dr Phelps Apr 30 Patient had to be urged to eat during march & April but seems to have gained somewhat physically: Is troubled much by constipation: Fairly clean in habits: Rather careless & untidy in appearance: Is hesitating & suspicious. Appears No special sickness noted: Always asks if he may go home. May 1 '97 Wt. 110.# Will answer some questions hesitatingly but will not talk much. Goes out walking: June 2 Visited by friends. Oct 2 Wt 108.# No special change in condition. Apr 27 '98 Trans. to Infirmary. Wt. 107 # Seems

Personal and Medical History of

to be failing: Temp. at times subnormal. Lies quietly in bed. May 2 '98 Temp. slightly subnormal: In bed & being fed mechanically. June 2 Wt. 96.# Still in bed. July 2 Wt. 117.# Again up & about: Has to be pushed about: Is very stupid July 4 '98 Trans. to A.[illegible] July 8: Visited by relatives - Jan 1 '99 No special change since last note. Feb 1-99- July 31 '99. (Dr. Wanous) Feb 1 - Wt. 109.# May 1 - Appears to be in a gradual decline. Appetite poor. May 11 Trans. to Infirmary & put to bed. At times stubborn & refuses medicine. June 5 Visited by priest. June 20 Visited by wife & daughter. Continues to refuse medicine: Grows gradually weaker. July 8 given clothes & allowed to sit up. July 25 Appetite very poor: Drinks milk. Aug 1. In stupor - Died August 3rd at 12;10.

Condition of body- Small bruise on hip also a few on face - old scars on face & left side of abdomen. Sore on nose: Teeth in fair condition

Died

Personal and Medical History of Charles D. Walker

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

For the 4697 see fol 225

Whole No. 4698

Residence, Olmsted Co., Minn.

Date Admission, February 13th 1897.

Admitted by Dr. R. M. Phelps Hour,

How Sent, J. A. Leonard J. of P. Olmsted Co.

Sex, male.

Age, 16.

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, None.

Degree Education, Common School.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, Olmsted Co. Minn. (Parents New York.

Physicians Committing, J. G. Cross & C. P. Granger

Correspondents,

No. for Year, 211

Insane Relatives, None.

Cause Exciting, Not known

Cause Predisposing, Not known.

Form, imbecile

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, About 2 yrs. Ago.

Duration, 2 yrs

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 14 yrs.

Time of Leaving, Jan. 25. 1898

Time in Hospital, 11 m. 12 d.

Result, Discharged Aug. 10 '98 Unimproved.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by Dr Hargy Feb 13/97

MENTAL ACTIVITY:

Clear or Confused, Clear

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Fairly good

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dull

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Somewhat slow

Own Mental State, Fair

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient is an overgrown boy, was somewhat backward in school. Is fairly good looking but careless about dress. Slow in his movements - seems confused - large head. Is probably better behaved here than at home. On day of admission was in a room with cot of making purposeless motions. No such behavior noted since. - Mother says noticed deformities since Typs of age.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, No.

Special Subjects, Says vaguely about killing the devil

Transitory or Not, Conceals his delusions at present.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, Reticent - Poor of attention impaired

Personal and Medical History of Charles D. Walker.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 9 WEIGHT, 137½ lbs. NUTRITION, Fairly good.

WOUNDS OR ABNORMALITIES, Slight Darwin tubercle both ears. Skin small. Skin somewhat greasy.

TONGUE, Tremors, papillae prominent Coatings, Grayish coat Promptness Movement,

PUPILS, Equality, Equal. Size, Normal

Response Light, Yes Accommodation, Yes.

SIGHT, — Has habit of contracting muscles about eyes as if myopic

HEARING, Good.

COORDINATION, Arms, Fair

Legs, "

TREMORS, Hands, None Tongue, Slight

Facial Muscles, None General, None.

REFLEXES, Patellar, 6 equal. EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating, Slow.

FACIAL EXPRESSION,

TAKEN, 1897

SENSIBILITY,

HEART, 1st mitral sound loud & harsh. 2nd faint. Mitral sound Clicking. impulse forcible & diffused - area of superficial dullness increased. Rate irritable & easily changed.

LUNGS,

Chest symmetry somewhat flattened Expansion 2 in. Excursion 3 in.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Says has unilateral Headaches.

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

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

Mother or Mat. Relations,

Father or Pat. Relations, Some obscure trouble; says is sick every winter

Brothers or Sisters, One brother dead - had night terrors.

Personal and Medical History of Charles D. Walker

1897

This patient was brought here by Sheriff Stewart attended by mother, 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 2 years ago, by excitement at night; noisy & destructive: Disease seems increasing: not variable: No rational intervals: Derangement manifested by delusions of prosecution: Is disposed to injure others: is not filthy or destructive: Previous peculiarity Worrying over his delusion; desire at times to kill the evil one: No severe disease or head injury: Has not been confined or restrained: Has received no treatment: On personal examination has delusions: Does not answer questions readily. On admission put upon B & E. (C. H. N. Rpt Complexion light: hair dark: eyes brown: Condition of skin good: Is clean: Behavior good.)

Feb 26 Physicians note. Patient has shown practically no improvement since admission. At first he was somewhat awed by his new surroundings & did not show all his unnecessary movements. Later resumed his "fighting the devil". Patient is a boy, large for his age, with a small head & weak chin. He is inclined to be careless about his dress, his gait is unnatural & he hangs his head, rarely being seen standing firmly erect. Seems to be defective.

Feb 28 Summary Nurses Notes by Dr Phelps. Talks in a foolish way: Seems quite feeble-minded: Habits neat & clean: Sits listlessly about. Wt. 140.

Mch 15 Seems to be becoming even more stupid & foolish Apr 1 Talks somewhat more than he did, laughs at his own speeches. Apr. 13 Went home today; about the same in every way.

June 8 '97 Rptd. Stands in a dull, feeble minded, imbecile way. Swaying back & forth most of day. July 20 25-28. Visited by father & brother Aug. Very stupid Has to be pushed along to go to meals & bed. Oct. 7 Wt. 138 - No special

1898 improvement. Jan 25 '98 Went home with parents, no special improvement noted. Very dull rather quiet in manner - Very feeble minded.

Discharged.

Personal and Medical History of

Personal and Medical History of David E. Washburn

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

For #4678 see Pob. 221

Whole No. 4677

Residence, 2641 Pillsbury Ave., Minneapolis, Minn.

Date Admission, February 12th 1897

Admitted by Dr. R.M. Phelps Hour, 4 P.M.

How Sent, P.M. Harvey J. of P. Hennepin Co.

Sex, Male.

Age, 18 yrs.

Civil Condition, Single

Children, -

Age Youngest Child, -

Occupation, None

Degree Education, Common school.

Profession Religion, Not a church member

Habits, Not intemperate.

Nativity, New-york (Father Ny. Mother Eng.)

Physicians Committing, Geo. C. Barton & W.A. Hale MD.

Correspondents, A.B. Washburn 2641 Pillsbury Ave Minneapolis
Dr. Chas. E. Booth 605 Wright Blk. Minneapolis, Minn.

No. for Year, 210

Insane Relatives, None.

Cause Exciting, Epilepsy

Cause Predisposing, Previous attack.

Form, Somnatic Epileptic

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, November 1896.

Duration, 3 mos.

No. of Attack, Several.

No. of Admissions, 4th At Yankton. School for Feeble Minded at Faribault & at St. Peter.

Age First Attack, 9 yrs.

Time of Leaving, Jan. 22 1901.

Time in Hospital, 3 yrs. 11 mos, 10 days.

Result, Died. In States Epileptic.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam 2/13/96 by Dr Herzog

MENTAL ACTIVITY:

Clear or Confused, Fairly clear-

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Somewhat impaired

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Slow

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS: None noted

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Fairly coherent

Voluble or Reticent, Voluble

GENERAL DESCRIPTIVE REMARKS: Patient is a defective epileptic, facial expression dull & heavy thick lips Acromegalous cast of countenance: Says has not had a fit for 3 weeks. Had them mostly at night. If awake has an aura "feels something slowly rising from the stomach" Can find no marks on head as from fall in childhood. Patient very slow in all his movements.

ON, CONTINUED.

RISTICS.

NUTRITION, Good

eloped. Antihelix prominent

Promptness Movement, Prompt.

normal.

mmodation, Slow

ut squint.

gue, Done

eral, None

EXAM. URINE,

Careless,

Irregular,

Poor,

Irregular,

Temp.,

s - Done also

AL OR SUDDEN,

briety,")

In case it is necessary to telephone regarding David Washburn. Call up Mr. Craig- Undertaker - Telephone No. 795 J South - Minneapolis

E. Washburn (11/13/97)

Nov. 1.

Rochester Insane Asylum

Mr. Dr. Kilbourn Sup. of Rochester Asylum, I, David E. Washburn while in the bay up on the hall of C. 1. - while walking once or twice back in the bay. Mr. John Aye head nurse of this hall said sit down David and just because I said no to him he walked up behind me with tow or 3 other nurses and then I sit down on the floor and then tow of them took me by the colr and jerked me up on the bench and put my hands way up on my back and I sit these for about one minute or so and then John Aye said put him on the floor and when they jerked me up to put me on the floor, I got my hands away and held them around my chin and they tryed to X get my hands free

over

Personal and Medical History of David E. Washburn

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

For H678 see Vol. 201

Whole No. 4697

Residence, 2641 Pillsbury Ave., Minneapolis, Minn.

Date Admission, February 12th 1897

Admitted by Dr. R.M. Phelps Hour, 4 P.M.

How Sent, P.M. Harvey J. of P. Hennepin Co.

Sex, Male.

Age, 18 yrs.

Civil Condition, Single

Children, -

Age Youngest Child, -

Occupation, None

Degree Education, Common school.

Profession Religion, Not a church member

Habits, Not intemperate.

Nativity, New-York (Father Ny. Mother Eng.)

Physicians Committing, Geo. C. Barton & W.A. Hale MDS.

Correspondents, A.B. Washburn 2641 Pillsbury ave. Minneapolis

Dr. Chas. E. Booth 605 Wright Blk. Minneapolis Minn.

No. for Year, 210

Insane Relatives, None.

Cause Exciting, Epilepsy

Cause Predisposing, Previous attack.

Form, Convulsive Epilepsy

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, November 1896.

Duration, 3 mos.

No. of Attack, Several.

No. of Admissions, 4th At Yankton. School for Feeble Minded at Faribault & at St Peter.

Age First Attack, 9 yrs.

Time of Leaving, Jan. 22 1901.

Time in Hospital, 3 yrs. 11 mos. 10 days.

Result, Died. In Status Epilepticus.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam 2/13/96 by Dr Herzog

MENTAL ACTIVITY:

Clear or Confused, Fairly clear-

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Somewhat impaired

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Slow

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS: None noted

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Fairly coherent

Voluble or Reticent, Talkable

GENERAL DESCRIPTIVE REMARKS: Patient is a defective epileptic, facial expression dull & heavy thick lips Acromegalous cast of countenance: Says has not had a fit for 3 weeks. Had them mostly at night. If awake has an aura "feels something slowly rising from the stomach" Can find no marks on head as from fall in childhood. Patient very slow in all his movements.

Personal and Medical History of David E. Washburn.

A. B. Washburn
#1424 23rd St. S.
Minneapolis Minn.

Correspondent for David E. Washburn (1/13/97)

No. 1.

File

Rochester Insane Asylum

Mr. Dr. Kilbourn Sup. of Rochester Asylum, Mr. David E. Washburn while in the bay up on the hall of C. 1. — while walking once or twice back in the bay. Mr. John Aye head nurse of this hall said sit down David and just because I said no to him he walked up behind me with two or 3 other nurses and then I sit down on the floor and then two of them took me by the collar and jerked me up on the bench and put my hands way up on my back and I sit these for about one minute or so and then John Aye said put him on the floor and when they jerked me up to put me on the floor, I got my hands away and held them around my chin and they tryed to X get my hands free

(over)

ION, CONTINUED.

ERISTICS.

NUTRITION, Good

eveloped - authelix prominent

Promptness Movement, Prompt.

, normals.

ommodation, Slow

ut equint.

gue, Done

eral, None

EXAM. URINE,

Careless,

Irregular,

Poor,

Irregular,

Temp.,

s - Diabetes

AL OR SUDDEN,

briety,")

Personal and Medical History of Da

HERBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

For H&P see Vol. 221

Whole No. 4677

Residence, 2641 Pillsbury Ave., Minneapolis, M

Date Admission, February 12th 1897

Admitted by Dr. R.M. Phelps Hour, 4 P.M.

How Sent, P.H. Harvey J. of P. Hennepin Co.

Sex, -male.

Age, -18 yrs.

Civil Condition, -Single-

Children, -

Age Youngest Child, -

Occupation, -None-

Degree Education, -Common school

Profession Religion, not a church

Habits, Not intemperate.

Nativity, New-york (Father

Physicians Committing, Geo. C. Bo

Correspondents, A.B. Washburn 2641

Dr. Chas. E. Booth 605 Wright B

EX

Exam 7/13/96 by Dr Herzog

MENTAL ACTIVITY:

Clear or Confused, Fair

Quick or Sluggish, D

MEMORY:

Past Events, D

Recent Events,

Special Subjec

PERCEPTIV

Alert or

Correct or Illu

REASONING POWER:

Ordinary Subjects, Slow

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient is a

thick lips Acromegalous cast of countenance: D

Had them mostly at night. If awake has an

from the stomach" Can find no marks on

Patient my slow in all his movements.

Fairly coherent
Valuable

ial expression dull & heavy

ad a fit for 3 weeks.

feels something slowly rising

head as from face in childhood.

Personal and Medical History of David E. Washburn.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft. 1/2 in WEIGHT, NUTRITION, Good

WOUNDS OR ABNORMALITIES, Nose turned to right. Pelvis of ear underdeloped. auricles prominent
Skin greasy. some acne. Slight pupuses under eyelids

TONGUE, Tremors, Coatings, Clear Promptness Movement, prompt.

PUPILS, Equality, Yes Size, normal.

Response Light, Slow Accommodation, Slow

SIGHT, Seems good Eyes. Very slight left divergent squint.

HEARING, Slight impairment

COORDINATION, Arms, Fair

Legs,

gue, Some

eral, None

EXAM. URINE,

Careless,

Irregular,

Poor,

Irregular,

Temp.,

es - Smakes

UAL OR SUDDEN,

ebriety,")

to hold them on my back
and they said he will bite
and they said if you hurt
you. Williams, Where, and
your hands down I would not bite
I told them & would not bite
them, then Williams said &
guess you won't and hurt his
fingers rite in and hurt his
pulled my head my eyes and
told him to let. stare and I
out and he kept my eyes
-ing on my eye right on skull
they got my hands and thumb
them was up to my neck and
I all Williams kneeled his full
wait on the side of my head
and I could not hardly breathe
while he was on my head in
that position. And when I was
jerked from the bench, I held
my hands like I told you and for
Marion sneaked up behind while
and St. John Aye were holding hands
I all filled my feet out from in
under me and I fell with a
crash to the floor that knocked
my wind all out of me and
I all doing as I told you,
You can think of the
terrible condition I was
in. Now Mr. Kilbourn do
you really think that is
right for them to do. Putting
my arms way up to the back
of a man's neck when he
is doing right. And doing the
rest which I told you. Mr. John Howe
told me to write this to you.

Yours Respectfully

David E. Washburn

on. Hall, C.I.

And I have also seen
them kick patients
right in the stomach
3 or 4 times with their point
ed shoes, too.

over

Personal and Medical History of Da

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

For #678 see Vol. 221 4677

Whole No.

Residence, 2641 Pillsbury Ave., Minneapolis, M

Date Admission, February 12th 1897

Admitted by Dr. R.M. Phelps Hour, 4 P.M.

How Sent, P.H. Harvey J. of P. Hennepin C

Sex, -Male.

Age, -18 yrs.

Civil Condition, -Single-

Children, -

Age Youngest Child, -

Occupation, -None-

Degree Education, -Common sch

Profession Religion, not a churc

Habits, Not intemperate

Nativity, New-york (Fa

Physicians Committing, Geo. C. F

Correspondents, A.B. Washburn 2

Dr Chas. E. Book 605 Wright

Exam 2/13/97 by Dr Her

MENTAL ACTIVITY

Clear or Confused

Quick or Slug

MEMORY:

Past Ev

Recent

Special Subjec

PERCEPTIVITY

Alert or Dull

Correct or

REASONI

Ordinary Subjec

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patie

Thick lips. Acromegalous cast of countenance

Had them mostly at night. If awake has a

from the stomach" Can find no marks on head as

Patient very slow in all his movements.

d expression dull + heavy

a fit for 3 weeks.

something slowly rising

on face in childhood.

airly coherent

Valuable

Personal and Medical History of David E. Washburn.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft. 1/2 in WEIGHT, NUTRITION, Good

WOUNDS OR ABNORMALITIES, Nose turned to right - Pelix of ear undeveloped - antheln prominent
Skin greasy - some acne - slight pupillary inequality

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

PUPILS, Equality, Yes Size, normal.

Response Light, Slow Accommodation, Slow

SIGHT, Seems good Eyes - Very slight left divergent squint.

HEARING, Slight impairment

COORDINATION, Arms, Fair

Legs,

TREMORS, Hands, None Tongue, Done

Facial Muscles, None. General, None

REFLEXES, Patellar, 5 Eq.

Other

ARTICULATION,

Slurred,

Hesitating, Yes.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, 2nd pulmonic sound clicking 1st pulmonic mat - Cardiac dullness slightly increased - slight irregularity.

LUNGS,
Chest type - Right side prominent
Expansion 1 3/4 in. Circum. 36 in.

TAKEN,

EXAM. URINE,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Fell down flight of stairs at age of 3 yrs. senseless - remained

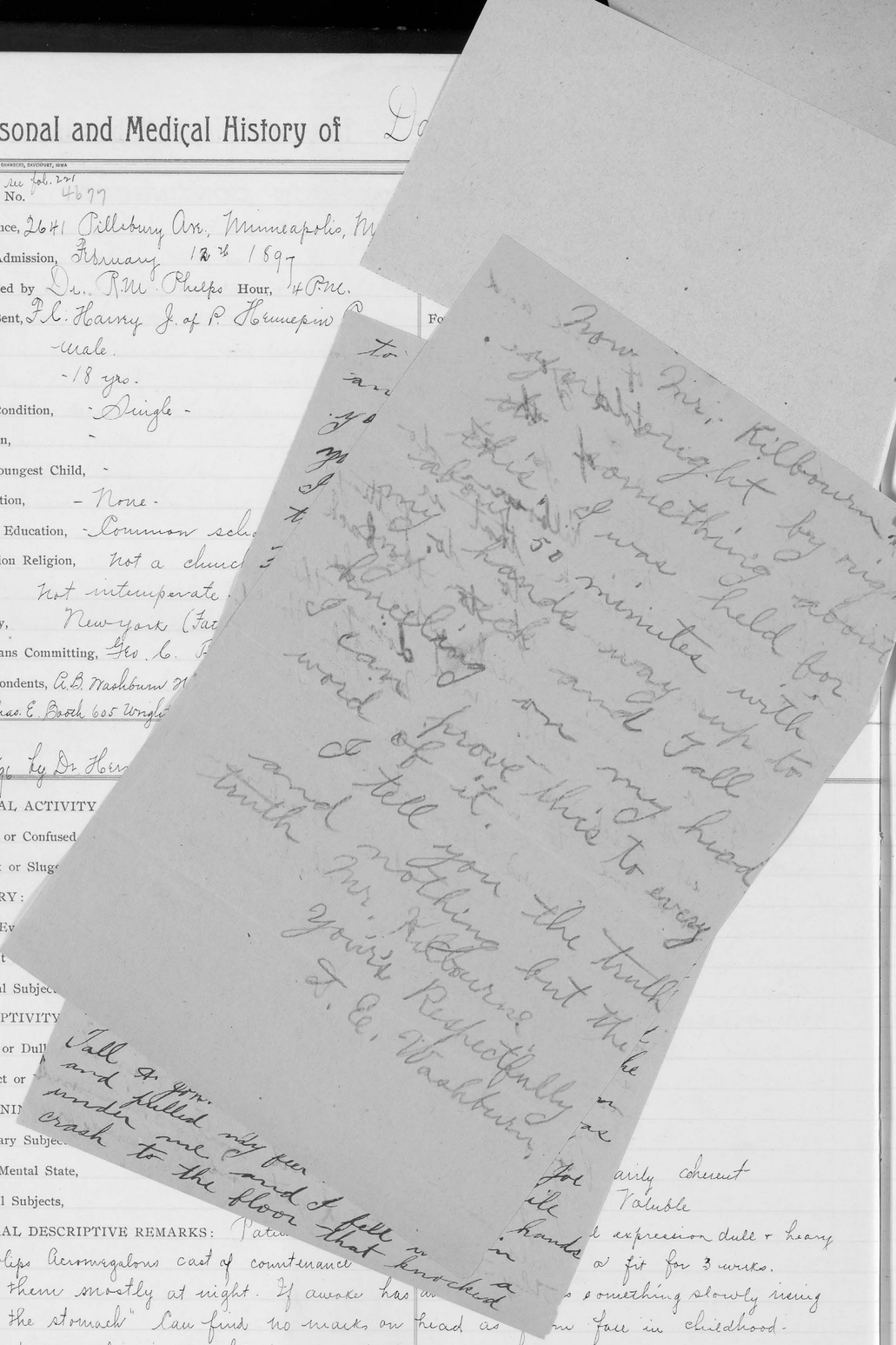
LENGTH OF INVASION, 1st attack 9 yrs of age ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Thinks Consumption

Father or Pat. Relations,

3 Brothers or 4 Sisters, all healthy



Personal and Medical History of David E. Washburn.

1897

This patient was brought here by Sheriff's Deputy Lewis Maisch, in fair physical condition, with the following history: No history of consanguinity. First attack occurred when patient was 9 yrs. old: Has had several since: Disease appears increasing, is variable with rational intervals: Derangement manifested by violent outbursts of temper: Patient is disposed to injure others: is not filthy or destructive: No previous peculiarities shown: No history of intemperance in parents or self: No severe disease or head injury excepting epilepsy: Patient was confined at Yankton when 9 yrs old - at Faribault Institution for Feebleminded when 14 yrs. & at St. Peter from 1894 until Oct. 1896. On personal examination patient showed excitement & general appearance of chronic epilepsy. On admission put upon B.3 E. (Cattle Pat. Complexion light: hair dark brown: eyes blue: Condition of skin good: bruise on left leg: Is clean: behavior good: Talks quite freely.)

Feb. 25 Physicians Note Patient is a large, heavy, overgrown, high grade, epileptic imbecile with heavy dull features. His convulsions have so far been rather of the nature of petit-mal. There has been no complete fall, no biting of tongue & no subsequent coma. Has been on bromides 20 gr. of the mixed bromides of Potass. Sod. & Ammon. with 3 ss Fowlers solution 3 times a day. He is reported as being very intractable but so far behavior has been fair with the exception of one days.

Feb 28 Summary Nurses Notes by Dr Phelps. Patient has a great many convulsions: On Feb 27 had twenty one between 8 & 10 AM. & one at 4 PM. Rather ugly & quarrelsome during day. Told nurses he would fight night nurse when he came on duty and did so. Trans. to 6'. Wt. 191 lbs. Mch 1 Patient better at times quiet but very uncertain. Mch 3 Rather noisy at 12:45 when he had a fit. He was singing a song at the time convulsion came on & after it was over took up song just where he left off. Mch 8 Had twenty five convulsions between 8:15 & 9:25 PM. Was given hypodermic Nitro-glycerine Had convulsions following this at 4 & 5 AM. Apr 1 Has convulsions almost daily & frequently as many as 8 or 10 a day. Has been receiving bromides the greater part of time: Is fairly intelligent for most part but temper is very uncertain. On Apr 8 tried to run away & after being brought back was very ugly, fighting several times. Trans. to 6'. Apr 30 Patient receiving some patent medicine sent from home. It is noted on this date that he has had no fit for two days. May 3 Wt. 174 lbs. Is inclined to be at times quite violent & irritable & more unreasonable in every way, Especially so after series of convulsions: Frequently tries to Escape. May 1 '98 Wt. 191 lbs. Patients condition during intervening time about same. Notes show numerous convulsions & much trouble with other patients: Is frequently very

Personal and Medical History of David E. Washburn

mischievous & hard to manage in every way. Jan 31 '99 Notes concerning condition & behavior very numerous, but condition, however, changes very little: At present is fairly quiet & well behaved: Feels some of going home. Is however very changeable. Feb 1 - July 31 '99. (Dr. Wanous) Wt. 191 lbs Subject to epileptic convulsions which occur nightly: Is inclined to be very ugly after having spell. May 17. Fell on heater in convulsion while undressing for bath. Shoulder & arm severely burned. May 1 In restraint six hours. July 16. Had trouble with Haines, threatened to kill him: July 15 1900 Eloped while outside. Aug 1 - Jan 31 1900. Dr Chapple. Wt. 195 lbs Aug 18 Had tooth pulled by Dr Smith. Aug 25 Tooth extracted Sept. 23 Attempted to elope. Oct 2 Burned back on heater during convulsion. Sept 20 Threw cuspidor at another patient. Nov. 2 Fell against heater in convulsion burning thigh. Nov. 8 Fell against heater causing wound 2½ inches long. Also burned right hand. Jan. 13. Attempted to strike patient Wright with chair: Tried to kill him. Became very maimed & deluded: Imagined he was being poisoned. Jan 15 Put in restraint sheet. Continues maniacal. Condition failing considerably: given baths and hypodermics of strychnia. began to improve. Jan 23 Visited by father. Jan 26 Medicine discontinued. During most ap period patient had convulsions very frequently - as many as 15 during one night, most of them light attacks. Is very frequently violent & quarrelsome & best part of time restrained by muff Feb 3/900. Transferred to 6'. March 25. One finger broken. - May 1/15 May 1 - 15. In muffs (for violence & pugnacity) - May 29 - June 5. In muffs (for same reason). July 2/ Eloped. July 8. Returned. Was arrested at Spring Valley and brought back by Nurse Keifer. "1/3 July 17. Vaccinated. July 31. No change noted. Has had frequent convulsions & been very humble-some & disagreeable; frequently pugnacious & fighting with other patients. Becomes much confused at times, after convulsions - During February, rather more maniacal than usual. and "thought people were going to kill him". Usually much constipated, requiring frequent cathartics. Aug 1 Wt 190 lbs - Nov 30. No change specially noticeable. Jan 16/1901. Very humble and pugnacious 1901 patient: Constantly getting into trouble: will attack others without provocation, with a Jan 16. chair or anything on hand: Has convulsions very frequently: is on treatment which seems 17 to have but little effect (Jan 16) had 34 convulsions in day. Jan 17. Transferred to T.H. 21 Dump (at 2 PM) 105°. P 140. R 38. In condition of "Status Epilepticus" - Convulsions 22 given Cold Sponge bath & cathartics - Jan 21. Has aroused from Stupor and is very restless & pugnacious - 5 PM. T 101 3/10. P 128. R 40. Jan 22. Temperature subnormal - Is failing fast. Expired at 4 15 PM -

Died

Personal and Medical History of John Hedburg.

EDSLEY, FISCHER & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4679

Residence, St. Paul, Minn.

Date Admission, February 13th 1897

Admitted by Dr. R. M. Phelps Hour,

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

Sex, Male.

Age, 46.

Civil Condition, Married

Children, 4.

Age Youngest Child, --

Occupation, Hostler.

Degree Education, Poor.

Profession Religion, Not a church member

Habits, Intemperate.

Nativity, Sweden (Parents Sweden)

Physicians Committing, C. H. Whitcomb & D. C. Riggs.

Correspondents,

No. for Year, 212

Insane Relatives, None.

Cause Exciting, Syphilis.

Cause Predisposing, None given.

Form, Dementia syphilitic

Accompanying Bodily Disorder, Syphilis.

Suicidal or Not, not.

Date of this Attack, About 3 months ago.

Duration, About 3 months.

No. of Attack, 1st

No. of Admissions, ~~2nd~~ 1st this attack City & Co. Hospital St Paul.

Age First Attack, 46

Time of Leaving, Apr. 1, 1898

Time in Hospital, 1 yr. 1 mo. 19 d.

Result, Discharged Aug. 16 1898 Unimproved.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam by Feb. 16 by Dr. Herzog

MENTAL ACTIVITY:

Clear or Confused, Slightly confused.

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Fair

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dull.

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, See nurses notes

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, Voluble.

GENERAL DESCRIPTIVE REMARKS: Has been a drinking & sporting man. driving hack dissipated. Is now markedly spastic - gait characteristic. left leg particularly involved toes stick to the floor - swing to left leg like in hemiplegias. Has hallucinations but talks quite readily & rationally when at his best. Is, however, a little triffe slow & verbose.

Medical History of John Hedburg.

W. Smith
Dalstorp
Minn
Correspondent
John Hedburg 12/24/97

Mrs. D. Petterson,
Dalstorp,
Chisago Co., Minn.

Correspondent for John A. Hedburg.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, 169 NUTRITION, Impaired

WOUNDS OR ABNORMITIES, Scars on both legs - broke out last spring

TONGUE, Tremors, Promptness Movement, prompt.

PUPILS, Equality, Size, Normal.

SIGHT, Accommodation, Excessive

HEARING,

COORDINATION, Arms, Impaired

Legs,

TREMORS, Hands, Slight Tongue, Fine

Facial Muscles, None. General, None

REFLEXES, Patellar, 10 - left more than right Ankle clonus more marked on right foot. Tendo Achillis clonus

Other reflexes much exaggerated. Abdominal & cremasteric reflexes abolished. EXAM. URINE,

ARTICULATION,

Slurred,

Hesitating, Somewhat.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs - Strength Sounds fairly good.

LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Says had syphilis 4 yrs. ago. Fairly clear history - Last fall had severe headaches shifting before eyes - something

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, Consumption Children 8 - 6 - 3½ - 2 - baby not healthy - lumps inside ear discharge from ear.

Personal and Medical History of John Hed

EUDLEY, FISLAR & GRABORG, DAVENPORT, IOWA

Whole No. 4679

Residence, St. Paul, Minn.

Date Admission, February 13th 1897

Admitted by Dr. R. M. Phelps Hour,

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

Sex, Male.

Age, 46.

Civil Condition, Married

Children, 4.

Age Youngest Child, --

Occupation, Hostler.

Degree Education, Poor.

Profession Religion, Not a church member

Habits, Intemperate.

Nativity, Sweden (Parents Swedes)

Physicians Committing, C. H. Whitcomb & C. E. Riggs.

Correspondents,

No. for Year, 219

Insane Relatives,

Cause Exciting, ?

Cause Predisposing,

Form, ?

Accompanying Bodily Disorder, Syph.

Suicidal or Not, not.

Date of this Attack, About 3 months ago.

Duration, About 3 months.

No. of Attack, 1st

No. of Admissions, 2nd 1st here as an Insane City & Co. Hospital St Paul.

Age First Attack, 46

Time of Leaving, Apr. 1, 1898

Time in Hospital, 1 yr. 1 mo. 19 d.

Result, Discharged Aug. 15. 1898 Unimproved.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by Feb. 16 by Dr. Herzog

MENTAL ACTIVITY:

Clear or Confused, Slightly confused.

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Fair

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dull.

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, No unusual traits

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, Voluble.

GENERAL DESCRIPTIVE REMARKS: Has been a drinking & sporting man. driving hack dissipated. Is now markedly spastic - gait characteristic. left leg particularly involved toes stick to the floor - swing to left leg like an hemiplegia. Has hallucinations but talks quite readily & rationally when at his best. Is, however, a little triple about & verbose.

Personal and Medical History of John Hedberg.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft. ½ in. WEIGHT, 169 NUTRITION, Impaired

WOUNDS OR ABNORMALITIES, Syphilitic scars on both legs - broke out last spring

TONGUE, Tremors, Coatings, Promptness Movement, Prompt.

PUPILS, Equality, left slightly smaller. Size, Normal.

Response Light, Excessive Accommodation, Excessive

SIGHT, Impaired

HEARING, Good.

COORDINATION, Arms, Impaired

Legs,

TREMORS, Hands, Slight Tongue, Fine

Facial Muscles, None. General, None

REFLEXES, Patellar, ½ - less exaggerated than right Quick closure more marked in left foot. Tache

Other reflexes much exaggerated - Abdominal & cremasteric reflexes abolished.

ARTICULATION,

Slurred,

Hesitating, Somewhat.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs - Strength sounds fairly good.

LUNGS,

TAKEN,

EXAM. URINE,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Says had syphilis 4 yrs. ago. Fairly clear history - last fall had severe headaches shifting before eyes - vomiting

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, Consumption Children 8 - 6 - 3½ - 2 - baby not healthy - lumps under jaw discharge from ear.

Personal and Medical History of John Hedburg.

1897

This patient was brought here by Sheriffs deputy Samuel Monks in fair Physical condition, with the following history:- No history of consanguinity or heredity: First attack: First symptoms manifested about 3 months ago: Disease appears increasing: Is variable with irregular rational intervals: Derangement manifested on subject of visions voices & illusions: Is not disposed to injure others: Filthy in habits: No previous peculiarities shown: Is intemperate: Has Syphilis: Was confined at City & County Hospital St. Paul for 4 or 5 weeks: Has received irregular treatment for Syphilis.
On personal examination Certain history of Syphilis with gradual increase of physical & mental weakness.
On admission Put upon Infirmary East (C. H. N. Ft) Complexion light: hair brown: eyes blue: 1 scar across back of right hand: Pimples on different parts of body: Four scars on back of left leg & two on right leg: Is dirty: behavior good)

Feby 13 Nurses Notes (Summary) Came on ward at 7.30 Dirty, given bath & put to bed. Answers questions fairly well. Ulcers on both legs: Slightly lame in left leg. Physical condition appears fair: Feby 14 Slept 7 hrs. last night. Has been very quiet today. slept most of time. Complains of some trouble in holding urine. Habits fairly clean. Appetite good. Bowels irregular.

" 15 Has delusions: thinks that someone here was operated upon last night & that his wife attended the operation. Bowels constipated.

" 17 Enema given: Blue ointment rubbed on back: Very quiet: Appetite good: Lies very quiet in bed. Feb. 20 Urine in 24 hrs. 46 oz. Can see no change in patient: Bowels constipated & do not move without an enema.

" 25 Up on ward this PM. Walks about considerable. Blue ointment treatment continued. Dr. Herzog notes "Right pupil somewhat large: Spastic gait & exaggerated reflexes quite as marked as on admission: Bowels do not move without an enema: Frequent & imperative micturition, seems to be from defective bladder innervation." Feby 26 Patient has been up on ward most of day. Very quiet. Answers questions fairly well: Appetite good. Habits fairly clean. Still holds his delusions. Appears to have gained some in flesh.

Mch 1 Summary Nurses Notes by Dr. Phelps. Up on ward: Reads a good deal: Talks in a fairly intelligent way, altho delusions noted. Thinks his wife has been here. Receives medicine internally & blue ointment Mch 17 Trans to Bd No special change. Apr. 1 Has had to have enemata at times on account of obstinate constipation. blue ointment & iodide of potash continued. Receives baths 3 times daily. Wt. 170. Apr 19 Paralysis of entire left side tongue protrudes to left. Trans. to Infirmary: Fell out of bed a couple of times last night. May 1897 Patient in bed on Infirmary recovering from hemiplegia on left side of body: Is rather stupid & mixed in mind

Personal and Medical History of

1897

May 8 up on ward today: Can hardly walk: Is receiving electrical treatment. Drags foot but seems stronger. July 1897 Wt. 163# Jan. 1898 Wt. 190# Apr. 1898 Went home this morning on trial: Somewhat feeble in mind yet seems fairly free from delusions: Is quiet & well behaved.

Discharged.

Personal and Medical History of Henry Tully

EBBERT, PIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4689

Residence, Havanna Minn.

Date Admission, February 22nd 1897.

Admitted by Dr. H. Herzog. Hour, 7 PM.

How Sent, W.A. Eggleston, J. of P. Steele Co.

Sex, Male.

Age, 54.

Civil Condition, Single.

Children,

Age Youngest Child,

Occupation, Laborer.

Degree Education, Common English.

Profession Religion, yes. Church of England.

Habits, Not intemperate.

Nativity, Ireland (Parents Ireland)

Physicians Committing, E.E. Bigelow + Theo L. Hatch.

Correspondents,

No. for Year, 222

Insane Relatives, None known of.

Cause Exciting, Not known

Cause Predisposing, Not known.

Form, Dementia terminal

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, February 21st 1897.

Duration, 1 day.

No. of Attack, 1st (Says he had trouble in Wisconsin

No. of Admissions, 1st

Age First Attack, 54

Time of Leaving, 11th December 1901

Time in Hospital, 4 yrs 9 mos 19 Ds

Result, Transferred to Hastings Asylum

O.K. Spw

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog. 2/24/97. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Fairly clear.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Fair

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dull.

Correct or Illusive, In the main correct.

REASONING POWER: Slow.

Ordinary Subjects,

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Depressed.

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, fairly coherent.

Voluble or Reticent, voluble.

GENERAL DESCRIPTIVE REMARKS: Patient is a tramping laborer of not high life mentally; has a marked brogue. Had trouble at poor farm, says they bothered him about a girl + he resisted it. Then they went to tie him down + he fought vigorously. Was tied at poor farm 2 hrs. Was in straps one night at jail. Questionable whether or not he had hallucinations. Says tremors are not always present but due to nervousness caused by the light + the restraint.

Personal and Medical History of Henry Tully.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft. 1 in. WEIGHT, 178 NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, right heel gangrenous from frost bite - scars of wrist ties.

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

PUPILS, Equality, Yes. Size, Contracted slightly

Response Light, Accommodation,

SIGHT, Good.

HEARING, "

COORDINATION, Arms, Slightly impaired

Legs, " "

TREMORS, Hands, None Tongue, Slight

Facial Muscles, of lips General, Yes. excursions, quite large. not extinction

REFLEXES, Patellar, 10 Equal. EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

TAKEN, 1897.

SENSIBILITY,

Arteries. Circulation impaired.

HEART, No murmurs.

Strength sounds, fair.

LUNGS,

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, None obtainable

Brothers or Sisters,

Personal and Medical History of Henry Tully.

1897

This patient was brought here by Sheriff Barnard in good physical condition with the following history:- No consanguinity known. 1st symptoms of this (4th) attack manifested Feb. 21'97 by violently attacking other inmates of the poor farm. Disease appears stationary. Is variable: no rational intervals: Derangement manifested by various delusions: Is disposed to injure others: No information concerning filthy or destructive habits: Patient acknowledges that he has been quarrelsome: Father addicted to drunkenness, mother drank some, & patient also drank some: Has sustained no injury to head but has had convulsions: Was confined in county jail 90 days for vagrancy: Nothing known as to cause of disease, or treatment pursued. On personal examination says that he hears bad voices night & day & bad words that were spoken to him at a quarrel in Milwaukee: He believes that a contractor left a present of money with a person there for him & they would not give it to him. On admission put upon S.B.3 E. (G.S.H.U.Rpt Complexion light: hair dark brown: eyes blue: Condition of skin good: Scar above left ankle: several bruises & scratches on arms & legs: Is clean: Behavior good).

Feb 98 Physicians note. Has been practically no change since admission except some slight gain in physical health. Patient is feeble-minded but shows no such violence as he did at Almshouse just before admission. Has probably always been in about his present condition - a feeble-minded itinerant.

Apr 1 Summary Nurses Notes by Dr Phelps. Has seemed on the whole quiet. Has been very indolent. Shows very little improvement. Wt. 191 lbs.
Apr 13 Trans. to Infirmary. Apr. 30 Has continued quietly in bed needing only general care. May 1'97 Wt. 175#. Patient sent here as a tramp but is careless & untidy; rather dull in manner; does not speak of special delusions but is dull & demented. Feb 26 Very destructive to day: tried to break furniture: Says that patients annoy him: Has usually been rather quiet & at times irritable. Jan 31'99 Patient now at Annex. Is quiet & dull.
Feb 1 - July 31'99. Wt. 195#. Apr 14 Continually writing letters to physicians. Physical condition seems good. Does no work. Aug 1 - Jan 31'1900. Wt. 180#. Aug 9. Trans to Infirmary - ate nothing for several days: wanted to starve himself. Very melancholy. Fed by tube. Aug 15 Trans. to Annex: Eats fairly well.
Aug 16. Again fed by tube. Aug 17 Trans. to Infirmary. Again fed. Aug 22. Trans. to Annex. During September ate very little. Wanted to starve himself. Had vomiting spells. Sept. 30 Began to eat well again. Jan 30. General
To 1900 condition unchanged. Has frequent spells when he tries to starve himself & requires feeding for several days. Physical condition fairly good. Habits
Jany 31 quite cleanly. Sleeps soundly. Is usually demented. Plays games & at
Feby 1 times works some on ward. Feby. Wt 183#. P.T. July 20. Vaccinated: good results.
July 20 31 no change to note: Has been in good health: Has good appetite. Worked some on farm, during June.

Personal and Medical History of Henry Tully

1900

July 31 Aug 1 1901 Jany 31 Feby Aug 1 Dec 11 Works on ward; habits quite cleanly; usually quiet: seldom speaks: occasionally has "noisy spells" - Is very demented. Aug 1. Wt 176#. Sept 10. Transferred to D.3. Jany 31'1901. very little change; is a dull, listless, demented man; works a little on ward: cleanly: avoids conversation; sits by himself: plays checkers: talks to himself a great deal. Feby. Wt 195#. May 1. No change - Wt 191#. Works a little on ward - Nov 1. Wt 199½#. - Dec 11 - No change during year - Works on ward, occasionally; and in garden, during summer. Health very good: very demented: irrational. Was, today, transferred to Hastings State Asylum.

Personal and Medical History of Thomas Leary

BEGLEY, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4691

Residence, Austin. Minn.

Date Admission, February 20th 1897.

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

How Sent, D.D. Washburn & of P. Moore Co.

Sex, Male

Age, 43

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Laborer

Degree Education, Common School

Profession Religion, Catholic

Habits, Very intemperate

Nativity, Ohio (Parents Ireland)

Physicians Committing, Est. Washburn & C.H. Johnson

Correspondents, John Leary (brother) Austin Minn
Michael Bell, Guardian Austin(?)

No. for Year, 224

Insane Relatives, Uncle & two 3 cousins.

Cause Exciting, Unknown.

Cause Predisposing, Heredity.

Form, Intermittent acute

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, not.

Date of this Attack, 2 weeks ago.

Duration, 2 weeks.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 43

Time of Leaving, May 26. 1897

Time in Hospital, 3 mos. 1 da.

Result, Discharged Sept. 28. 1897
Recovered.

EXAMINATION ON ADMISSION.

Exam by Dr. Herzog Feb. 20th 97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Slightly confused.

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Fair

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dull.

Correct or Illusive, In main correct.

REASONING POWER:

Ordinary Subjects, Not clear.

Own Mental State, Does not understand.

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Fairly coherent.

Voluble or Reticent, Reticent

GENERAL DESCRIPTIVE REMARKS: Patient is melancholic; has lost weight, speaks in monosyllables is not very accurate in his statements. Attention poor. Says he has rheumatism of the bowels. Tenderness epigastrium & right ileocecal region, slight tenderness over entire abdomen. Liver cannot be palpated. Slight crepitus on palpation but no evidence of fractured rib. Abdomen prominent but no demonstrable effusion. Veins over abdomen enlarged. Cirrhosis of liver suspected. Sub maxillary glands swollen.

Personal and Medical History of Thomas Leary.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 10½ WEIGHT, 159½ (usual 180) NUTRITION, Impaired.

WOUNDS OR ABNORMALITIES, Lobule of ear high arched palate. Skin greasy: Comedones

TONGUE, Tremors, Coatings, White coat on dorsum Promptness Movement, Somewhat slow.

PUPILS, Equality, Yes Size, Normal.

Response Light, Yes Accommodation, Yes.

SIGHT, Fair

HEARING, "

COORDINATION, Arms, Slightly impaired

Legs, "

TREMORS, Hands, Slight Tongue, Quite marked.

Facial Muscles, None General, None.

REFLEXES, Patellar, 2 Equal. EXAM. URINE,

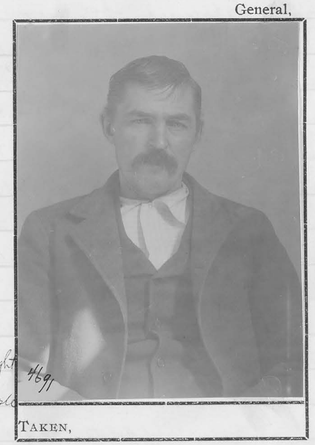
Other

ARTICULATION,

Slurred,

Hesitating, Slow.

FACIAL EXPRESSION,



4/97

TAKEN,

SENSIBILITY,

HEART, 1st Mitral sound transmitted to right 2nd Pulmonics sound sharp. Strength. Sounds all weak: Apex beat at nipple line third r. in to left.

LUNGS,

Expansion 35 in. in Circumf. Exp. 1 in. Breath sounds, right apex slightly dull with bronchial breathing tympanic sound right mid axillary line. Auscultation unsatisfactory.

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,") Denies Consanguinity of parents

Mother or Mat. Relations,

Father or Pat. Relations, Uncle in Columbus Ohio, Thomas Hogan (convict) died there.

Brothers or Sisters, John Leary Here Inebriate.

Personal and Medical History of Thomas Leary

1897

This patient was brought here by Sheriffs deputy John C. Johnson Jr. in fair physical condition, with the following history:- Parents were cousins: First symptoms of this (1st) attack manifested 2 weeks ago; moody & does not work as he did formerly. Disease appears increasing; not variable: no rational intervals: Derangement manifested by various delusions: Not disposed to injure others: no information concerning habits: No previous peculiarities, was always cheerful: Patient has been a hard drinker: No severe disease or injury to head: Has not been confined or restrained: Has received no treatment. On personal examination he is moody & does not seem to care what becomes of himself. Commitment recommended because he wanders about & is exposed to want of food & shelter or to accident. On admission put upon B 3 E (Gtl. Rpt. Complexion dark; hair gray; eyes blue: condition of skin good: Is clean. Right leg slightly deformed. Behavior good.)

Mch 9 Physician's Note. Patient has shown marked mental improvement since admission. Can not make out any delusions or hallucinations. Says that he might have stayed longer at home but his relatives were afraid he was losing his mind & thought had best take it in time. Says he feels all right now. There is nothing at present to confirm suspicion of cirhosis expressed in entrance examination.

Mar 11 Patient talks rationally: Spends most of time playing cards & games. Habits neat & clean but is slouchy in dress. Appt. Continues rational but is rather cranky: Will do no work: Anxious to go home: Thinks he is well & able to care for himself: Appetite good: Bowels regular. Wt. 177 & 178

May 1 Patient is rather abstinate & cranky on some subjects but is fairly well-behaved: Does a little work: Appetite good: Bowels regular. Wt. 184 lbs. Pulse 78. Transferred to Wd. May 9

May 14 Went to work at barn: Seems to be improving.

25 Went Home.

Discharged.

Personal and Medical History of

Personal and Medical History of Charley Anderson

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. #695

Residence, Pickland, Freeborn Co. Minn.

Date Admission, March 2nd 1897.

Admitted by Dr. LeB Coy Hour, 8 P.M.

How Sent, Herman Blackmer, Jo. Co. Freeborn Co.

Sex, male.

Age, 32.

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, Farm Laborer.

Degree Education, Common School.

Profession Religion, Yes. Lutheran.

Habits, Not Intemperate.

Nativity, Denmark.

Physicians Committing, H.H. Wilcox & A.C. Wedge M.D.

Correspondents, Hans Anderson (Brother) % Engine Room, Hotel Portland, Portland, Oregon.

No. for Year, 227

Insane Relatives, None.

Cause Exciting, Psychological delusion.

Cause Predisposing, Unknown.

Form, Paranoia

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Feby. 1st 1897.

Duration, 1 mo.

No. of Attack, 2nd History of this case unclear - continuous attack since all probability

No. of Admissions, 1st

Age First Attack, 29.

Time of Leaving, Aug. 2. 1897

Time in Hospital, 5 mo.

Result, Discharged Feb. 9. 1898 Much Improved

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog 3/2/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Clear.

Quick or Sluggish, Somewhat sluggish

MEMORY:

Past Events, fair

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Slightly dull.

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, fair

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient is not very bright. Describes his trouble with the girl as described in commitment. Says he had same kind of trouble in Kansas. If sent out would go back to Kansas. The first time denied in his attentions. Somewhat run down - no marked physical impairment.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, Indifferent

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, No.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent.

Voluble or Reticent, Fairly voluble.

Personal and Medical History of Charley Anderson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft. 1½ WEIGHT, 149 (usually 160) NUTRITION, Somewhat impaired

WOUNDS OR ABNORMALITIES, Narrow face, high arched palate.

TONGUE, Tremors, Coatings, yellow coat. Promptness Movement, prompt.

PUPILS, Equality, Equal Size, normal

Response Light, yes Accommodation, yes.

SIGHT, Good.

HEARING, "

COORDINATION, Arms, fair

Legs, "

TREMORS, Hands, No. Tongue, Slight

Facial Muscles, " General, None.

REFLEXES, Patellar, & Equal. EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs.

Sounds fair

LUNGS,

Expansion slight - no abnormalities.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Had similar trouble 4 years ago in Kansas.

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 Charley Anderson.

1897

This patient was brought here by Sheriffs deputy W.L. Mitchell attended by Herman Kleinke in fair physical condition with the following history:- No history of consanguinity, heredity or intemperance in parents or self: First attack occurred 6 years ago + lasted 3 years: Not confined in any hospital: First symptoms of present attack manifested Feby. 1st 1897 by persistent attention to a girl who resents his company. Disease appears increasing: not variable: no rational intervals: Seems entirely gone on a 17 year old girl who refuses his attentions. The parents of the girl have tried to get rid of him, & ordered him away but he persists in returning; they have also sent the girl away but still he hangs on - apparently hoping that he may find her. He has also refused the orders of the Sheriff + County Attorney. Not disposed to filthy or destructive habits: No previous peculiarities: No severe disease or injury to head: Has not been confined or restrained: Has received no treatment. On personal examination looks as if he were weak minded + is undoubtedly laboring under a sort of psychological delusion regarding this girl.

On admission put upon B3 (G.H.A. Apt. Complexion light: hair slightly gray: eyes blue: Condition of skin good: Vaccination scars on both arms: Is clean-behavior good)

Mar 15 Physicians Note. Patient has been very well behaved since admission. Somewhat feeble-minded. Wishes to go to Portland, Oregon. + as he has some $50.00 + a note for $150.00 would probably get along for some time.

Mch 25 Patient seems quite rational: asks about money matters: Is very restless sleeps very little, is out of bed when there is the least noise on the ward: does a little work but does not stick to any one thing: wants to work where there is most company. Appetite fair: Bowels regular. Mch 27 Trans. to B3.

Apr 2 No change since above note: Has annoying habit of following doctors + nurses about ward. Wt. 154 lbs. Apr 15 Appetite very poor: Eats very little - put upon tonic. Apr. 30 Medicine discontinued. Appetite has not improved. Habits unchanged: May 1 No change. Thinks of nothing but going home. Is on regular diet - Wt. 153½ lbs. May 18+19 Refused food. Eats only small piece of bread. June 1 Since last note appetite has been fair: Seems a little brighter mentally; Habits neat + clean: Does some work on ward. Wt. 154 lbs. July 1 Patient somewhat more agreeable of late. Goes at his work systematically: is neat + clean in habits + dress. Has not spoken of going home for some time. Makes no attempt to elope + is obedient + agreeable. Wt. 154½ Pulse 90. July 8. No change. Aug 2 Remains quiet + well behaved: Is neat in dress + habits. Wants home today.

Discharged.

Personal and Medical History of

Personal and Medical History of William E Lane

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4696

Residence, Stillwater, Minn.

Date Admission, March 3rd 1897.

Admitted by Dr. C. B. Coy Hour, 6.50 P.M.

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

Sex, male.

Age, 31.

Civil Condition, Married

Children, 2

Age Youngest Child, —

Occupation, Lumberman.

Degree Education, Common School.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Stillwater, Minn. (Parents New Brunswick)

Physicians Committing, B. J. Merrill & E. Sydney Bolegyn

Correspondents, none given in papers.

No. for Year, 229

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form, Dementia paralytica

Accompanying Bodily Disorder, Convulsions.

Suicidal or Not, Not.

Date of this Attack, One year ago

Duration, About 1 year.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 30

Time of Leaving, May 3. 1897

Time in Hospital, 2 months

Result, Died. General Paresis

EXAMINATION ON ADMISSION.

Recom. by Dr. Herzog 3/3/97.

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, In main correct.

REASONING POWER:

Ordinary Subjects, Poor.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient is quite grossly paretic. Shows no definite delusions but a feeling of well-being. Is slovenly & untidy in personal habits. No history of syphilis obtainable.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Exalted.

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, somewhat incoherent

Voluble or Reticent, Voluble

William E. Lane,

Be it enacted by the House and Senate of Rep Peresentatives of the

Specimen of handwriting of William E. Lane March 4/97.

ADMISSION, CONTINUED.

CHARACTERISTICS.

NUTRITION, Impaired.

g. Ears small. protruding, deficient helix - arched palate. tight red. Promptness Movement, slow.

Size, slightly contracted.

Accommodation, slow.

Legs, some improvement

TREMORS, Hands, Some

Facial Muscles, About Lips

REFLEXES, Patellar, O equal.

Other

ARTICULATION,

Slurred, Yes.

Hesitating, Yes

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs noted

LUNGS, Chest narrow. Sounds good.

Tongue, Coarse & fine.

General, Some.

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

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

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

Mother or Mat. Relations, No history.

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of [illegible]

HERBERT, FISCHER & CHAMBERS, DAVENPORT, IOWA

Whole No. 4696

Residence, Stillwater, Minn.

Date Admission, March 3rd 1897.

Admitted by Dr. C. B. Eby Hour, 6 50 P.M.

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

Sex, male.

Age, 31.

Civil Condition, Married

Children, 2

Age Youngest Child, --

Occupation, Lumberman.

Degree Education, Common School.

Profession Religion, Catholic.

Habits, Not Intemperate.

Nativity, Stillwater, Minn. (Parents New Brunswick)

Physicians Committing, B. J. Merrill & E. Sydney Boleyn

Correspondents, none given in papers.

No. for Year,

Insane Relatives,

Cause Exciting,

Cause Predisposing,

Form, Dementia P.

Accompanying Bodily Disorder, Cons

Suicidal or Not, Not.

Date of this Attack, One year ago

Duration, About 1 year.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 30

Time of Leaving, May 3. 1897

Time in Hospital, 2 months

Result, Died. General Paresis

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog 3/3/97. **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, In main correct.

REASONING POWER:

Ordinary Subjects, Poor.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient is quite grossly frantic. Shows no definite delusions but a feeling of persecution. Is slovenly & untidy in personal habits. No history of syphilis obtainable.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Exalted.

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, somewhat incoherent

Voluble or Reticent, Voluble

Personal and Medical History of William E. Lane,

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 11 in. WEIGHT, 131 NUTRITION, Impaired.

WOUNDS OR ABNORMALITIES, lobule of ear lacking - ears small. outstanding, deficient helix - arched palate.

TONGUE, Tremors, Coatings, bright red. Promptness Movement, slow -

PUPILS, Equality, right slightly larger Size, slightly contracted.

Response Light, no. Accommodation, slow.

SIGHT, Fair -

HEARING,

COORDINATION, Arms, Impaired -

Legs, Some impairment

TREMORS, Hands, Some Tongue, coarse & fine -

Facial Muscles, About lips General, Some.

REFLEXES, Patellar, O equal - EXAM. URINE,

Other

ARTICULATION,

Slurred, yes -

Hesitating, yes

FACIAL, EXPRESSION,

SENSIBILITY,

HEART, No murmurs noted

LUNGS, Chest narrow. Sounds good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

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

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

Mother or Mat. Relations, No history.

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of William E. Lane.

1897

This patient was brought in by Sheriffs deputy James Lane attended by Mrs. James Lane, 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 1 year ago: Disease appears increasing: Is not variable: No rational intervals: Derangement manifested by cerebral degeneration - on no particular subject. Not disposed to injure others: Not filthy or destructive: No previous peculiarities shown: Had a convulsion Jany 1893 & 2 on Feby 11 1897: Has not been confined or restrained: No treatment known of: No further particulars noted on personal examination. On admission put upon B.3 (G.H.H. Rpt. Complexion light: hair black: eyes brown: Condition of skin good: Vaccination scars on left arm: Is clean: behavior good: Memory very poor)

March 16 Physicians note Patient remains practically the same as on admission except that he is slightly quieter. He is unquestionably paretic but the progressive character of the trouble is doubtful. On first examination particularly with the history of 3 convulsions the diagnosis of general paresis seemed fairly plausible but on further examination it seems quite likely that the condition is one of quite marked feeble-mindedness.

March Patient untidy in habits & dress: Talks incoherently & in a drawling manner: Seems unable to keep mind on any one subject: Does no work: Is very troublesome: Appetite voracious: Bowels regular: Sleeps very little: & is generally restless & noisy for several hours during night:

Apr 1 Very slouchy of late & has been filthy in habits several times:

Apr 2 Trans. to B". Slept in his own floor. Apr. 3 Is very noisy & talkative - irrational & incoherent. Apr. 13 Patient has been in bed past two days: Has had to be catheterized: Appetite not very good: On light diet: Very noisy & restless at times. Trans. to Infirmary.

Apr 14 Temp. 94° P. 100 R, 18 Ate light meals: Very restless since receipt on ward: Out of bed very often: Catheterized at 8 PM. Liquids given between meals. Bowels constipated. Apr. 15 Patient restless all night: Urinated today: Temp 98°.

17 Has to be fed by nurse: Very restless: Filthy in habits. Talks irrationally 5 PM. Temp. 101° P. 130 R 30. Apr 21 No change in patient: Still restless: Seems to be growing weaker: Bowels constipated - Temp. ranges from 98 2/5 to 99°.

22 Temp. 100° 3 PM. No other change. Apr 26 Visited by Father Riordan.

23 Temp. 97° P 72 R 18 PM. Temp. 104° P. 124 R 20. Patient had a convulsion after which he was unconscious all day: Takes no nourishment: Urinates often:

29 Still stupid Temp. 104 2/5 Brandy every hr. Strych. 1/40 gr. every three hours: Cold sponge baths given. 30 Visited by mother today - Same treatment continued.

May 1 Still very weak & in stupid condition: Mice every hr. Temp. A.M. 103 3/5 PM. 102. At 4.30 A.M. had convulsive movements of right side: Pulse fairly good.

2 No change noticed until toward night seemed to be failing: Pulse much weaker. May 3 Failed gradually during night: Mice given every hour - Pulse very weak: Breathing labored: In comatose condition Died at 9.50 A.M.

Dr Sprague notes Died after epileptiform attack in General Paresis - Left side paralysis.

Died.

Personal and Medical History of

Personal and Medical History of Frederick Eppermann (Ferdinand F. Eppermann)

EUBERT, FIELAB & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4697
Residence, Olmsted Co, Minn.
Date Admission, March 3rd 1897.
Admitted by Dr. P. M. Phelps. Hour, 6:30 P.M.
How Sent, J. A. Leonard Jap. Olmsted Co.
Sex, Male.
Age, He does not know. (About 46)
Civil Condition, Single
Children, -
Age Youngest Child, -
Occupation, Laborer.
Degree Education, None.
Profession Religion, None.
Habits, Not intemperate.
Nativity, Germany. (Parents Germany)
Physicians Committing, W. W. Mayo. + C. J. Granger.
Correspondents,

No. for Year, 230
Insane Relatives, Do not know.
Cause Exciting, Unknown.
Cause Predisposing, -
Form, dementia terminalis
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, About 2 wks. ago.
Duration, About 2 weeks.
No. of Attack, 2nd 1
No. of Admissions, 2nd (1st from 1879 to 1891)
Age First Attack, -
Time of Leaving, June 24th 1902.
Time in Hospital, 5 yrs 3 mos 21 ds
Result, Unimproved: Discgd. Aug 14-1902 By Bd C.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient very markedly imbecile. Said to be Epileptic but no fits known. Has been living in family of Wm. Smart the Hostler for several years. Claims he received very little. Slept cold & worked too hard, as the reason for the trouble which caused his recommitment.

Personal and Medical History of Frederick Eppermann.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8 in. WEIGHT, 145 NUTRITION, Fair.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Left pupil ulceration on cornea. Rt ~~Size~~, slightly elongated.
Response Light, Accommodation,
SIGHT, Supposedly impaired.
HEARING, Fair.
COORDINATION, Arms,
Legs,
TREMORS, Hands, None. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Normal EXAM. URINE,
Other Normal
ARTICULATION, Imbecile, slurred
Slurred, indistinguishable.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Normal.
LUNGS, - Normal -

TAKEN,

Arteries - possibly slight impairment.
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 3 yrs. in St. Peter then here until taken out by Mr Smart - No sickness reported in that time.
LENGTH OF INVASION, Imbecile - evidently ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Can't find out - Don't seem to know.
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Frederick Eppermann.

1897

This patient was brought here by sheriff Smart, in fair physical condition, with the following history: No history of consanguinity: First attack occurred about 20 years ago. patient was confined in Rochester hospital from 1879 to 1891: Result of treatment unofficial: First symptoms of present attack manifested about 2 wks. ago by being ugly & quarelsome: disease appears increasing: not variable: no rational intervals. Derangement manifested by ugliness & desire to injure others & filthy & destructive: Nothing known concerning heredity; intemperence in parents or self: Previous peculiarities, severe disease or injury to head:
On personal examination is dull & stupid: cannot answer questions
× Note for further information see Vol. 1. Folio 6. No. 6.
On admission put upon: (G.H.W. Rpt. Complexion light: hair brown: eyes blue: Condition of skin good. Is clean. Behavior good)

Mch 16 Summary Nurses Notes by Dr. Phelps. Patient during two week period after coming here has been quiet and of his usual behavior: Has been here before and is well known. Is quite thoroughly imbecile but has considerable intelligence in work etc. General health is quite good. Has been transferred to Annex. Apr. 30 Condition exactly the same. Is rather silly: Speech has an imbecile defect and it is hard to understand him. May 1'97 Wt. 166#. July 31 Works on farm daily: Health good. Is thoroughly imbecile, but quite reliable in behavior: Jan 31'99 Intervening notes show no change in patients behavior Feb 1 - July 31'99. (Dr. Manous.) Wt. 157#. Does no work: General condition good: Habits untidy: Is demented. Aug 1 - Jan 31 1900. (Dr. Chapple) Wt. 148#. Little change during period: Health, appetite & behavior good. Habits untidy: Works about grounds Much demented. Febry 1900 Wt 142#. Per. July 20. Vaccinated: result negative. July 31. No change to note, during period. Health, appetite & behavior good: habits untidy: works for Ambulance-Driver Wt 141#. Sept 10. Transferred to D^r. Jany 3/1901 No change: Works regularly: Is very demented and silly in manner. Eats & sleeps well. Febry. Wt 153"— May 1. Wt 146# Wt 146#. Nov. Wt. 153#— Jany 3/02. No change, mentally, whatever: has worked regularly: and at James Smarts. Health good.
1900 To Jany 31 Febry 1 July 31 Augt 1901 Jany 31 Augt 1902 Jany 31
June 25/02 Has been working for James Smart. Today taken out permanently by him.

Personal and Medical History of

Personal and Medical History of Louis Erickson.

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4700.

Residence, Sent here from Work house Ramsey Co.

Date Admission, March 4th 1897.

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

How Sent, J. Willrich, Jof P. Ramsey Co.

Sex, -male-

Age, ? — (June 35)

Civil Condition, -

Children, -

Age Youngest Child, -

Occupation, —

Degree Education, -

Profession Religion, -

Habits, -

Nativity, -

Physicians Committing, Frederick Leavitt + J. Chase. Mds.

Correspondents,

No. for Year, 233

Insane Relatives, —

Cause Exciting, —

Cause Predisposing, —

Form, — dementia syphilitic

Accompanying Bodily Disorder, —

Suicidal or Not, —

Date of this Attack, —

Duration, —

No. of Attack, -

No. of Admissions, -

Age First Attack, —

Time of Leaving, June 16. 1899

Time in Hospital, 2 yr. 3 mo. 12 d.

Result, Disf. Chronic Parenchymatous Nephritis

EXAMINATION ON ADMISSION.

Exam by Dr. Phelps 8/25/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Very confused.

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events, } Obliterated for time being.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Very poor.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State, } Very poor.

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient can tell nothing accurately. Rambles along in a demented way. Drunkard but the chances are toward a syphilitic dementia. Was picked up + there is no history + he so far has been able to give us no reliable information.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Slightly

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Vague.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Louis Erickson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7 in. WEIGHT, NUTRITION, Impaired.

WOUNDS OR ABNORMALITIES, Skin fair condition - tone pallor

TONGUE, Tremors, — Coatings, — Promptness Movement, Fair.

PUPILS, Equality, Equal Size, Normal.

Response Light, Sluggish Accommodation,

SIGHT, Normal.

HEARING,

COORDINATION, Arms, —

Legs, -

TREMORS, ~~Hands~~, None of note Tongue,

Facial Muscles, General,

REFLEXES, Patellar, ? Exaggerated EXAM. URINE,

Other

ARTICULATION,

Slurred, Slightly

Hesitating, Quite hesitating + slow.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal.

LUNGS, Normal.

Arteries - Can't detect any abnormality.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Louis Erickson.

1897

This patient was brought here by Sheriff's deputy Charles Peichow in fair physical condition. No information concerning patient given in Commitment papers. On personal examination can get no information out of patient.

Note made by F Leavitt M.D. on papers - "I have examined patient at workhouse where he was sent for 30 days & can get no intelligent replies to any questioning & have always found him insane."

On admission put upon B³ E (O.H.W.R.) Complexion light: hair light brown: eyes blue: Condition of skin good. Large sore on left leg & one on thumb. (Is clean: behavior good: Is very stupid)

Mar 17 Physicians note - Patient thoroughly demented. Very slight improvement since admission. Talks little except in answer to questions & then is a rule irrationally. Some days is considerably brighter than others. Usually sits in north bay trying unsuccessfully to tie his shoe or else pulling at sole of shoe. Articulation hesitating & slurred. Like a general paretic. Suspicion of syphilis partially confirmed by his taking fair sized doses of Potass - Iodide & Mercurial ointment without showing drug effect. Specific treatment Continued.

Mar 18 Patient very restless making all sorts of gestures with his hands: Appetite fairly good: Ointment applied to back every day. Mar 19 Slept none. Mar 22 Restless & noisy: Appetite poor

" 24 Very restless & irrational - bites finger nails & picks at shoes: Mar 23 Slept none during night.

" 27 Very troublesome & restless: appetite poor. Mar 28 Ate fair dinner: had to be fed.

30 Blue ointment discontinued Apr 1 Wt. 145½ Pulse 92 Apr 2 Very restless both night & day: Apr 4 Was knocked down by patient Brannon - no marks visible Apparently very weak. Appetite very poor. Apr 9 Temp. 99⁸ Pulse 90. Has been on medicine constantly. Apr 13 During night had trouble with other patients: Received slight cut on head. Sleeps very little. Apr 20 No change in patients behavior: always noisy & restless: & incoherent & irrational in speech.

" 22 Taken for a walk by nurse. Apr 25 Out with crowd. Apr 26 Out with crowd Very much quieter today: Slight improvement in appetite: Habits occasionally filthy May 3 Wt. 119. Pulse 104. Appetite fairly good: Bowels regular: No improvement in mental state: Still on medicine. Rubbed daily with blue ointment.

May 6 Struck in face by patient Youngberg. May 7 Troublesome & destructive during night.

" 11 Bowels very loose - Slept one hr. during night. May 30 Notes show no improvement in patients condition: Is noisy & destructive & continually troublesome often bothering & fighting with other patients.

June 1 Wt. 117 Pulse 96. Slept none during night. June 9 Attempted several times to elope while out walking. June 24 Restless most of night

Aug 29 '97 Wt. 130# Sept 1 Wt. 142# Looks very incoherent. Is supposed to be somewhat syphilitic History unknown. Is dull & quiet, talks incoherent. Nov 7 Trans. to Infirmary: Seems to be having spells of vomiting & fever. Nov 9 Trans. back to B'.

Jan 31 '98 Wt. 169# Patient is growing filthy: Is very quiet, dull & demented: Is growing

Personal and Medical History of

more paretic in appearance. Feb 1 - July 31 '99 (Dr. Wanous) Wt. Feb 1. 166# Demented & unable to look after himself. Habits filthy. Feb 28 Gradually failing is scarcely able to be up. March 27 Trans. to Infirmary & put to bed. May 3 Has a bad sore on arm & left side, which were dressed. May 21 Is gradually failing & vomits frequently. June 16 Continued to fail until death at 5:30 today. Condition of body - Large bedsores on both hips: black & blue spots on body. Large bed sore on left hip.

Died

Personal and Medical History of Ole Christofferson

COGGEY, FOLAN & CHAMBERS, DAVENPORT, IOWA.

Whole No. H705
Residence, Pine Island, Goodhue Co, Minn.
Date Admission, March 11 1897.
Admitted by Drs. R.M. Phelps Hour, -
How Sent, Axel Haller J. of P. Goodhue Co.
Sex, - Male -
Age, - 30 -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, - Farmer -
Degree Education, - Common School -
Profession Religion, - Lutheran -
Habits, Not intemperate
Nativity, Norway (Parents Norway)
Physicians Committing, B. Jacking & A.W. Jones M.D.
Correspondents, Jennie Christofferson (mother) Zumbrota, Minn.

No. for Year, 238
Insane Relatives, None Known (Father committed Suicide)
Cause Exciting, Unknown
Cause Predisposing,
Form, Melancholia acute
Accompanying Bodily Disorder, Emaciation.
Suicidal or Not, yes - Tried to poison & hang himself on Feb. 27/97.
Date of this Attack, One month ago.
Duration, About 1 month.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 30
Time of Leaving, Feb. 1. 1898
Time in Hospital, 11 mos. 10 da.
Result, Died - Suicided by Hanging.

R.M. Phelps Aug 1897.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused -
Quick or Sluggish, Slow.
MEMORY:
Past Events, Seems Correct.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull -
Correct or Illusive, Incorrect.
REASONING POWER:
Ordinary Subjects, Dulled.
Own Mental State,
Special Subjects, Very much perverted

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

GENERAL DESCRIPTIVE REMARKS: Had operation for piles first at St Marys - After recovering from this showed melancholia. Was sent here after attempt to hang himself. Is still quite melancholy & thinks ought to be killed "as he will never get over this" Thinks has inflammation in abdomen. Tongue shows bloating & possible tubercular condition, tho not very probable. Says has been troubled for 6 or 8 mos. Is dull with strained, anxious, wandering expression & moves about in a slow, dull half-stuporous way.

Personal and Medical History of Ole Christofferson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft. WEIGHT, 140 lbs. NUTRITION, Rather poor.
WOUNDS OR ABNORMALITIES, None. Skin - Some pallor & anaemia
TONGUE, Tremors, Coatings, None - Promptness Movement, Fairly prompt.
PUPILS, Equality, Equal. Size, Normal.
Response Light, Yes - Accommodation,
SIGHT, Normal.
HEARING, Normal.
COORDINATION, Arms, Normal.
Legs,
TREMORS, Hands, None of note Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Normal. EXAM. URINE,
Other
ARTICULATION,
Slurred, Normal.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,

TAKEN, 1897.

HEART,
Palpitates some but appears normal
LUNGS,
No special impairment noted.
General Appearance suggests possibility of Tuberculosis.
OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Says has piles now as bad as before operation.
LENGTH OF INVASION, Says 6 or 8 mos. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies.
Mother or Mat. Relations, L. Healthy.
Father or Pat. Relations, Father Suicided 30 yrs ago.
Brothers or Sisters,

Personal and Medical History of Ole Christopherson

1897

This patient was brought here by Sheriff's deputy J. C. Powers. in fair physical condition, with the following history:- No history of consanguinity: This is first attack + 1st symptoms were manifested about one month ago by melancholy: Disease appears increasing: not variable + with no rational interuals: Derangement manifested by Hypochondria; Thinks he caused the disease by self-abuse. Not disposed to injure others: Not filthy or destructive: No insane relatives so far as known by witnesses: Father committed suicide at age of 34: No previous peculiarities shown: No history of intemperance in parents or self: No severe disease or head injury: Has not been confined or restrained: Has received no treatment. On personal examination is pale + emaciated, eyes staring, pulse rapid + irregular; Temperature normal, memory weak.
On admission put upon B3 E (Qtn. Rpt. Complexion light: hair light: eyes blue: Complexion skin good: mole on chest + right cheek: Is clean: Good: Physical condition weak.)

Mch 11 Nurses Notes (Summary) Patient came on B3 at 7 Pm. given bath + put to bed. Seems stupid. Mch 12 Slept but 1 hr. during night - Appears more weak today - Answers questions fairly well. Trans. to Infirmary. at 2 Pm. + put to bed. Enema given with good results: Answers question quite rationally. Says that he was sent here because he attempted suicide by hanging: has mark on neck which he says was caused by rope. Complains of throat being sore, apparently some pain on swallowing. Habits fairly clean: Bowels constipated: Sleeps poorly.

Mch 16 Says cause of his insanity was operation for haemorrhoids.

" 18 Put on massage treatment. 3 x week. Still complains of pain in swallowing. Mch 21 Bowels constipated - On cascara 10 gtts 3 x day. Mch 22 Talks but very little of late: complains of pain in chest. Mch 23 Visited by relatives: Talked quite freely to them - wants to go home.

Mch 25 Bowels do not move freely on own account. Enema given. Talks only when spoken to. Still complains of pain in chest. Complains of trouble in holding urine - Is still quite weak - appears to be run down in general. Skin in fair condition. Appetite fair. Does not sleep very well. Thinks that he will never get well. Bowels irregular.

Apr. 1 Wt. 128 lbs. Pulse 80. Appears to be gaining physically. Up this Pm. Appetite is fairly good: bowels constipated: Sleeps well: Is clean in habits: Will not talk much but answers questions: Is quiet + well-behaved. Apr. 20 Visited by a friend. May 1 no change during past month. May 11 Transferred to B3 - May 30 Temp sub-normal + patient not well - enema given - took up on following day.

June 1 Still very despondent; quiet. Never speaks unless addressed: Appetite fairly good bowels constipated - Wt. 158½ lbs. Pulse 90. July 1 Wt. 159 lbs. No change either mentally or physically. July 23 Eczema Marginalis discovered on patients thigh. washed with green soap + medicine applied.

Personal and Medical History of Ole Christopherson

1897

Aug 1 Wt. 160½ Pulse 90. Patient remains the same mentally + physically - Still deluded + despondent. Still has eruption on thighs. Sept 1 Wt. 161 Pulse 90. Patient remains about same - Dress slouchy: habits fairly clean: Sept 5 This Pm at 2:20 attempted suicide by hanging - twine broke + thus attempt was not successful. much to his regret - Received bruises on head + face when he fell.

Oct 1 Wt. 161½ lbs. Pulse 78. Has been more cheerful since above event: Has worked and offered to assist on ward - when not at work seems despondent. More tidy in dress + habits. Oct 18 Threatened suicide today - kept in bed + closely watched. Oct 24 Remained in bed this A.M. Refused breakfast. Bowels constipated. Enema given. Is very despondent: Says he wants to be hung. Visited by friend this A.M. Oct 29 Still in bed - Trans to Infirmary.

Oct 30 Lies quietly in bed: makes no complaints Says he has pain in abdomen - wishes he could die.

Nov. 1 Wt. 150 Patient much depressed - Complains of pain in abdomen: Nov. 2 Lies quietly in bed: Still complains of pain in abdomen but does not speak unless spoken to Talks about an attempted suicide Threatens to make another attempt if he gets a chance - Nov. 5 Visited by his sister. Nov. 6 Very much depressed: Cries most of time today. Nov. 8 Up + dressed today: Says he feels much better.

10 Trans. to B3. Nov. 10 Appetite good: Bowels inclined to be constipated: Sleeps poorly: Cleanin habits: Answers questions intelligently but is depressed + melancholy - Is very suicidal - Nov 11 Visited by friend. Nov 12 Very despondent. Threatens suicide - Nov. 28 Visited by friends. Nov 30 No change -

Dec 1 Wt. 161½ lbs. Pulse 82. Dec 6 Refused to work this A.M. Seems extremely despondent. + threatens suicide Jan 1 Has resumed work, is a neat bed-maker + very slouchy in habits + dress: Jan 31 Appears same both mentally + physically, is still quite despondent.

Fb 1 About 6:15 this morning patient was found hanging by the neck from window screw in bar on north side of B3 ward. Artificial respiration was performed but proved of no avail. Dr Herzog was summoned at once + artificial respiration continued until 7:15 but patient could not be revived. Roommate said patient left room at 5:30 + did not return. The act was probably premeditated as rope used was ingenuously made from handkerchiefs a necktie + some pieces of wire.

Died.

Personal and Medical History of Warren E. Fairbanks.

HERBST, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4707

Residence, Dodge Center, Minn.

Date Admission, March 13th 1897.

Admitted by Dr. A. F. Kilbourne Hour, 10 A. M.

How Sent, First Olson J. of P. Dodge Co.

Sex, male.

Age, 55.

Civil Condition, married

Children, none

Age Youngest Child,

Occupation, Farmer & Stock dealer.

Degree Education, Fair

Profession Religion, None.

Habits, Excessive use of tobacco.

Nativity, Newyork. Parents Vermont.

Physicians Committing, D. W. Ransom & C. D. Bigelow.

Correspondents,

No. for Year, 240.

Insane Relatives, Maternal Aunt. Father intemperate

Cause Exciting, Financial troubles.

Cause Predisposing, —

Form, Dementia melancholic with

Accompanying Bodily Disorder, Nervousness - insomnia - Constipation

Suicidal or Not, Not.

Date of this Attack, About 6 weeks ago.

Duration, about 6 weeks.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 55.

Time of Leaving, May 24. 1897

Time in Hospital, 2 mos. 11 da

Result, Discharged Nov. 3. 1897 Unimproved

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. 3/15/97 by Dr. F. H. Herzog.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Fair

Recent Events, Poor

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, Seems correct.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, somewhat

DELUSIONS:

Systematized or Not, See note.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, incoherent

Voluble or Reticent, Reticent

GENERAL DESCRIPTIVE REMARKS: Patient seems quite demented but speaks at times of people having control over him. Talks ramblingly of things happening back in war times. On attempting to stand right leg seemed to give way under him & he began to rub the thigh & complain as if in pain. On taking his seat seemed all right. On standing again acted in same way. Then fell to chair grasping praecordial region, tears running down cheeks, spell soon passed off. Has nervous twitching of hands & entire body. Power of attention impaired. Constipated since admission in spite of 5 gr. calomel. Suspicion of syphilis.

Personal and Medical History of Warren E. Fairchild.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 10½ WEIGHT, 144 Usually 160 NUTRITION, Impaired

WOUNDS OR ABNORMALITIES, has ruptoid looking crust on face. Papular eruption on palms. Skin acne rosacea

TONGUE, Tremors, Coatings, heavy white Promptness Movement, fairly prompt.

PUPILS, Equality, Equal. Size, Normal.

Response Light, slow Accommodation, slow.

SIGHT, — Has brown spot on left iris

HEARING, —

COORDINATION, Arms, apparently extreme

Legs, incoordination.

TREMORS, Hands, None Tongue, slight

Facial Muscles, None General, None.

REFLEXES, Patellar, 5 equal. EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating, yes.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries somewhat atop.

HEART, No murmurs.

Sounds good.

LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Warren E. Fairbanks.

1897

This patient was brought here by Sheriffs deputy John Howard, attended by Julius Bussvitz + Burt Burdick, in fair physical condition, with the following history:- No history of consanguinity. First symptoms of attack manifested about 6 mths ago. Had delusions of persecution also concerning religion. Disease appears increasing. Variable with irregular rational intervals. Derangement manifested by delusions of persecution; religious insanity + fear of violence + personal injury. Showed disposition to injure others only once. Is not filthy or destructive. During last presidential election patient would get very excited on political questions, an unusual thing for him. Father addicted to excessive use of alcoholics, patient uses tobacco to excess. No severe disease or injury to head. Has been watched + doors fastened + kept him in at night. Has been under practically no medical treatment as he refused to take medicine. On personal examination is extremely nervous. Constant agitation of right hand, insomnia, Talkativ, extreme constipation. On admission put upon B 3 E (Gstn Rpt. Complexion light: hair gray: eyes blue: condition of skin good: Dental scars on face + inside of left foot. Behavior good)

March 13 Nurses Notes - (Summary) Patient came in on B 3 at 11 oc A.M. Given bath, put to bed. Extremely nervous: ate light dinner. Mch 15 Has been very restless, going through all kinds of motions, turning himself out. Appetite very poor: Bowels constipated. Trans. to Infirmary + put to bed. Bowels constipated, was given an enema, which required four nurses. Talks incoherently + irrationally. Has twitching movements of hands. Mch 16 Patient says that he was sent here for spite work. Very restless. Is frightened + pulls his hair when temperature is being taken. Enemas have but little effect on patient.

Mch 17 Restless, as usual. Given an enema, repeated. effect light. Mch 18 Patient more quiet today. Mch 20 Restless, crying one minute laughing the next. Says that he had the grippe about a month ago which was the start of his sickness. Mch 22 Restless all night. Says that he does not know how long he has been here or where he is. Mch 25 Does not seem to improve, restless most of night + out of bed often. Pugnacious, attempted to strike N.W. with vessel. Fairly quiet during day. Mch 26 Visited by friends. Called them by name. Has been on blue ointment treatment since 18 inst. Appetite fair: Bowels do not move without cathartics. Slight breaking out on face. otherwise skin appears in good condition. Still restless + pugnacious at times. Says he feels good + wants to get up. Can notice no improvement.

Apr 1 Still very nervous - out of bed + on hall often. Requires several nurses to manage him.
" Wt. 126 lbs. Bowels irregular: Restless + noisy most of night. Takes only light food:
" Refuses emulsion + other medicines: Drinks milk between meals. Apr 7 Bromides discontinued. Put upon other medicine: No change in patient. Bowels irregular.

Personal and Medical History of Warren E. Fairbanks.

Apr 12 More quiet today: Still refuses emulsion: Takes milk between meals:
" 18 Refuses medicine, which is put in milk: Cries at times during day: Is very nervous.
" 19 More quiet + rational today: Has tremors of right hand.
" 21 Lame in both legs; no swelling: Cannot stand on feet. Temp. 102 2 this PM. A.M. Temp. 101 6 P. 106 R 24 PM. Temp. 103 1 P 118 R. 28. A great deal of pain in legs + knees. Ointment applied. Apr 23 Temp. 102 3 P. 110 R 18. PM. T. 103 P 116 R 22. Visited by friends: no change in condition. Slept none during night Apr 24 Temp. 101 8 in AM, 102 PM.
" 27 Seems much better: Can use limbs quite freely: Is restless + very talkative: Pulls bedclothes off: Temp. not over 100 today: Apr 30 Temp. normal: Sleeps during day at times: night rest much broken: No improvement in condition.

May 1 On regular diet: Still restless + has tremors of right hand: Takes milk between meals:
" 3 Wt. 125½ lbs. No change. May 4 Visited by son: Slept 8 hrs during night. May 5 More quiet today.
" 7 Restless all night. Complained of pain in knees: right knee swollen: Refuses medicine. Temp. 102 2 this PM. May 8 Knee rubbed with ointment + bandaged: Temp. A.M. 100 PM. 101 7.
" 10 Knee redressed: no swelling: little pain: Is restless + out of bed often. Appetite good. Bowels irregular: May 11 Visited by brother + sister: Knew them - talked irrationally.
" 12 Visited by wife: Says she is not his wife: would not talk to her.
" 14 Very restless: Had to be held one hr. Given hypo. at 7 30 PM. May 17 Has been quieter since last note + sleeps better at night. May 19 Visited by relatives: Talked irrationally to them: Physical condition fair. May 21 Dressed + out for a while this afternoon: Quiet but rather weak: 23 Not so nervous + restless of late.
May 24 Appetite good. Bowels quite regular: Still rather weak.
May 24 Visited by relatives + taken home.

Discharged.

Personal and Medical History of Ernest Gable

BUDLEY, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4711

Residence, St. Paul Minn.

Date Admission, March 17 1897.

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

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

Sex, - male -

Age, - 49 -

Civil Condition, - married -

Children, - one -

Age Youngest Child, -

Occupation, Laborer

Degree Education, None.

Profession Religion, None.

Habits, Unknown.

Nativity, Germany.

Physicians Committing, G. Stramm. + Talbot Jones.

Correspondents, - wife Pauline Gable, 250 Minnesota St. St. Paul Minn.

No. for Year, 244.

Insane Relatives, Unknown

Cause Exciting, Epilepsy possibly

Cause Predisposing, — —

Form, dementia terminal

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Never attempted. Propensity active

Date of this Attack, 14 or 15 yrs. ago.

Duration, 14 or 15 years.

No. of Attack, - -

No. of Admissions, Has been in City Hospital St. Paul.

Age First Attack, 35 yrs. about

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

Exam. Mch. 18 by Dr. H.H. Herzog.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Fair.

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent, ✓

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, of persecution.

Special Subjects,

Transitory or Not, fixed

HALLUCINATIONS: possibly of hearing.

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, fairly coherent

Voluble or Reticent, Voluble.

GENERAL DESCRIPTIVE REMARKS: Patient has lived on flats + made his living sorting rubbish on the "dump". Has been of low intelligence, quarrelling with his neighbors. Hears his wife, who has left him, talking outside his door at night. The neighbors children tell him he has been chosen for some office. Feebleminded.

Personal and Medical History of Ernest Gable.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, Gothic arched palate.

TONGUE, Tremors, Coatings, heavy yellow coat Promptness Movement, Protrudes to right.

PUPILS, Equality, Opacity of cornea of right eye. Size, Normal.

Response Light, Somewhat excessive Accommodation, somewhat excessive.

SIGHT, Fluid in right eye.

HEARING, Fair.

COORDINATION, Arms, Some incoordination

Legs, "

TREMORS, Hands, Some. Tongue, Yes.

Facial Muscles, No. has a lateral tremor of head General, None.

REFLEXES, Patellar, 9 Equal.

Other Slight ankle clonus.

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION, Arteries somewhat stiff.

SENSIBILITY,

HEART,

LUNGS,

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Had Epilepsy - but no convulsions for past 8 or 10 years.

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 Ernest Gable.

1897

This patient was brought here by Sheriff's deputy P. J. Missen in fair Physical condition with the following history:- Nothing known as to consanguinity, heredity or intemperance in parents or self:. Has had various attacks: First symptoms manifested 14 or 15 yrs. ago: Disease appears increasing: Not variable. No rational intervals: Derangement manifested by delusions that neighbors are trying to kill him: Is disposed to injure others, is filthy & destructive: Has had epilepsy for an indefinite length of time: Has not been confined or restrained, except at City Hospital, St. Paul, & has received no treatment. On personal examination various delusions are shown.

On admission put up on B 3 E (Ast. Rpt. Complexion light: Hair slightly gray: Eyes Blue: Condition of skin good: Scar on forehead: Double hernia: Is dirty: behavior good.)

Physicians Note.

Mar 30 Patient remains about same. Somewhat feebleminded. Looks much better since getting cleaned up. Quiet & well behaved. Willing to do anything that is asked of him. Helps a little on ward.

Apr 30 Summary Note, by Dr Phelps. No special change in patient since admission. Is quiet on ward; goes out walking, obeys promptly and seems in good health. Is, of course, quite demented. - May 1'98 Patient quiet & demented for the most part: Talks little: Neat in behavior: June Noted as talking to himself. May 23'98 Patient ran away was caught in the city & returned: Has been recently working on farm. Jan 31'99 Condition unchanged in every way. Fro1- July 31'99. (Dr. Chapple) Wt. 127# Fr 873. Ear sore - is improved on treatment. May 17 Attacked by B. Anderson. Both eyes discolored. Peculiar in actions & in fair Physical condition.

Aug 1- to Jany 31 Jan 31' 1900. (Dr Chapple) Wt. 130.# No changes of importance. Health fairly good. Is at times noisy; otherwise behavior good. Habits untidy: does nothing.

May 1 Wt 133#. P80. July 20. Vaccinated: result good. July 31. Very little change: habits very untidy: is

July 20/ 31 inactive. Thoroughly demented: does nothing. Inclined to be contrary & noisy, at times. Health fairly good.

Aug 1 Wt 132#. Sep 10. Transferred to D 1. Sep 13. To D 2. Jany 31/1901. No change from day to day: quite

(1900) Jany 31 neat in habits & dress: very inactive: Talks a good deal to himself, & at times, very noisy.

July 2 Wt 134#: May 1. Wt 129#: Aug 1. 125#: Nov 1. 127# - Jany 31/02 Has been in fair health during

July 31 1901 year. Inactive; rather slouchy: at times, extremely noisy & incoherent.

Aug 1- Weight 125#; Jan. 31/02 Habits very untidy; indolent at times - Very slouchy; noisy at times; fully demented; has been failing somewhat. No illness of consequence.

Personal and Medical History of

Personal and Medical History of Edward Tracy

ESSERY, PYCAR & GRABACKE, DAVENPORT, IOWA

Whole No. 4714
Residence, St. Paul, Minn.
Date Admission, March 18' 1897.
Admitted by Dr. R.M. Phelps, Hour, 7 P.M.
How Sent, G. Willrich, Jop P. Ramsey Co.
Sex, Male.
Age, - Not known.
Civil Condition, Married.
Children, -
Age Youngest Child, -
Occupation, Laborer.
Degree Education, -Slight.
Profession Religion, - - - -
Habits, - Not known.
Nativity, - Ireland -
Physicians Committing, G. Stamm & Frick Leavitt
Correspondents,

No. for Year, 247.
Insane Relatives, Not known.
Cause Exciting, Not known
Cause Predisposing, Not known.
Form, melancholia acute
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, Several days ago.
Duration, Several days.
No. of Attack, Unknown.
No. of Admissions, Unknown
Age First Attack, Unknown
Time of Leaving, Dec. 3. 1897
Time in Hospital, 8 mo. 15 da.
Result, Discharged May 4. 1898
Much Improved.

EXAMINATION ON ADMISSION.

Exam. by H. Hoffmann 3/18/97

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient argues fairly well. Says he had no objection to eating but did not wish to eat prison fare. Says it was his own business that he did not eat on the train. That he refused information as to where he was going etc. on same ground. Patient is "Cranky" & irritable, insolent in tone. Shows no delusions.

Personal and Medical History of Edward Tracy.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION,
WOUNDS OR ABNORMALITIES, Darwin tubercle of ear, deficient helix, no lobule.
TONGUE, Tremors, Coatings, Coluticish coat. Promptness Movement, Prompt.
PUPILS, Equality, Equal. Size, Normal.
Response Light, Yes. Accommodation, Yes.
SIGHT, Good.
HEARING,
COORDINATION, Arms, Good
Legs, "
TREMORS, Hands, None Tongue, Slight.
Facial Muscles, " General, None
REFLEXES, Patellar, 5 Equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs noted.
Sounds fairly Good. Regular. Slow
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of Edward Tracy.

1897

This patient was brought here by Sheriffs deputy O. J. Unicen in fair physical condition: Nothing known concerning patient except that he is said to have become insane on Railroad train between Spokane Washington & St. Paul, refused to eat, talk or sit: Manifests derangement by stupidity & melancholy: was confined in County Jail, St. Paul, for several days. On personal examination refused to answer all questions. Melancholy. On admission put upon B³ (Ayer Rpt. Complexion sandy: hair black: eyes blue: Condition of skin good: Is dirty: behavior good)

Mar 28 Physician's Note. Has improved slightly in physical appearance since admission. Insists that he is not insane but "got his Irish up" & defends his position with some show of reason. Says he was hatless on train because his hat blew out of the window. That he did not eat on the train because he did not care to pay "6 bits" for a meal in the diner & had no opportunity to get meals at stations. Quarrelled with conductor over his check, which conductor had placed in band of the window & he refused to sit in that seat. Says would have bought a meal in St. Paul but was arrested before he had a chance. Refused to eat "prison grub or hospital grub" Admitted on admission that he was very hungry. Questionable as to how far his opinion is correct. Is less surly to officers than at first.

19 Summary Nurses Notes. Is very obstinate. Still in bed: Refused all nourishment. 20 Fed with tube. Is up on ward today: Habits very untidy.

21 Behavior much improved today, tho talks insultingly to nurses. Bowels irregular. Mch 23 Surly & ill-tempered today: also restless & discontented: walks hall continually. Mch 25 Out for a walk. Mch 26 Eats nothing but bread. Refuses all other food. Mch 31 Behavior does not change: Still very restless. Bowels irregular. Apr 19 No change in patient: Still refuses all food except bread: Bowels constipated, requires frequent cathartics. Wt. 156½ lbs. Apr. 19 Trans. to B².

May 1 A very obstinate patient: Will not talk unless spoken to: Does not show any delusions but at times will not eat: Physical condition seems failing Will do no work: Sleeps well. May 5 Trans. to A'. May 9 Patient obstinate & surly; does no work: walks floor continually: Seems confused in his ideas - wonders why he is kept here. Appetite very Poor: Trans to B³.

May 15 Has taken very little nourishment since he came on ward: Seems to be failing quite rapidly: Bowels irregular. Trans. to Infirmary. May 22 Talk profane & abusive: Habits filthy: Will take no nourishment except milk: Rolls about in bed. Pulse good.

24 Lies in bed with head covered: Takes only milk: Bowels constipated: Habits filthy Temperature normal June 20 Patient up on ward: Is eating well: Talks irrationally Tears his clothes & is untidy in habits: June 26 Trans. to B¹ Appetite poor: Destructive during night: July 3 Wt. 135 lbs. Appetite poor: Is kept in bed as he requires

Personal and Medical History of Edward Tracy.

close watching July 10 Behavior has improved somewhat: Is allowed on hall & is eating in Dining room: Is destructive at times: Put upon extra diet.

July 29 Refuses extra diet: Bowels regular: No further improvement in behavior: Habits clean but untidy: Does no work. Aug 4. Behavior variable: at times quiet & at others very talkative, also destructive & stubborn. Does no work. Aug 30 Behavior much improved: Is allowed on hall. Sept 12 Appetite good: Bowels regular. Complains because kept on this ward: Has gained over 10 lbs. during past month. No delusions noticeable of late: Habits neat & clean. Sept 15 Trans. to C² E.

Oct 30 No change. Nov 1 Patient is well behaved: Talks very sarcastically but rationally Physical condition good: Does no work: Is very anxious to go to Ireland. Habits neat & clean: eats & sleeps well. Wt. 187 Pulse 72. Dec. 3 Mentioned.

Discharged.

Personal and Medical History of Louis Biegler

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4716
Residence, St Paul, Minn.
Date Admission, March 20 '97
Admitted by Dr R.M. Phelps. Hour, 7 P.M.
How Sent, G. Willrich J. of P. Ramsey Co.
Sex, - male -
Age, - 46 -
Civil Condition, - married -
Children, - 1 -
Age Youngest Child, -
Occupation, - Laborer.
Degree Education, - not known
Profession Religion, yes Catholic -
Habits, Intemperate -
Nativity, Germany
Physicians Committing, B.J. Paxton & H. Hahn.
Correspondents,

No. for Year, 249.
Insane Relatives, Unknown.
Cause Exciting, Unknown
Cause Predisposing, Unknown.
Form, Mania acute delirious
Accompanying Bodily Disorder, none mentioned.
Suicidal or Not, Not
Date of this Attack, March 17. 1897.
Duration, 3 days.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 46
Time of Leaving, June 29. 1897
Time in Hospital, 3 mos. 9 da.
Result, Discharged Sept. 28. 1897. Recovered.

EXAMINATION ON ADMISSION.

Exam. 3/20/97 by Dr Herzog.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, sluggish.
MEMORY:
Past Events, None
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, None.
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 is in an acutely delirious condition with nutrition much impaired. Is totally delirious. Can answer no questions. Shouts loudly, meaningless rhymes. Echolalia. Strikes, bits & spits at nurses. Is well muscled & exhibits much strength in spite of his impairment of nutrition. Face seems serious, was fed with tube tonight.

Personal and Medical History of Louis Biegler

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, not given WEIGHT, not given NUTRITION, —
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Mouth dry, light sordes ~~Coatings~~, on tongue & teeth. Promptness Movement, does not protrude
PUPILS, Equality, yes Size, slight dilation.
Response Light, ? Accommodation, ?
SIGHT,
HEARING,
COORDINATION, Arms, Much impaired
Legs,
TREMORS, Hands, yes. Tongue, yes.
Facial Muscles, General,
REFLEXES, Patellar, Not Tested. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Sounds rapid & weak.
LUNGS, Breath sounds can be heard in both lungs. Patient noisy.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of Louis Biegler.

1897

This patient was brought here by Sheriffs Deputy M. Flannigan attended by Ed Peterson in restraint - physical condition apparently good; with the following history:- Nothing known as to consanguinity or heredity: First symptoms of attack manifested March 17th 1897: Disease is not variable; no rational intervals: Grandeur manifested on religious subjects + others. Is disposed to injure others: Not suicidal: is filthy and destructive: No previous peculiarities noted: No injury to head, has recently had "La grippe": Has been confined in County jail for 3 days past: Has received no treatment. On personal examination patient acutely maniacal. On Admission put upon Infirmary Ex (Gtt. III. Apt. Complexion light: Hair dark, partly gray: Eyes gray: Condition of skin good: vaccination marks on left arm: Scars on right + left groin as if from operation Bruises on right elbow + on various other parts of body: Is clean: behavior mild)

Apr 2. Physicians note. Patient received in acute delirious condition Temp. 106th: given cold tub bath bringing Temp. down to 103 2 + 1 oz. salts + 1 quart. Egg nog with whiskey by tube. In restraint from evening of admission to 12.30 P.M. on 22nd. Restless, noisy + delirious all of this time. Slept 0 the first 2 nights + but 2 hrs. the 3rd night. Had to be fed twice by tube, after that took large quantities of liquid food. Evening of 23rd Temp. rose to 104 2 24th A.M. 105 4 P.M. 106 3. Controlled by cold tub baths. 25th A.M. 100 6 continued to run between 100 + 101 up to Apr. 2nd when it touched normal in the morning. Slept 7 hrs. on the 28th most of afternoon on 24 + has slept well at night ever since. Became quieter the 26th + has been growing better since. During 26th, 27th + 29th took insufficient nourishment on 29th fed with tube. Added milk toast + custards to diet. Has since eaten well. Bowels have been uniformly constipated. Moved by salts. Glyc. sup. or enema. Now is quiet + well behaved. Still in bed. Answers simple questions rationally: Has no memory of what occurred during delirium. Is confused on attempting much mental exertion. Very marked improvement. Much better than looked for.

Apr. 7 Up on ward some time this afternoon. Temp. A.M. 98 4 - P.M. 100 2. Apr. 8 Has delusions today thinks devil was with him last night + that people are going to injure him.

9 Is quiet + more rational today. Apr. 10 Slept but one hr. last night: Complains of pain in head: Temp. 101 4 this P.M. Appetite good Apr. 11 Complains of pain in head + occasional chills extending down through body to extremities. Cold applications applied to head during night. Later perspired freely + said he felt better Temp. at 5 P.M. 103 4. Apr 12 Very weak: Vomited dinner: Dozed during day, waking with a start. Temp. 99 6 in A.M. 101 2 P.M. Apr. 13 A good deal of pain in back. Talks more rationally Temp 101 2 P.M. Apr. 14 No change. Apr 15 Lies quietly in bed: very weak: Still on liquid diet Temp. A.M. 100 2 P.M. 103. Bowels regular. Apr. 16 Feels better today. Put on regular + extra diet. Temp. 99 6 - 102 6. Apr 20 Has been improving slightly since last note. Sleeps poorly at night but a good deal during day: Temp. more

Personal and Medical History of Louis Biegler.

nearly normal. Talks quite rationally. Apr 27 Patient still perspires profusely at night. Objects to medicine, thinks it is poison: Coughs a good deal: expectorates a little: Appetite good: Temp. about normal: Bowels irregular. May 1 Wt. 120. Patient seems a little better. Night sweats have decreased + seems stronger: Still on medicine.

May 5 Complains of soreness in left shoulder + muscles of legs + thighs. May 14 Still has soreness in shoulder + in legs: Alcohol baths given: Perspires freely at times. Is feeling fairly well: Is sleeping well. May 16 Up this PM. Is cheerful + seems improving physically. May 21 Has been up every afternoon since last note: No change.

May 28 Able to be up most of day: Limbs still sore: Night sweats not so severe. Bowels regular. June 1 Seems to be feeling quite well: Talks rationally: Does a little work on ward: Takes medicine in wine 3x day. June 15 Has complained frequently of headaches during month. June 25 Has been very cheerful + pleasant of late: Makes no complaints. June 29 Sent Home.

Discharged.

Personal and Medical History of Arthur Nepil

EBBERT, PICLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4717

Residence, St. Paul, Minn.

Date Admission, March 20 1897.

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

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

Sex, Male.

Age, 17.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Schoolboy.

Degree Education, 1st year high school.

Profession Religion, Yes Protestant.

Habits, Not intemperate.

Nativity, Nebraska.

Physicians Committing, P. D. Boler A. W. Dunning

Correspondents,

No. for Year, 250

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing, Unknown

Form, Confinement in county

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, 5 Mths ago.

Duration, 5 Mths.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 17.

Time of Leaving, June 6. 1900

Time in Hospital,

Result, Transferred to Hastings 10 Apr 1900

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog. 3/21/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Somewhat confused

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Fairly good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dull.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, slightly

DELUSIONS:

Systematized or Not, Yes.

Special Subjects, Persecution.

Transitory or Not, Fixed.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient is a young boy with a wide broad forehead & head & shoulders somewhat too large for rest of his body. Says he passed the examinations for highschool & was as bright as rest of class except that he never talked much. Holds head down & will not look in the face. Confesses masturbation after some pressing. Most of his answers are "Yes sir" & "no sir". Volunteers no information. Admits concious of persons here have been troubling him but refuses to tell who. Says this is castle of Inferno. Quiet since Admission.

Personal and Medical History of Arthur Nepil.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8 in. WEIGHT, 140½ lbs. NUTRITION, Body somewhat undernourished face full.

WOUNDS OR ABNORMALITIES, Right ear triplication of crevia faucata - phocomelus right arm. Skin. Some acne on face. disagreeable smell to body

TONGUE, Tremors, Coatings, white coat. Promptness Movement, Fairly prompt.

PUPILS, Equality, Yes. Size, Somewhat small.

Response Light, Yes. Accommodation, Yes.

SIGHT, Good.

HEARING, "

COORDINATION, Arms, Fair

Legs, "

TREMORS, Hands, Slight. Tongue, None.

Facial Muscles, None General, None.

REFLEXES, Patellar, Equal. EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating, Yes.

FACIAL EXPRESSION,

4717

TAKEN, 1897

SENSIBILITY,

HEART, No murmurs.
Impulse feeble.

LUNGS,
Expansion fair.

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 on farm & attended school.

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 Arthur Nekib

1897

This patient was brought here by Sheriff's deputy St. Flandrate, in fair physical condition, with the following history: No history of consanguinity, heredity or intemperance in parents or self:- First symptoms of attack manifested 5 weeks ago by delusions of all kinds, persecution especially. Is disposed to injure others: Not filthy or destructive: No previous peculiarities: No severe disease or head injury: Has not been confined or restrained: No treatment pursued. On personal examination - no further information given)
On admission put upon B3 (Y.M.U. Dpt. Complexion light. Hair black: eyes brown. Condition of skin good. Scars on right side of back: Vaccination scars on left arm: Is clean: Right arm short. Behavior good)

Apr 2 Physician's Note shows very slight improvement since admission. Exact cause of outbreak of violence unknown. Says he did it "for fun". On being questioned in regard to his delusions of persecution is silent or evasive in his answers. A friend from St. Paul says that he was afraid the Catholics were after him to kill him. Is somewhat egotistical with paranoiac tendencies.

Apr 9 Summary Notes by Dr. Phelps. Patient has been at times rather ugly: has not, however, been actually violent: Is very easily irritated & quite despondent.

May 7 Patient rather irritable: Has gotten into trouble at times with other patients Wt. 144#. July 5'97 Visited by friends Oct 7'97 Wt. 160#. July 4-6 Visited daily by relatives very dull, slouchy & careless. Jan 31'99 Wt. 161#. No special change in behavior. Feb 1 - July 31'99. (Dr. Chapple) Wt 162. Patient demented, & filthy. Transf to B', Appetite good. Goes out with crowd. May 30 Eyes in bad condition/ receives treatment for same - improved. Aug 1 - Jan 31'1900 Wt. 164#

1900 Very little change during period; is perhaps slightly more demented.
To Habits untidy: Chews paper wads, & sits in one place most of time constantly nodding head: Does not talk unless questioned.
Jan 31 Goes out for exercise daily: Physical condition has improved
Feby 1 slightly. Feby 1/1900. Wt 179#. P 78. May 6. Transferred to Annex. June 6. No change
May 6 in Mental or physical condition. Is quite fleshy: very demented: untidy: Sits in one
June 6 place all the time. Does not talk, nor answer questions. Bowels regular: has received treatment for sore Eyes.

Was, today, transferred to Hastings Hospital.

Personal and Medical History of

Personal and Medical History of James J. Opheim.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4718

Residence, Adams, Mower Co. Minn.

Date Admission, March 21 1897.

Admitted by Dr. Kilbourne Hour, 6:30 P.M.

How Sent, A. D. Washburn J. of P. Mower Co.

Sex, Male.

Age, 40.

Civil Condition, Married.

Children, 7

Age Youngest Child, —

Occupation, Farmer.

Degree Education, Common School.

Profession Religion, Lutheran.

Habits, Not Intemperate.

Nativity, Norway.

Physicians Committing, B. F. Lockwood & A. W. Allen.

Correspondents, Dr. Dahlquist Ned. Adams. Minn. Family Physician.

No. for Year, 251

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form, Manic acute delirious

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, March. 18 '97.

Duration, 3 days.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 40

Time of Leaving, Apr. 28, 1897.

Time in Hospital, 1 mo. 2 da.

Result, Discharged Sept. 28, 1897. Recovered.

EXAMINATION ON ADMISSION.

Exam. by Dr Harzog 3/21/97.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused

Quick or Sluggish, Clear.

MEMORY:

Past Events, much impaired

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Lacking

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient is in an acutely manical condition. Knows his name & age. Can not answer more complete questions. Talks some on religion but for the most part is profane. Is very much excited & struggles powerfully.

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 James J. Opheim.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, —— WEIGHT, —— NUTRITION, fair.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, heavy brownish Promptness Movement, does not protrude

PUPILS, Equality, Yes Size, dilated

Response Light, slight Accommodation, No.

SIGHT,

HEARING,

COORDINATION, Arms, Impaired

Legs, "

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Not Tested. EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Sounds seem good. Great difficulty in hearing on account of restlessness of patient.

LUNGS, Seems to be no Pneumonia.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of James J. Opheim.

1897

This patient was brought here by sheriffs deputy John C. Johnson Jr. attended by John F. Magaries in apparently good physical condition; with the following history:- Nothing known as to Consanguinity: First symptoms manifested March 18'97 - became incoherent on religious subjects: disease appears increasing: Is variable. There are no lucid intervals: Derangement manifested on religious subjects: Thinks he is engaged in a controversy. Drove his wife out of house & broke up furniture: Is disposed to injure others: Not suicidal or filthy in habits: No destructive: Previous peculiarity a passionate & violent temper: No severe disease or injury to head: Has been confined & restrained: Hand cuffs on ankles one day. No treatment: On personal examination patient presents an incoherent appearance: Talks incessantly on religion: Commitment recommended as he is liable to injure others & destroy property. Disease is such as to require treatment under restraint. On admission put upon M & E (Yth & Rpt. Complexion dark. hair black: eyes gray: condition of skin good: Is clean: Behavior noisy)

Apr. 3 Physicians Note Patient was admitted in acute maniacal Condition. Temp. 102 F. During the first week was kept on B' most of the time in bed. Part of the time in sheet. Did not do well. Slept little & was noisy & irrational. Bowels inclined to be constipated. On liquid diet. Occasional hypnotics, mostly Chloral & Hyoscyamus. On the morning of 7th Temp. was 105 6. Temp. remained elevated during entire first week at times touching 100°. After transfer to the Infirmary was kept in sheet for first afternoon & night. Later had 4 then 2 nurses in constant attendance. On the 30th Temp. touched normal & has remained nearly so since. Is now quiet but restless. Kept abed. Answers ordinary questions fairly well. Has vague religious notions about being a great sinner &c. Takes large amounts of nourishment, egg-nog, Milk, Mellins food, milk toast &c. Was up & out walking Apr 3rd. Gave no trouble. Has done very well considering extreme mania.

Apr. 5 Ext. 158. Patient on light diet Gr.iv salt solution: Talks quite rationally. Sleeps well.
8 Has been up on ward part of afternoon: walks about ward: Is very quiet. Reads a good deal. Apr. 13 Eats well: Bowels regular: Sleeps well: Fairly clean in habits: Talks freely & intelligently: Has rather a sullen disposition & is stubborn: Is improving mentally: Goes walking. Draws. to B3 today. Apr. 23 Allowed to go Home - Last Prog notes - Appeared quiet & rational but recovery was so rapid & recent that we were afraid of a relapse but finally consented to allow him to go home on Trial.

Discharged.

Personal and Medical History of

Personal and Medical History of Theodore J. Lawton.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4722.
Residence, St. Paul, Minn.
Date Admission, March. 24th 1897.
Admitted by Dr. H.H. Herzog Hour, 6.45 P.M.
How Sent, G. Willrich Jail P. Ramsey Co.
Sex, Male.
Age, 48.
Civil Condition, Married.
Children, 2.
Age Youngest Child, —
Occupation, Real estate dealer.
Degree Education, Common school.
Profession Religion, Not a church member.
Habits, Not intemperate.
Nativity, Mass.
Physicians Committing, O.A. Beal & J.C. Nelson.
Correspondents,

No. for Year, 255.
Insane Relatives, None.
Cause Exciting, Worry.
Cause Predisposing, —
Form, dementia paranoides
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Never attempted. Propensity active
Date of this Attack, 3 days ago
Duration, 3 days.
No. of Attack, 1st but has been more or less deranged for 2 or 3 yrs
No. of Admissions, 1st
Age First Attack, —
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam by Dr. Herzog 3/25/97

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, ✓
Depressed,
DELUSIONS:
Systematized or Not, Partially unsystematized.
Special Subjects, Of grandeur.
Transitory or Not,
HALLUCINATIONS: Of hearing
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Somewhat incoherent
Voluble or Reticent, Voluble.

GENERAL DESCRIPTIVE REMARKS: Is a quite marked paranoic, probably progressive. Was formerly a fairly successful real estate agent. Now tells of his mountains full of gold & silver of his universal remedies & of eventually controlling the whole world. Has hallucinations of hearing. varied. Quite markedly ataxic gait. Speech is quite characteristic.

T J Lawton
T. J. Lawton
specimen of handwriting
March 25/97

Theodore J. Lawton.

ADMISSION, CONTINUED.

CHARACTERISTICS.

137. NUTRITION, Impaired
Clear Promptness Movement, Slow.
Frequent Size, Slightly dilated.
Accommodation, slight.

HEARING,
COORDINATION, Arms, Some impairment
Legs,
TREMORS, Hands, Slight. Tongue, Coarse & fine.
Facial Muscles, Of lips in speaking General, ?
REFLEXES, Patellar, 0 EXAM. URINE,
Other
ARTICULATION,
Slurred, Slurred.
Hesitating,
FACIAL EXPRESSION,

SENSIBILITY,
Arteries somewhat atheromatous & prominent temporals
HEART, No murmurs.
Apex beat forcible. Somewhat rapid & irregular
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Denies syphilis. Moderate drinker
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 Theodore J. L[illegible]

EBERT, FIELAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4722.
Residence, St. Paul, Minn.
Date Admission, March. 2nd 1897.
Admitted by Dr. H.W. Herzog Hour, 6:45 P.M.
How Sent, G. Willrich J. of P. Ramsey Co.
Sex, Male.
Age, 48.
Civil Condition, married.
Children, 2.
Age Youngest Child, —
Occupation, Real estate dealer.
Degree Education, Common school.
Profession Religion, not a church member.
Habits, Not intemperate.
Nativity, Mass.
Physicians Committing, O. A. Brad. & J. C. Nelson.
Correspondents,

No. for Year, 255.
Insane Relatives, None.
Cause Exciting, Worry.
Cause Predisposing, —
Form, dementia paranoic
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Never attempted. Propensity active
Date of this Attack, 3 days ago
Duration, 3 days.
No. of Attack, 1st but has been more or less deranged for 2 or 3 yrs
No. of Admissions, 1st
Age First Attack, —
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam by Dr. Herzog 3/25/97

MENTAL CHARACTERISTICS.

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

MEMORY:
Past Events, Impaired
Recent Events,
Special Subjects,

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

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

GENERAL DESCRIPTIVE REMARKS: Is a quite marked paretic, probably progressive. Was formerly a fairly successful real estate agent. Now tells of his mountains full of gold & silver of his universal remedies & of eventually controlling the whole world. Has hallucinations of hearing. Varied. Quite markedly ataxic gait. Speech is quite characteristic.

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

DELUSIONS:
Systematized or Not, Partially unsystematized.
Special Subjects, Of grandeur.
Transitory or Not,

HALLUCINATIONS: Of hearing

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent, Somewhat incoherent
Voluble or Reticent, Voluble.

ersonal and Medical History of Theodore J. Lawton.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5½ in. WEIGHT, 137. NUTRITION, Impaired
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Clear Promptness Movement, Slow.
PUPILS, Equality, Left larger. Left external squint. Size, Slightly dilated.
Response Light, No Accommodation, slight.
SIGHT,
HEARING,
COORDINATION, Arms, Some impairment
Legs,
TREMORS, Hands, Slight. Tongue, Coarse & fine.
Facial Muscles, Of lips in speaking General, Eco.
REFLEXES, Patellar, 0 EXAM. URINE,
Other
ARTICULATION,
Slurred, Slurred.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries somewhat stiff & prominent temporals
HEART, No murmurs.
Apex beat forcible. Somewhat rapid & irregular
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Denies syphilis. Moderate drinker
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 Theodore J. Lawton.

1897

This patient was brought here by Sheriffs deputy C.J. Nunn in poor physical Condition. With the following history: No history of consanguinity: heredity or intemperance in parents or self: Attack came on 3 days ago but patient has been more or less mentally deranged for 2 or 3 years: Disease appears increasing: Is Variable: No rational intervals: Derangement manifested by mental aberration Considers himself a man of great wealth: Not disposed to injure others: Not filthy or destructive: No previous peculiarities shown: No severe disease or head injury: Has not been confined or restrained: Has not received treatment: On personal examination wild & excitable manner & debilitated. On admission put upon B3 E (Gth. Rpt. Complexion light: hair brown: Eyes blue: Condition of skin good: Scars on back of head. Is clean: Unnatural growth on left arm: Behavior good.)

Apr. 6. Physicians Note Very much the same as on admission. Restless & troublesome nights, out of bed frequently. Slouchy & untidy during day. Still make diagnosis of paresis.

Apr. 23 Summary Nurses Notes by Dr Phelps. Shows considerable melancholy since coming: Is quite well behaved, but has, however, in a quiet way delusions of various kinds. May 1897 Wt. 140# Rather demented, irritable quick tempered & rather obstinate: At times attempts to escape: Sept 1897 Patient very changeable in behavior, has at times attacked nurse to knock her down & kill her. Paretic symptoms prominent: Delusions increasing: More unreliable: Jan 31 1899 During intervening time patient has rather steadily failed & become more demented & untidy: rather unsteady: At one time injured himself by falling several times Feb 1 - July 31 1899 (Dr. Warnock) Wt. 129 Pulse 96 June 1899 Extremely nervous & disturbed. July 1899. Noisy during night: July 25 Visited by sister & brother. Several teeth missing. Sister said he lost them before admission to hospital. Aug 1 - Jan 31 1900. Wt. 138# Pulse 80. Nov 1 Wt 135# Pulse 96. Dementia has increased slightly during period. Has been almost constantly noisy. Talking loudly to himself. Very incoherent Frequently strikes himself on head & elsewhere causing bruises. Put Jan 31 1900 cuffs several times to prevent it. Habits quite untidy.

Dec 1. Received slight cut on forehead. Is stubborn & kept in bed most of time. Physical condition fair. Feb 2 1900. Wt 133#. P.S. —

May 10 Transferred to Annex. July 20. Vaccinated: result negative. July 31, No change. Is

July 20 somewhat emaciated, but otherwise appears in fair physical health. Very demented.

Aug 2 Constantly talking or singing in an incoherent & unintelligible manner. Has habit of

31 rubbing arms or striking himself on head with his hands, so that they become raw. Says that he is Vanderbilt, America & various other personages: habits filthy.

Sept 10/13 Transferred to D. Sept 13. To D. Oct 16. Transferred to 7 W. Has abscess of right shoulder.

Oct 19 Shoulder operated upon by Dr. Warnock and Dr. C—: Head of humerus excised and drained.

Personal and Medical History of Theodore J. Lawton.

1900

Oct 20 1900 Patient very weak: given stimulants, Whiskey & strychnine. Oct 20. Visited by brother. —

Jan 26 1900 Wt, missed: much improved in strength, but still emaciated: Shoulder nearly healed. Jan 27. To A 4

31 Improving gradually, in physical condition: has but little use of right arm: no mental change.

Feb 1 to Apl 29 Is very noisy: profane and abusive in language: has habit of striking his head with his well hand, and singing noisily. Febr. Wt 119#. July 8. Transferred to 7 W. for treatment of Shoulder, which is still discharging: irrigated & dressed daily. April 29. To A 4: Shoulder healed: physical condition quite good. May 1. Wt 131#. July 31. No change mentally. Causes no trouble, but is

May 1 to July 31 very incoherent and noisy, at times. Aug 1. Wt 134#. Dec 14. Transferred to 20. —

1900 to Jan 31 1901 General health seems to change little or none. Is noisy: full of delusions: untidy: has but little use of right arm.

Aug 1/02 Wt. 142#. Nov. 12 (Dr. Chapple). Patient has the habit of striking himself on the head with hand - resulting in a large ulcer on forehead. Was put in muffs until wound healed. Nov. 19. To 2 W. Nov. 27 To Annex. Dec. 21. Visited by brother. Jan. 31-03 Condition about the same. Noisy & talkative; very irrational; is very much demented.

Personal and Medical History of Carl O. Christenson.

ROBERT, VISCAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4724

Residence, Adolpho Pa., Minn.

Date Admission, March 27' 1897.

Admitted by H.H. Herzog M.D. Hour, 8 P.M.

How Sent, D.D. Washburn Asst Supt Moose Ls.

Sex, male.

Age, 20.

Civil Condition, Single.

Children,

Age Youngest Child,

Occupation, Labour.

Degree Education, Common school.

Profession Religion, Lutheran.

Habits, Not intemperate.

Nativity, Minn. (Parents. Norway)

Physicians Committing, E.K. Washburn & A.W. Allen.

Correspondents, Ole Christenson. (Father)
Blooming Prairie Minn.

No. for Year, 257.

Insane Relatives, Maternal uncle.

Cause Exciting, Attack of La Grippe.

Cause Predisposing, —

Form, Mania acute

Accompanying Bodily Disorder, none mentioned.

Suicidal or Not, Not.

Date of this Attack, one month ago.

Duration, one month.

No. of Attack, ~~2 before~~ + (Judged continuous)

No. of Admissions, 1st

Age First Attack, 18

Time of Leaving, July 23. 1897

Time in Hospital, 3 mo. 26 da

Result, Discharged Nov. 3. 1897
Improved

EXAMINATION ON ADMISSION.

Exam. Mar. 30/97 by Dr Herzog. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Quick.

MEMORY:

Past Events, Poor

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Poor

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

~~Coherent~~ or Incoherent,

Voluble or ~~Reticent,~~

GENERAL DESCRIPTIVE REMARKS: Patient has probably never recovered fully from his previous attacks. Is somewhat undersized with a small weak chin. Large hands. Is now in a quite typical adolescent state. Restless, making purposeless motions; posing in strained attitudes, rolling eyes, talks incoherently, at times on religious subjects, at others profane. Is troublesome, keeps putting his hands on other patients who resent it.

Personal and Medical History of Carl O. Christenson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5½ in. WEIGHT, 125 NUTRITION, Impaired.

WOUNDS OR ABNORMALITIES, Fingers marked slightly, but by patient P. Finland.

TONGUE, Tremors, Coatings, dry whitish coat. Promptness Movement, Prompt.

PUPILS, Equality, Yes Size, Somewhat contracted.

Response Light, Yes Accommodation, Yes.

SIGHT, —

HEARING, —

COORDINATION, Arms, Slight impairment.

Legs,

TREMORS, Hands, Slight Tongue, Yes.

Facial Muscles, None General, None.

REFLEXES, Patellar, 6 Equal. EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs.
apex beat forcible. somewhat irregular

LUNGS,
Expansion fair

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Brother states that he had two previous attacks. did not fully recover although neighbors noted nothing

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 Carl O Christenson (or Christianson)

1897

This patient was brought here by sheriffs deputy Christ O. Christianson in fair physical condition, with the following history: No history of consanguinity: First attack 2yrs ago: 2nd 1 year ago each lasted 3 months: First symptoms of present attack manifested one month ago: Disease appears increasing: Not variable: No rational intervals: Derangment manifested on all subjects: Not disposed to injure others: No filthy habits but destroys clothing: No previous peculiarities shown. Father intemperate: patient uses tobacco: No severe disease or head injury: Has not been confined or restrained: No information concerning treatment.
On personal examination, whispers to himself continually, spits on his hands & laughs to himself: On admission put upon B³ (Gen Rep: Complexion dark: hair brown, eyes brown, condition of skin good: Is clean: Behavior fragmentary.)

Nov 9. Physician's Note. Was restless much of first two nights, after that slept well. Has improved considerably in behavior. Can now be out about the hall & is neither noisy nor violent but is uneasy, walks about the hall: Does not talk much: Is dull of comprehension. Has had no rise of temperature. Has taken a mixture of potassium Bromide & Cannabus Indica.

Apr 21 Patient was kicked on hip by one of patients, Apr. 30. Visited by brother.

May 3 Patient is very quiet while on hall but rather uneasy when out walking: Keeps wandering away from crowd, but does not attempt to run away: Pulse & Temp normal: Appetite very good: Is improving somewhat in his mental abilities. Trans. to B³.

June 1 Patient very restless has disagreeable habit of nudging patients & nurses when passing them: Talks little, habits & dress neat: Does some little work on ward: Wt. 128½ lbs. Pulse 90±.

July 1 Pulse 100 Wt. 130: Patient is very quarrelsome: Attacked nurse Clifton

Neat & clean in habits & dress: Appetite good: Bowels regular.

15 Patient is not so disagreeable as he was: Seems more pleasant. Physical condition good. Went home today.

Discharged.

Personal and Medical History of

Personal and Medical History of Samuel Youngberg.

EGBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4727
Residence, St. Paul, Minn.
Date Admission, March 30' 1897.
Admitted by Dr R.M. Phelps Hour, 7 P.M.
How Sent, J. Willrich J. of P. Ramsey Co.
Sex, male.
Age, 38 yrs.
Civil Condition, married.
Children, 3.
Age Youngest Child,
Occupation, Laborer.
Degree Education, Attended public School some.
Profession Religion, not a church member.
Habits, Rather intemperate.
Nativity, Sweden.
Physicians Committing, H.P. Nippert & Olof Dahlberg.
Correspondents,

No. for Year, 260.
Insane Relatives, Half sister. (Same Father)
Cause Exciting, Unknown
Cause Predisposing,
Form, Dementia terminal
Accompanying Bodily Disorder, Headaches
Suicidal or Not, Not.
Date of this Attack, 1½ yrs ago.
Duration, 1½ yrs.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 36
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Examn by Dr Hayes 3/31/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Somewhat confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Fair
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Somewhat dull.
Correct or Illusive, Correct.
REASONING POWER:
Ordinary Subjects, Slight impairment.
Own Mental State, Fair
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, somewhat.
DELUSIONS:
Systematized or Not, No.
Special Subjects, of persecution.
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Fairly coherent
Voluble or Reticent, Voluble.

GENERAL DESCRIPTIVE REMARKS: Patient suffers from mild dementia: somewhat simple minded. Thinks that everyone is against him. Has been a laborer seldom staying long at one job. Was married 7 years ago. Saved little or no money. For past 1½ yrs. has only worked one week. Partly because he could get no work, partly because of his headache. Wife had to go out washing. He did not properly care for children. Says he was a little "wrong headed". Denies trying to injure anyone. Put on specific treatment.

Samuel Youngberg.

...ION, CONTINUED.

...RISTICS.

NUTRITION, somewhat impaired.

Promptness Movement, Prompt.
Somewhat enlarged.
...commodation, Slight.

...ue, Fair
...ral, None.

8/10/98 EXAM. URINE,
Sp. gr. 1036
Color yellow - clear.
Reaction Acid.

Careless,
Irregular,
Poor,
SLEEP, Good, Poor, When not working Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL, Sunstroke 12 yrs ago. Headaches since. Suspicious Mental sore 11 yrs. ago Non-inflammatory Subs: Sore mouth as eruption. Has drank considerably.
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,

Mr. Ryan
I am trying to get a job with
at the Stoneware but I dont
no if I can or not but that
as soon as I am in seat I will come
to see
S. Youngberg

Telegraph Mrs Gunnberg
Afton, Minn
In case of death of Samuel
Youngberg -
Also Mrs S. Youngberg
546 Bradley St
St Paul Minn

Copy of petition of Ellen Youngberg for
appointment of Samuel Youngberg
received Apr. 24 '99

47 v 1

Personal and Medical History of Samuel [illegible]

EGBERT, FIDLAR & CHANDLER, DAVENPORT, IOWA.

Whole No. 4727
Residence, St. Paul, Minn.
Date Admission, March 30' 1897.
Admitted by Dr R.M. Phelps Hour, 7 P.M.
How Sent, J. Willrich J. of P. Ramsey Co.
Sex, male.
Age, 38 yrs.
Civil Condition, married.
Children, 3.
Age Youngest Child,
Occupation, Laborer.
Degree Education, Attended public School some.
Profession Religion, not a church member.
Habits, Rather intemperate.
Nativity, Sweden.
Physicians Committing, H.D. Nippert & Olof Soheberg.
Correspondents,

No. for Year, 260.
Insane Relatives, Haly
Cause Exciting,
Cause Predisposing,
Form,
Accompanying
Suicidal or
Date of
Durati
No
No.
Age First A
Time of Leavi
Time in H
Result

EXAMINATION

Exam. by Dr Hinzey 3/31/97

MENTAL CHAR.

MENTAL ACTIVITY:
Clear or Confused, Somewhat confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Fair
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Somewhat dull.
Correct or Illusive, Correct.
REASONING POWER:
Ordinary Subjects, Slight impairment.
Own Mental State, Fair
Special Subjects,

EM.
Normal,
Indifferent,
Exalted,
Depressed, somewha
DELUSIONS:
Systematized or Not, No.
Special Subjects, of persecution
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Fairly coherent
Voluble or Reticent, Voluble.

GENERAL DESCRIPTIVE REMARKS: Patient suffers from mild dementia: somewhat simple minded. Thinks that everyone is against him. Has been a laborer seldom staying long at one job. Was married 7 years ago. Saved little or no money. For past 1½ yrs. has only worked one week. Partly because he could get no work, partly because of his headache. Wife had to go out washing. He did not properly care for children. Says he was a little "wrong headed". Denies trying to injure anyone. Put on specific treatment.

Personal and Medical History of Samuel Youngberg.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 9½ in. WEIGHT, 144 lbs. NUTRITION, Somewhat impaired.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Clear. Promptness Movement, Prompt.
PUPILS, Equality, approximately. Slightly irregular in outline. Size, Somewhat enlarged.
Response Light, no Accommodation, Slight.
SIGHT, Of both eyes impaired.
NG, Good
DINATION, Arms, Slight impairment.
Legs,
EMORS, Hands, Slight Tongue, Fine
Facial Muscles, None General, None.
EFLEXES, Patellar, 5 equal 8/10/98 EXAM. URINE,
Other Sp. gr. 1036
ARTICULATION, Somewhat Color yellow - clear.
Slurred, Scandinavian drawl. Reaction acid.
Hesitating,
FACIAL EXPRESSION,

ENSIBILITY,

HEART, No murmurs noted. Impulse forcible - Sounds loud Rapid Slightly irregular.
LUNGS, Expansion good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, When not working	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, Sunstroke 12 yrs ago. Headaches since. Suspicious Mucal sore 11 yrs. ago. Non-inflammatory Subs: Sore mouth as eruption Has drank considerably.
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 Samuel Youngberg.

1897

This patient was brought here by Sheriff's deputy R. J. Meisen in fair physical condition with the following history:- No history of consanguinity: First symptoms manifested about 11 mos. ago by melancholia: Disease appears to be slowly increasing: Is variable, he appears to be rational most of the time: Derangement manifested on no special subject: No previous peculiarities noted: No history of intemperance in parents or self: Suffered from sunstroke about 11 years ago & has always had headaches since then: Patient has received no treatment: On personal examination patient appears weak both in mind & body: Incoherence in thoughts, melancholic, slight suicidal ideas:- Seems to be slowly & gradually failing. His memory is getting weaker & he probably needs treatment, both for mental & physical ailment. On admission put upon B³ Gen. Rpt. Complexion light: hair brown: eyes blue: Condition of skin good: Vaccination mark on left arm: scar above, left knee: Is clean: behavior good.)

Apr 12. Physician's Note- Is about the same as on admission - There is a slight dementia, quite symmetrical, no definite delusions. Is very anxious to go home to support his family - Sees no inconsistency in the desire & the fact that he did no work for a year & a half. Is on minutions of mercury with no appreciable effect. Is quiet, cleanly, & tidy, does some work.
17 No special change in patients mental condition, is at times very despondent & cries. Works on ward very willingly: Appetite is good & bowels regular. Taken with vomiting spell today - complained of severe headache Apr. 19 Very noisy & pugnacious, has to be kept in bay. Apr 27 Extremely noisy since above note: also abusive. Trans. to B¹. Apr. 30 Goes out daily with crowd: Has occasional crying spells: Is very anxious to go home: Eats on Hall: Habits clean: Does no work.
May 3 Wt 147 lbs Pulse 76. May 20. Has been troublesome & pugnacious all month & has had several encounters with other patients. Still upon medicine. June 1 Wt 149 P. 76
July 3 Wt 143 P 86. Patient is working in dining room & on ward & is doing fairly well. At times is very talkative & noisy using profane & abusive language.
9 Visited by brother today & taken home by him.
Nov. 5/97 Patient returned. Temp. 100 P. 58 R 18. Given bath & put to bed. Nov. 7 Is irrational & ill behaved. Put upon medicine 3 times per. day. Nov. 9 Refused medicine: Very slouchy in habits
15 Memory very poor: Sleeps fairly well. Dec. 1 Behavior much better of late: Has been very sleepy - Spends most of day in room. associates with no one. Medicine discontinued. Appetite good: bowels regular. Is gaining flesh rapidly. Wt. 160 lbs. Pulse 116. Jan 1 Very well behaved during past month: Memory very poor. Jan 8 Seems recovering memory to some extent. Moves about upon ward now & assists with work. Wt. 168 P. 104
Feb. 1 Continues to improve mentally - Physical condition good. Mch 1 Patient talks a great deal about going home. Thinks he is able now to go home & help support his family. Appetite good bowels regular. Wt. 172 P. 78. Continues to assist with ward work. Behavior good.
Mch 4 Taken home by brother - June 6 '97 Came back about midnight. Fairly quiet. July 2 Had a hard convulsion while out with crowd. Sept. 14 Examination of urines showed

Personal and Medical History of Samuel Youngberg

presence of albumen Oct 31 Has been recently on Infirmary: Seems to be doing fairly well. Nov. 1 Wt. 145 lbs. Lies quietly in bed in a very demented condition
Dec 1. Now up on ward. Quite nervous, foolish & demented: Has to be closely watched & helped about dressing & undressing. Jan 2 Trans to B¹. Is a little better able to be up & about. Seems nervous & demented Feb 1 - July 31 99 (Dr. Warnock) Physical condition good: Is restless & demented: Has to be kept in bay.
Aug 1 - to - 1900 Jan 31 1900 (Dr. Chapple) Aug 1. Wt. 114 9. Pulse 90. Has shown increasing dementia: Is very dull & does not seem to understand anything when spoken to: will hardly answer questions quite intelligently: Habits very untidy. Eats from tray: Has habit of rubbing chin with hand causing large abrasions. Sept 30 - Feb 1901 ulcerated tooth extracted: no illness during period. Feb 2/1901. Wt 151 lbs Pulse 96
Feb Transferred to I.W.: Has cellulitis of right leg. Apl 3. Abscess on leg opened. Apl 12. Upon ward, wounds
Apl 13/12 healed: Has been in muffs, while in bed, else he would remove dressings. Apl 29. Transferred to B¹.
29 July 20. Vaccinated. July 31. No change mentally or physically; Extremely demented; Slovenly
July 20/3. and filthy in habits. Does not talk. Seems to understand but little that is said to him: Has to be pushed about. Expectorates everywhere. Is dressed & undressed by nurses. Has habit of rubbing his chin with hands, so as to cause abrasions. Aug 1 Wt 139 lbs Nov 30. Becoming more demented.
Aug 1 1901 Jan 31 Is now demented: Kept in straight-jacket, most of time: is destructive to clothing: has to be dressed & undressed by nurse: does not seem to understand what is wanted of him. Talk very incoherently: Health fairly good: Habits dirty: Expectorates everywhere.
Feb 1 1902 Wt 140 lbs: Aug 1. Wt 138 lbs Sept 1 Is 25 lbs Nov 1. Wt 150 lbs Jany 31/02. Fair physical health,
Jany 31 During year: no change of importance. Has had an occasional "epileptic seizure" - Extremely demented: inactive: incoherent: filthy
Mar 17 02. To I. W.; had several convulsions; was noisy for several days.
Mar. 27 To Annex. May 10 Visited by wife. Sept. 14 Received large scalp wound by being pushed & falling down stairs, while going to breakfast; Wound sutured. Oct 30. To I.W. Very stupid, filthy & sleepless. Destructive. Jan. 31/03. Still in bed; has occasional convulsion; extremely destructive; demented; filthy; pulls bed clothing about. Eats & sleeps well.

Personal and Medical History of Glyde Smith

BURGETT, FIOLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4728
Residence, Winona Co. Minn.
Date Admission, April 1st 1897.
Admitted by Dr. H. H. Herzog Hour, 7 P.M.
How Sent, H. L. Buck. J. of P. Winona Co.
Sex, Male
Age, - 26 -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, Laborer.
Degree Education, Common School.
Profession Religion, Methodist -
Habits, Not intemperate.
Nativity, Minnesota.
Physicians Committing, J. McGaughey and Pierce M.D.
Correspondents, None given in papers.

No. for Year, 261
Insane Relatives, Father's Sister.
Cause Exciting, Masturbation (said to be)
Cause Predisposing, Heredity?
Form, Paranoia
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, About 9 months ago
Duration, About 9 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 26
Time of Leaving, May 29. 1897
Time in Hospital, 1 mos. 28d.
Result, Discharged Nov. 3. 1897 Improved.

EXAMINATION ON ADMISSION.

Exam. by. Dr. Herzog 4/1/97.

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient is in fair health. Admits has always been dull but thinks he is getting brighter of late since he quit masturbating. Has masturbated for years. Speaks of being a "slave to the habit." Talks like all feeble minded persons who worry about it. Thinks that people avoid him because they think he assaulted a young girl. No foundation for his belief. Thinks brothers do not act rightly nor wisely. Threatened to burn a car containing his brothers goods rather than see him leave. Brother became frightened & sent him down here.

Personal and Medical History of Glyde Smith

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6ft 2½ WEIGHT, 182 NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, Habit of ear depression no tobacco. Has a tumor on end of tongue. Says it has been much larger but took medicine & it went away then returned & has been this size for 3 or 4 years.
TONGUE, Tremors, Cankers in mouth Coatings, heavy coat Promptness Movement, prompt.
PUPILS, Equality, Yes Size, Normal.
Response Light, Normal Accommodation, Normal.
SIGHT, Good.
HEARING, "
COORDINATION, Arms, Fair
Legs, "
TREMORS, Hands, Slight Tongue, None.
Facial Muscles, None General, None.
REFLEXES, Patellar, 6 Equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating, Yes.
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds good.
LUNGS, Expansion. Good

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Total Abstainer.
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, Aunt Insane
Brothers or Sisters,

Personal and Medical History of Clyde Smith.

1897

This patient was brought here by Sheriff Aug. Fuhrmann in good physical condition with the following history: No history of consanguinity, or intemperance in parents or self: First symptoms noted about 9 months ago when he became suspicious: believed that he was charged with rape etc. Disease appears increasing: is variable with irregular rational intervals: He still believes that his friends avoid him, owing to charge of rape: He attemps to manage affairs of mother + brothers: visionary schemes: Not disposed to injure others: Not filthy or destructive: Insane relatives - father's sister, in asylum in Illinois: Previous peculiarity, profound religious impressions: No severe disease or head injury: Has not been confined or restrained: Has received no treatment. On personal examination says he is still charged with attempted rape: Labors under great excitement: Is incoherent. On admission put upon B's E Off'l Rpt. Complexion light: hair brown: eyes brown: Condition of skin good: Marks on forehead: Small pimples on legs: Is clean: behavior good

Physician's Notes

Apr. 13 Is somewhat uneasy at staying here - Shows no particular delusions beyond those mentioned in the entrance examination. His brother does not seem to think there was anything the matter with him previous to last winter. On close inquiry however, admits that he had been constantly worrying about his health. Is quiet + well behaved, slightly dull, however. Had a slight attack similar to La Grippe for a couple of days since coming here. Has been on small doses of K. I in Sp. Sarsap - Comp. No change since admission. Seems feeble minded.

Apr. 14 Patient is very pleasant + agreeable: No delusions noticed: On medicine 3 x day.

Apr. 17 No change mentally or physically: Trans. to A'-

" 30 Patient steadily refuses to do any work: Neat in habits + dress: Health apparently good

May 1 Patient quiet + well behaved: Does a little work: Talks rationally: Habits cleanly dress neat: Health apparently good: Visited by brother today.

" 5 Ht. 182 P80 Trans. to A2. May 29 No change noticable: Went Home.

Discharged.

Personal and Medical History of

Personal and Medical History of Harry Russell

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4729
Residence, Rochester, Minn.
Date Admission, April 1, 1897.
Admitted by Dr. O. L. Phelps Hour, 5 P.M.
How Sent, J. A. Leonard J. of P. Olmsted Co.
Sex, Male.
Age, 26.
Civil Condition, Single.
Children, —
Age Youngest Child,
Occupation, Bartender.
Degree Education, Common school.
Profession Religion, None.
Habits, Very intemperate.
Nativity, Iowa.
Physicians Committing, A.W. Stuckfield & C.D. Granger.
Correspondents, None given in papers.

No. for Year, 162
Insane Relatives, None.
Cause Exciting, Drinking
Cause Predisposing, —
Form, Mania a potu
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, Mar. 30, 97.
Duration, 2 days.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 26
Time of Leaving, May 23rd, 1897
Time in Hospital, 1 mo. 23 da
Result, Discharged 5/23/97 Rec. Improved.

EXAMINATION ON ADMISSION.

Exam. by Dr Herzog 4/1/97. **MENTAL CHARACTERISTICS.**

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, slightly.
DELUSIONS:
Systematized or Not, No.
Special Subjects,
Transitory or Not, Yes.
HALLUCINATIONS: Not at present.
ILLUSIONS:
CONVERSATION:
Coherent or ~~Incoherent,~~
Voluble or ~~Reticent,~~ Fairly

GENERAL DESCRIPTIVE REMARKS: Patient has been fairly intelligent. Rest of family are fairly bright but father drinks & family frequently get into trouble of one sort or another. Patient has been drinking hard & had an attack of delirium tremens. Imagines he saw people watching him & talking about him. Imagines he saw his employer shot & stabbed, but is willing to consider these ideas as false.

Personal and Medical History of Harry Russell.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 6 ft. WEIGHT, — NUTRITION, is large & heavy for his age
WOUNDS OR ABNORMALITIES, deficient anthelix of ear. high arched palate
TONGUE, Tremors, Coatings, brown Promptness Movement, prompt.
PUPILS, Equality, yes. Size, normal.
Response Light, Normal. Accommodation, Normal.
SIGHT, Good. Conjunctivae suffused.
HEARING, Good.
COORDINATION, Arms, impaired
Legs, "
TREMORS, Hands, Quite marked Tongue, Yes.
Facial Muscles, none General, Yes.
REFLEXES, Patellar, Equal EXAM. URINE,
Other slight ankle clonus.
ARTICULATION,
Slurred,
Hesitating, Slightly
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds fair - somewhat distant. & ~~Is~~ rumpled sounding -
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of Harry Russell

1897

This patient was brought here by Sheriff's Deputy John Poez & Court Marshal Jos. Mc Dermott. with the following history:- No history of consanguinity or heredity: First symptoms manifested March 30 1897 by violent delirium Acute mania: Disease appears increasing: Variable with irregular rational intervals. Derangement now manifested by delusions & by violent & destructive behavior. Not disposed to injure others. Is filthy & destructive: No previous peculiarities noted: Has been in City Lock up for two days: Cause of disease drinking: Has received bromides. No further particulars noted on personal examination:- On admission put upon B[3] (Gen Rpt. Complexion dark. hair black: eyes blue: Condition of skin good. Anchor tattooed on left arm: Is clean: very stupid)

Apr. 14 Physician's Note. Patient does not seem to be insane. On admission believed in his hallucinations & founded delusions on them but on the second day being assured of their character gave them up. Since then has been rational & much as usual. Probably suffered from delirium tremens. Has been taking 1/40 gr. Strychnine Nitrate 3 × a day hypodermically, discontinued. Says feels good. Eats & sleeps well. Tremors nearly stopped.

Apr. 15 Seems to be alright physically & mentally: Behavior is good: Bowels regular. Appetite good: Apr 16 Is perfectly rational: No delusions or hallucinations: Works on ward & in Shop may makes himself agreeable Trans. to A[3]. May 8 Wt. 174 P. Jr. Patient is of a quiet disposition Habits neat & clean: Appetite good. Sleeps well: Bowels regular: Has parole. May 21 Went home today.

Discharged.

Personal and Medical History of

Personal and Medical History of Ole K. Loken

EGBERT, FIOLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4730
Residence, Vernon, Dodge Co. Minn.
Date Admission, April 1st 1897.
Admitted by Dr. R. M. Phelps Hour, 7 P.M.
How Sent, Sivert Olson, J. of P. Dodge Co.
Sex, -Male-
Age, - 45 -
Civil Condition, - Married -
Children, - 5 -
Age Youngest Child, -
Occupation, - Farmer -
Degree Education, - Common school -
Profession Religion, - Lutheran -
Habits, Intemperate -
Nativity, Norway.
Physicians Committing, A.N. Vaughn & Co. Wright M.D.
Correspondents,

No. for Year, 263
Insane Relatives, None.
Cause Exciting, Not known.
Cause Predisposing, Not known.
Form, Dementia Terminal
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Has attempted Propensity active.
Date of this Attack, 6 months ago.
Duration, about 6 months
No. of Attack, ~~2nd~~ 1st
No. of Admissions, 2nd
Age First Attack,
Time of Leaving, November 5th 1901.
Time in Hospital, 4 Yr 7 mo 4 Ds
Result, Died: Paresis

EXAMINATION ON ADMISSION.

Exam. by Dr Herzog 4/2/97.

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, Seems correct.
REASONING POWER:
Ordinary Subjects, Slow.
Own Mental State,
Special Subjects,

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

GENERAL DESCRIPTIVE REMARKS: Patient was diagnosed a Paretic when here before & has the physical signs now. His facial expression, articulation & tremors of tongue are quite typical. His incoordination is not quite so marked & he has no delusions of grandeur. He has progressed but slightly since he was here before. Now shows a considerable mild dementia which is quite symmetrical.

Personal and Medical History of Ole K. Loken.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, — WEIGHT, — NUTRITION, Good flesh.
WOUNDS OR ABNORMALITIES, Skin - puffy under eyes.
TONGUE, Tremors, Coatings, light brownish Promptness Movement, Somewhat slow.
PUPILS, Equality, Right larger Size, Right slightly dilated.
Response Light, Accommodation,
SIGHT, —
HEARING,
COORDINATION, Arms, Slightly impaired.
Legs, "
TREMORS, Hands, Slight. Tongue, Fine
Facial Muscles, None General, None.
REFLEXES, Patellar, Equal. EXAM. URINE,
Other
ARTICULATION,
Slurred, Yes.
Hesitating, Yes.
FACIAL EXPRESSION,
SENSIBILITY,
Arteries somewhat stiff - Temporals prominent.
HEART, No noted sounds
Strength sounds fairly good.
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of Ole K. Loken

Personal and Medical History of

1897

This patient was brought here by Sheriffs deputy Charles Gleason, in fair physical health, with the following history: No history of consanguinity or hereditity:- Patient was confined in this (Rochester) hospital from June 4 '95 to August 24 '95, when he went home improved. First symptoms of present attack manifested 6 months ago: disease appears increasing: is variable. Derangement manifested by stealing: No disposition to filthy or destructive habits. Previous peculiarity quick tempered & easily excited: Patient drinks hard when he can get liquor: No severe disease or head injury: Not confined during this attack. On personal examination no further information obtained as he is quite rational at times.

On admission put upon B[3] E Gen'l. Rep't. Complexion dark: hair brown: eyes blue: Condition of skin good: Scar under left eye & several on limbs: Is clean: behavior good.

Apr 14 Physician's Note. Patient has improved slightly in tidiness & behavior since admission. Has considerable symmetrical dementia. Is markedly untruthful. Is still quite paretic but has made very little progress since he was here before. The nature of his trouble whether or not the paresis is progressive, is questionable.

May 1 Wt. 149#. Oct 31 Patient quiet: Behavior fairly good: Is continually asking to go home: Is rather demented in appearance. Jan 31 99 Patient at times rather foolish but usually is quiet & dull & works in dining room. Feb July 31 99 Wt. 195#. Is rather quiet & inclined to appropriate other patients things. Generally sits idly about. May 8. Remains in bed. Refused to go to supper. May 21 Had to be catheterized. May 22 Trans. to Infirmary: Very pugnacious, had to be held. July 4 Visited by friends. July 11 Up on ward. Bowels regular: Seems very much better. Aug 1-1898 Jan 31 1900 (Dr. Chapple) Wt. 156 Nov 1 177# Aug 16 Trans. to B[2]. Mental condition failed somewhat during period. Is rather irritable & inclined to be pugnacious. Habits dirty. Very dull: Talks little. Feby 1900. Wt 160#. Pulse 84. May 3/98 Transferred to Annex. May 10 Visited by brother. Was struck by patient. M.D. Rentfrow, discoloring eye & cutting lower lid slightly. June 16 Visited by wife. July 20. Vaccinated. Result negative. July 31. Patient has remained in fairly good physical health, but has become more stupid and demented: very slouchy & filthy in habits, requiring daily baths. Talks very little & is quite incoherent. Very inactive. Sometimes noisy & rugby: Good appetite & sleeps well. Aug 1 Wt 172½ lbs. Sept 16. Transferred to D[1]. Sept 13. To D[2]— Nov 15 Transferred to T.W. & put to bed: (apparently a paralytic attack of right side) — Is unable to walk. Up, onward: in usual condition. Jan 31 1901 Is becoming more demented: very filthy & slouchy; in habits: Does nothing: Scarcely understands anything said to him. May 31 No change — Feby 28 Wt 173#: May 1 Wt 159#. Failing gradually of late. Lately, seems to be in pain. Is extremely demented. Aug 29. Visited by wife & friend. Oct 1. Visited by friend. Oct 25- To. IWT — getting very weak & helpless: is unable to walk. Is severely constipated: given salts. — Nov 15 Wt 116#. Patient is failing rapidly. Nov 5. Died 10[30] P.M.

Personal and Medical History of Peter Tereau

EBBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4733
Residence, St Paul, Minn.
Date Admission, April 2nd 1897.
Admitted by Dr. R.M. Phelps. Hour, 7 P.M.
How Sent, G. Ullrick J. Off. Ramsey Co
Sex, Male -
Age, - 38 -
Civil Condition, Widower.
Children, One living
Age Youngest Child, 13 yrs.
Occupation, Living man
Degree Education, None.
Profession Religion, Catholic -
Habits, ?
Nativity, Minnesota (Parents Canada)
Physicians Committing, Arthur Avery + C.E. Riggs
Correspondents, None given in papers.

No. for Year, 766.
Insane Relatives, ?
Cause Exciting, Unknown
Cause Predisposing, Unknown
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Threatened.
Date of this Attack, 3 yrs. ago.
Duration, 3 yrs.
No. of Attack, 1st
No. of Admissions, 1st (Has been at Stillwater for 2 yrs. for forgery)
Age First Attack, 35
Time of Leaving, Apr. 30 1898.
Time in Hospital, 1 yr. 28 da.
Result, Discharged July 30 '98 Recovered.

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog 4/3 97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Somewhat impaired -
Quick or Sluggish, Rather sluggish.
MEMORY:
Past Events, Slight impairment.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly alert -
Correct or Illusive, Correct
REASONING POWER:
Ordinary Subjects, Fair
Own Mental State,
Special Subjects,

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

GENERAL DESCRIPTIVE REMARKS: Thinks there is something the matter with his mind. Says he is not so clear on some days as on others. Previous mental grade was probably fair. Is under indictment for forgery. Has previously served 2 years for forging before. Sent to prison 3 years ago. Shows now a mild dementia with considerable incoordination which with the heightened reflexes would suggest paresis. See attached specimin of hand writing.

INSANE, NOT CRIMINAL.

Indictment Against Peter Tereau Is Dismissed.

The indictment against Peter Tereau was nolled by the county attorney yesterday. Tereau was charged with forgery in the second degree, it being alleged that Jan. 4 he passed a check for $45 on Caroline Sundquist, the signature of J. B. Moorhead having been forged to the check. Tereau was examined in the probate court and committed to Rochester, it being decided that he was suffering from paresis.

Be in enacted by the Snate and house of Representatives of the united states of America in congress assembled

Specimen of handwriting of Peter Tereau March 3/97 written from a printed slip. second word should be 'it'

Medical History of Peter Tereau.

ADMISSION, CONTINUED.

CHARACTERISTICS.

NUTRITION, Good flesh.

lean, toothmarked. Promptness Movement, fairly prompt.
outline + Size, slightly contracted -
Accommodation, yes.

nger to nose - Misses - much hesitation -
o foot - some difficulty Standing eyes shut - sways markedly.

TREMORS, Hands, Slight
Facial Muscles, Slight of lips
REFLEXES, Patellar, to Equal.
Other Ankle clonus.
ARTICULATION,
Slurred,
Hesitating, Yes -
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Good.
LUNGS, Good.

Tongue, Fibrillary.
General, None.

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, 5 or 6 yrs ago had typhoid. Fell from horse 4 yrs ago - denies syphilis.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Living well
Father or Pat. Relations, Living rheumatic.
Brothers or Sisters, 12 or 13 Children in family 2 Children 1 living

Personal and Medical History of

EBBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4733

Residence, St Paul, Minn.

Date Admission, April 2nd 1897.

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

How Sent, G. Ullrich J. Off. Ramsey Co

Sex, Male -

Age, - 38 -

Civil Condition, Widower.

Children, one living

Age Youngest Child, 13 yrs.

Occupation, Living man.

Degree Education, none.

Profession Religion, Catholic -

Habits, ?

Nativity, Minnesota (Parents Canada)

Physicians Committing, Arthur Searey & C.E. Riggs

Correspondents, None given in papers.

Cause

Cause Predis.

Form,

Accompanying Bodily Disc

Suicidal or Not, Threatened.

Date of this Attack, 3 yrs. ago.

Duration, 3 yrs.

No. of Attack, 1st

No. of Admissions, 1st (Has been at Stillwater for 2 yrs. for forgery)

Age First Attack, 35

Time of Leaving, Apr. 30 1898.

Time in Hospital, 1 yr. 28 da.

Result, Discharged July 30 '98 Reconvicted.

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog 4/3/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Somewhat impaired-

Quick or Sluggish, Rather sluggish.

MEMORY:

Past Events, Slight impairment.

Recent Events, "

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Fairly alert-

Correct or Illusive, Correct

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not, None noted

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Fairly Coherent

Voluble or Reticent, " Voluble

GENERAL DESCRIPTIVE REMARKS: Thinks there is something the matter with his mind. Says he is not so clear on some days as on others. Previous mental grade was probably fair. Is under indictment for forgery. Has previously served 2 years for forgery before. Sent to prison 3 years ~~5~~ ago. Shows now a mild dementia with considerable incoordination which with the heightened reflexes would suggest paresis. See attached specimin of handwriting

Personal and Medical History of Peter Dercau.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7½ WEIGHT, 169. NUTRITION, Good flesh.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Clean, Toothmarks Promptness Movement, Fairly prompt.

PUPILS, Equality, Equal. Slightly irregular in outline - Size, Slightly constricted - not centered but are normal naked eye.

Response Light, yes Accommodation, yes.

SIGHT, Keeps lids rapidly working

HEARING, Good.

COORDINATION, Arms, Some impairment - fingers & nose - misses - much hesitation -

Legs, Standing on one foot: some difficulty Standing eyes shut: sways markedly.

TREMORS, Hands, Slight. Tongue, Fibrillary.

Facial Muscles, Slight of lips General, None.

REFLEXES, Patellar, Is Equal.

Other Ankle clonus.

ARTICULATION,

Slurred,

Hesitating, Yes -

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Good.

LUNGS, Good.

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL, 5 or 6 yrs ago had typhoid - Free from Lues 4 yrs ago - denies syphilis.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations, Living well

Father or Pat. Relations, Living rheumatic.

Brothers or Sisters, 12 or 13 Children in family 2 Children 1 living

1897

This patient was brought here by Sheriffs Deputy Porteau in fair physical condition with the following history: Nothing known as to consanguinity, or intemperance in parents as self. No information concerning heredity: 3 yrs ago patient was sent to Stillwater for 2 years for forgery: Disease appears increasing: Condition seems to be progressive: Derangement manifested by impairment of memory, passing forged checks, & a progressive dementia: Not disposed to injure others: Not filthy or destructive in habits. Nothing known as to previous peculiarities: No severe disease; was thrown from horse & unconscious. No confinement except when at Stillwater. No treatment pursued. - On personal examination no further particulars noted. On Admission put upon B3 E (Gotten Rpt. Complexion dark. Eyes black: hair black: Condition of skin good: scar above instep on left foot: Is clean: behavior good)

Apr. 15 Physicians Note Shows practically no change since admission. Has been very well behaved, tidy & gentlemanly. Incoördination not marked. Shows rather more plainly while dancing.

Apr 30 Patient very well-behaved: Works on ward: Takes part in games & recreations: Is quite rational in every way. May 1st 97 79th Patient well behaved, agreable, talkative & rational: No peculiarities noted. Aug 30 97 Noted as taking a great interest in St Paul news & being intelligent in behavior. Dec 3 97 Complained of pain in head & side of face: Teeth extracted but did not relieve him: Jan 31 98. Patient has complained lately of buzzing sound in head & headaches at times. Mch 3 Patient seemed to be unconscious or fainted for a few minutes while being prepared for an operation. Diagnosis of Aneurism made & operation performed for same on Mch 4th. No notable happening. Mch 11th Talks freely: Says he does not feel any of the old pain in head since operation: Prominence of eye is failing & redness is going away: Operation seems to be successful in every way. April 30 Sent home. Seemed to be doing quite well since operation. Trouble with arteries leads to suspicion of syphilitic trouble which is denied: This would account for previous mental state as well as lesion of arteries.

Discharged.

Personal and Medical History of Edward D. Lacy

ECKERT, FIELAS & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4736
Residence, Tree Creek, Minn.
Date Admission, April 6' 1897.
Admitted by Dr A.F. Kilbourne Hour, 7½ P.M.
How Sent, C.D. Washburn J of P. Mower Co.,
Sex, Male.
Age, 21 Yrs.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Laborer.
Degree Education, None.
Profession Religion, Not a church member.
Habits, Not intemperate.
Nativity, Wisconsin.
Physicians Committing, E H. Washburn & A.W. Allen M.D.
Correspondents,

No. for Year, 269.
Insane Relatives, None - Father intemperate.
Cause Exciting, weak mind.
Cause Predisposing, intemperate
Form,
Accompanying Bodily Disorder, none mentioned.
Suicidal or Not, Not
Date of this Attack, About 2 months.
Duration, about 2 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, weak minded since 3 yrs. old.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by Dr Hogaq 4/8/97. **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.
Correct or Illusive, Correct.
REASONING POWER:
Ordinary Subjects, Poor
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS: None noted
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Coherent
~~Volable~~ or Reticent, Somewhat reticent

GENERAL DESCRIPTIVE REMARKS: Patient is an imbecile with quite a characteristic articulation & facies. Hair & beard unkempt. Doesn't know his age. Has been working in an elevator for his father. Evidently became troublesome. Wanders about rather aimlessly; makes purposeless motions.

F. R. Lacy
903 Pt N. Blvd
Chicago
Edw D Lacy's bro.

ON ADMISSION, CONTINUED.

ICAL CHARACTERISTICS.

IT, — NUTRITION, Some impairment.
, foolish cast of countenance, adherent lobules, projecting ears.
ings, grayish coat Promptness Movement, slow.

PUPILS, Equality, Yes. Size, Normal.
Response Light, Yes Accommodation, Yes.
SIGHT, Good.
HEARING, "
COORDINATION, Arms, Some impairment.
Legs, "
TREMORS, Hands, Slight Tongue, Slight
Facial Muscles, None General, None
REFLEXES, Patellar, 10 Equal. EXAM. URINE,
Other
ARTICULATION,
Slurred, as if tongue tied
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Sounds Fairly good
LUNGS, Fairly good.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of Edward D. Lacy

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4736
Residence, Tree Creek, Minn.
Date Admission, April 6' 1897.
Admitted by Dr A.F. Kilbourne Hour, 9th P.M.
How Sent, C.C. Washburn J of P. Mower Co.,
Sex, Male.
Age, - Yrs.
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, - Laborer.
Degree Education, - None -
Profession Religion, not a church member.
Habits, not intemperate.
Nativity, Wisconsin.
Physicians Committing, E H. Washburn & A.W. Allen M.D.
Correspondents,

No. for Year, 469.
Insane Relatives, None - Father intemperate
Cause Exciting, weak mind.
Cause Predisposing, intemperate
Form,
Accompanying Bodily Disorder, none mentioned.
Suicidal or Not, Not
Date of this Attack, About 2 months.
Duration, About 2 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, weak minded since 3 yrs. old.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by Dr. Hazen 4/8/97 **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.
Correct or Illusive, Correct.
REASONING POWER:
Ordinary Subjects, Poor
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS: None noted
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Coherent
~~Volable~~ or Reticent, Somewhat reticent

GENERAL DESCRIPTIVE REMARKS: Patient is an imbecile with quite a characteristic articulation & facies. Hair & beard unkempt. Doesn't know his age. Has been working in an elevator for his father. Evidently became troublesome. Wanders about rather aimlessly; makes purposeless motions.

OFFICERS:
ARTHUR F. KILBOURNE,
MEDICAL SUPERINTENDENT.
ERNEST Z. WANOUS,
ASST. MED. SUPERINTENDENT
WILLIAM H. KNAPP,
ACCOUNTING OFFICER

Aug. 9, 1900.

Personal and Medical History of Edward D. Lacy.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ WEIGHT, — NUTRITION, Some impairment.
WOUNDS OR ABNORMALITIES, Narrow head, foolish cast of countenance, adherent lobules, projecting ears.
TONGUE, ~~Tremors~~, Large Coatings, grayish coat Promptness Movement, slow.
PUPILS, Equality, yes. Size, Normal.
Response Light, yes Accommodation, yes.
SIGHT, Good.
HEARING,
COORDINATION, Arms, Some impairment.
Legs, "
TREMORS, Hands, Slight Tongue, Slight
Facial Muscles, None General, None
REFLEXES, Patellar, 10 Equal. EXAM. URINE,
Other
ARTICULATION,
Slurred, as if tongue tied
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Sounds Fairly good
LUNGS, Fairly good

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of Edward D. Lacy

1897

This patient was brought here by sheriff's deputy John C. Johnson Jr. in fair physical condition, with the following history:- No history of consanguinity or heredity:- This is first attack & first symptoms were manifested 2 months ago, but patient has been weak-minded since 3 yrs. old: Disease appears increasing: Is variable, being worse at times but there are no rational intervals: Is disposed to injure others, strikes & kicks - Had severe illness when 3 yrs. old & has been weak-minded ever since: Has used tobacco, father intemperate On personal examination is morose & gloomy: Needs treatment under legal restraint. On admission put upon 3d E.D.St.H. Rpt. Complexion light: hair gray: eyes blue: Condition of skin good. Vaccination marks on arm: Is clean: behavior Stubborn)

Apr. 19 Physicians Note First few nights patient did not sleep very well, - later slept full allowance. Is imbecile, fairly clean but untidy. Appetite good. Has tried to run away. May 1'97 Patient imbecile in appearance: Wt. 157#

Jan 31 99 General health fairly good. Is drifting along quietly without any happening of note. Feb 1 - July 31 '99 (Dr Wanous) Wt. 145# Has delusions: Talks to himself a good deal: No apparent change mentally or physically.

Aug 1 - to 1900 Jan 31 Jan 31 1900. (Dr. Chappee) Wt. 153, Pulse 90. No change during period: Has imbecile expression: Walks about ward with finger in mouth looking into rooms & asking queer questions: Talks to himself a great deal: Habits rather slovenly: Appetite good: Is rather restless at night Thin in flesh: Does no work. Feby 1900 Wt 149# P 64. May 3. Transferred to Annex July 20. Vaccinated. Result good: July 27. Received cut on palm of hand, when at work, outside (not serious). July 31. No change: has manner & appearance of imbecile: very incoherent & irrational in speech. Behavior good, but is quite restless. Strides about ward as if looking for something. Rather emaciated, but seems well. Is cleanly. Works about grounds.

Aug 1 to Jan 31 Wt 136#. Aug 6. Boil on jaw lanced. Aug 13. Visited by Brother. Sept 13. Transferred to D.

Jan 31 to Feby 1 No change: works regularly on farm: slouchy in habits: restless; constantly walking about, as if in search of something: very incoherent in conversation. Feby Wt. 134# May. Wt 148# Jul 6 Visited by brother & friend. Aug 1. Wt 145# Nov. 134# Jan 31/01. Has worked throughout year regularly, outside, with attendant Hong: Habits fairly cleanly: always well-behaved: very incoherent. Health good.

Jan 31/02 Patient works usually about the grounds with Mr. Hong. Quiet & peaceable but much demented; fairly good worker. Habits somewhat untidy

Personal and Medical History of

Personal and Medical History of F. L. Stevens.

ROBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4738

Residence, Winona, Minn.

Date Admission, April 7th 1897.

Admitted by Dr. R. M. Phelps. Hour, ✓

How Sent, H. L. Buck J. of P. Winona Co.

Sex, - Male -

Age, - 38 -

Civil Condition, married but separated from wife

Children, - One -

Age Youngest Child, —

Occupation, Clergyman & Insurance Agent.

Degree Education, University.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Vermont.

Physicians Committing, J. B. McGaughey & Thos. A. Price M.D.

Correspondents, O. L. Stevens Cor Winona & Howard Sts. Winona Minn.

No. for Year, 271.

Insane Relatives, None.

Cause Exciting, Religious Passion.

Cause Predisposing, —

Form, paranoia

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not

Date of this Attack, 2 yrs. ago.

Duration, 2 yrs.

No. of Attack, 2nd (unbalanced since 1st attack)

No. of Admissions, 2nd (In private hospital)

Age First Attack, about 33.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, fairly quick.

MEMORY:

Past Events, impaired -

Recent Events, Quite good.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, alert

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, good.

Own Mental State,

Special Subjects, ~~Religion~~ Not good.

GENERAL DESCRIPTIVE REMARKS:

Patient in good physical health, well-formed. full chested - Has delusions about religion - Talks in a slow reasoning, judicial manner - Constantly reverts to religious or legal matters. Is a paranoiac. Mental grade probably above average - well educated.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Yes -

Special Subjects,

Transitory or Not, Religion

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

July 2nd, 1897.
Rochester Hospital

F. L. Stevens victim

Messrs. Drs. Herzog, Phelps, and Eber:

A plain and brief statement of my personal mind and sense of my situation is required by my conscience of duty at this time. The U.S. Constitution based on the declaration of Independence - guarantees and demands for every man this right of free religious conscience - and the duty and right of private judgment in the most important matters of morals and religion - subject only to overt law-breaking discipline. Law is limited in Civil jurisprudence to overt actions. And religious conscience is subject to the Edification of the Church of Jesus Christ and the Holy Scriptures - for Examples of Obedience. and for Moral Education in the love of the Righteous. This has been

F. L. Stevens.

ADMISSION, CONTINUED.

CHARACTERISTICS.

74½ lbs. NUTRITION, Good.

rear on each arm. Skin in good condition
n L. Thigh.

Promptness Movement, prompt -

Size, R -

Accommodation, yes -

Tongue, Nor

General,

EXAM. URINE,

Taken,

Sounds Good - Regular

LUNGS, Expans. fair 2½ in -
Chest Symmetrical -
B. Sounds feeble.

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of J. L. S.

EDGETT, FISCAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4738

Residence, Winona, Minn.

Date Admission, April 7th 1897.

Admitted by Dr. R. M. Phelps. Hour, ✓

How Sent, H. L. Buck J. of P. Winona Co.

Sex, - Male -

Age, - 38 -

Civil Condition, married but separated from wife

Children, - One -

Age Youngest Child, —

Occupation, Clergyman & Insurance Agent.

Degree Education, University.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Vermont.

Physicians Committing, J.B. McGaughey & Thos. A. Prine M.D.

Correspondents, O.L. Stevens Cor Winona & Howard Sts. Winona Minn.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, fairly quick.

MEMORY:

Past Events, impaired.

Recent Events, Quite good.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, alert

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, good.

Own Mental State,

Special Subjects, ~~Religion~~ Not good.

GENERAL DESCRIPTIVE REMARKS:

Patient in good physical health, well-formed. full chested - Has delusions about religion - Talks in a slow reasoning, judicial manner - Constantly reverts to religious & legal matters. Is a paranoiac. Mental grade probably above average - well educated.

E

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Yes -

Special Subjects,

Transitory or Not, Religion

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

J. L. Stevens.

ADMISSION, CONTINUED.

CHARACTERISTICS.

74½ lbs. NUTRITION, Good.

rear on each arm. Skin in good condition
n L. High.

aw Promptness Movement, prompt -

Size, N -

Accommodation, yes -

Tongue, Nor

General,

EXAM. URINE,

TAKEN,

Sounds good - Regular

LUNGS, Expans. fair 2½ in -
Chest Symmetrical -
B. Sounds feeble.

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,

for many years since youth my one devoted christian aim. - The Bible has been my daily careful study in the legal & the best teachers in the Protestant World. But I have been a Student also of the fine independence, born of ethical truth of character. I am one of the few who have been called by long years of industry and of patient waiting on God - to learn these questions by meditation & prayer - who have faithfully exercised the sacred right of private judgement - Conscience is no infallible Guide - The Bible is a teacher to it. And the Church is the Authority over it in the truth of the living Lord God & Master. For this independence I have been subject to dishonors of narrow & vulgar minds. This is my one title to your due recognition. I have kept the faith of the Christian in my just life & trials - due to the desire in me to obey the word & spirit of God in the Church & one Communion body of Jesus - Christ - the Son of God.

While here for a trifling misdemeanor in overt action - in spirit - and inner mind it was not morally religious or understood at that time, Moral growth required my Expulsion by striking symbol of the reality of my deep love and need of offering from my unlearned parents. But was with no dishonor to them - as if done in their presence - or because of any anger. I had none whatever - but acted a true object lesson - as for children hard to learn - The Moral Judge of my sincere conscience & faithful independent judgment based in Each detail on the word of God. The Moral law & the Covenant law are my religion - indicated in Jesus Christ.

Personal and Medical History of F. L. Stevens

ECKERT, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4738

Residence, Winona, Minn.

Date Admission, April 7th 1897.

Admitted by Dr. R.M. Phelps. Hour, ✓

How Sent, H. L. Buck J. of P. Winona Co

Sex, Male.

Age, 38.

Civil Condition, married but separated from wife

Children, One.

Age Youngest Child, —

Occupation, Clergyman & Insurance Agent

Degree Education, University.

Profession Religion, Catholic.

Habits, Not intemperate.

Nativity, Vermont.

Physicians Committing, J.B. McGaughey & Thos. A. Prin

Correspondents, O.L. Stevens Cor Winona & Howard S
Winona, Minn

EXAMINATION

MENTAL CHAR

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, fairly quick.

MEMORY:

Past Events, impaired.

Recent Events, Quite good.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, alert

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, good.

Own Mental State,

Special Subjects, ~~Religion~~ Not good.

GENERAL DESCRIPTIVE REMARKS:

Patient in good physical health, well-formed. full chested - Has delusions about religion - Talks in a slow reasoning, judicial manner - Constantly reverts to religious & legal matters. Is a paranoiac. Mental grade probably above average - well educated.

Depressed,

DELUSIONS:

Systematized or Not, Yes -

Special Subjects,

Transitory or Not, religion.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

My action in regular baptism - was born wholesome - wise - prudent - based in scrupulous care on the word of God to all true Disciples of Jesus in Israel. Please see Hebrews, X. 20 - 24. My request and permission to do in all just as I have done. But is that to be considered by you or by any one insane - or even suspected of insanity. To have in Heaven seasons of prayer - twice a day, that never approach to God has been my fault & the Challenge to your minds as to its essential right & propriety under the privilege granted in the U.S. Moral formulations. What my present is incalculated to do - may not be in me insanity - who am a Called & Ordained minister of My God in Israel - whatever else in business I may seem to be. For this Cause I have been falsely accused and suspected of being insane by the ignorant & misdirected in the Environment where I move - in a narrow circle. I claim the right & title to an honorable discharge.

F. L. P. Stevens.

Personal and Medical History of F. L. Stevens.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ in. WEIGHT, 174½ lbs. NUTRITION, Good.

WOUNDS OR ABNORMALITIES, Vaccination scar on each arm. Skin in good condition Scars on L. scrapula - Large scar on L. thigh.

TONGUE, Tremors, 0 Coatings, clean Promptness Movement, prompt -

PUPILS, Equality, Equal - Size, N -

Response Light, yes Accommodation, yes -

SIGHT, quite good -

HEARING, "

COORDINATION, Arms, good

Legs, "

TREMORS, Hands, None Tongue, None

Facial Muscles, " General, "

REFLEXES, Patellar, Normal EXAM. URINE,

Other

ARTICULATION,

Slurred, Rather slow & studied.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs.
Sounds good - Regular

LUNGS, Expans. fair 2½ in - TAKEN,
Chest Symmetrical -
B. Sounds feeble.

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 L. L. Stevens.

1897

This patient was brought here by Sheriff's deputy A.W. Fuhrmann in fair physical condition with the following history:- No history of consanguinity, heredity or intemperance in parents or self: Patient was in private hospital for a few months 4 or 5 years ago & has been unsettled ever since: First symptoms of present attack manifested 2 yrs. ago by talking incoherently: disease appears increasing: is variable with irregular rational intervals: Derangement manifested on subject of religion: Is not disposed to injure others, is destructive of furniture & clothing: Previous peculiarity religious impressions: No severe disease or injury to head: Confined in hospital as above stated: Nothing known as to treatment:

On personal examination manifests great excitement & incoherence in talking: On admission put upon B[3] E (Gt. Kapit. Complexion dark hair black: eyes brown: condition of skin good: Mark on left shoulderblade Scar on inside of left thigh: Is clean: Talks very irrationally.)

Apr 21 Physicians Note Patient came in in an acute maniacal condition. Temp. 101 P. 114. Noisy, talkative, untidy, somewhat incoherent. Kept in bed until April 19. Temp. kept about 99°. Bowels constipated. Slept about 4 hours a night after first two nights. Gradually quieted down & became more coherent. Is now fairly neat & tidy in dress & habits. Is on ward B[3]. Has considerable self-control & does not discuss his delusions freely except with assistant physician. Has religious delusions & paranoiac ideas of grandeur. He is a "most accurate lawyer" an "expert in biblical criticism." Is extremely well educated & is entitled to some credit but not so much as he takes to himself. Is still somewhat incoherent, - that is is easily switched from one subject to another but will remain for considerable time on one point. May 31 99 Wt. 173#

July 99. Patient neat in appearance: Talks on religious subjects: Has an agreeable manner: At times will talk loudly & incoherently - July 13 Visited by some friends: Spends a good deal of time in room: praying & reading - Is working in laundry. Sept 16 99 Pounding on screens & yelling loudly out window - Jan 4 '98 Visited by friends

Jan 31 '99 Patient seems to have settled down in a chronic, quiet state. Is at times noisy & abusive. Feb 1 - July 31 '99 (Dr Manous) Wt. 180# Has delusions: Talks to himself a good deal: No apparent change in condition mentally or physically - eats & sleeps well. Is quite nervous. Aug 1 - Jan 31 1900 Wt. 173#

To Jan 31 1900 Very little change during period: Has been in good physical health. Spends much of time in room, reading & talking to himself - Frequently converses in a rather incoherent manner. Has delusions in regard to religion & other matters at times. Shows considerable excitement walking rapidly about hall.

Personal and Medical History of F. L. Stevens

1900

Feb 1 July 31 Wt 183#. Pg 6. June 1. Had dental work done by Dr. Sinclair. July 21. Vaccinated: result negative. No Change: has been in seemingly very good physical health: Takes Cold Sponge bath, night and morning. Is very quiet and well-behaved: tidy in habits. Talks but little but answers questions readily & usually intelligently. Has delusions on religious subjects and becomes quite incoherent at times. Usually, has a preoccupied appearance. Aug 1 Wt 176½ lbs Sept 17. - Visited by friends Jan 31/1901 Very little Change: is very tidy: regular in his habits: Talks & laughs to himself considerably: mind appears preoccupied: answers questions rationally and quite intelligently: Health very good. Feby. Wt 183½#. May 1. 179# Aug 1. 185# Nov 1. Wt 185# Little Change noticeable: has been in good physical health, during year: very regular and neat in habits: most of time, appears to be in deep study: reads a good deal: rarely speaks to other patients. Replies promptly & pleasantly when addressed. At times, walks about in a great hurry, & making gestures, as if he were addressing an audience. —

July 1 1901 Jan 31 Visited by father Jan 31/03 Has been in very good physical health. Habits very neat & tidy. Takes care of room but does nothing else. Writes and figures a good deal; occasionally laughs and talks to himself; converses little. Still very religious in his behavior Usually rambling & incoherent in talk.

Personal and Medical History of Edward Smith

HERBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. H739
Residence, States Prison, Stillwater, Minn.
Date Admission, April 9th 1897.
Admitted by R.M. Phelps, M.D. Hour, 7 P.M.
How Sent, C.G. Butts Jap't. Washington Co.
Sex, - male.
Age, - 36.
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, - Iron worker.
Degree Education, - Common School.
Profession Religion, Catholic
Habits, unknown.
Nativity, Minnesota.
Physicians Committing, Burton J. Merrill & W.W. Pratt M.D.
Correspondents, none given in papers.

No. for Year, 272
Insane Relatives, No information.
Cause Exciting, Unknown.
Cause Predisposing, Unknown.
Form, Paranoia
Accompanying Bodily Disorder, Debility - Granulated eyelids.
Suicidal or Not, Attempted. Propensity not now active
Date of this Attack, Within last 3 yrs.
Duration, During last 3 yrs.
No. of Attack, 1st
No. of Admissions, 1st (Has been at State Prison)
Age First Attack, 33 or 34
Time of Leaving, Aug. 27, 1904
Time in Hospital,
Result, Transfer to Hastings Ft Jos

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Slightly confused
Quick or Sluggish, Sluggish.

MEMORY:
Past Events, Fair
Recent Events, Some impairment.
Special Subjects,

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

REASONING POWER:
Ordinary Subjects, Fair
Own Mental State, Thinks something is wrong.
Special Subjects,

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

DELUSIONS:
Systematized or Not, Yes.
Special Subjects, of Persecution.
Transitory or Not, Fixed.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, Fairly Voluble.

GENERAL DESCRIPTIVE REMARKS: Patient has two scars on occiput from bullet wound. Right ear scarred. Has furtive expression of countenance. Hangs head. Has been in penitentiary before. Last time says was compelled to work when unable to do so. Two years ago attempted suicide. Has been in solitary confinement since. Hypochondriacal. worries about condition of bowels stomach & eyes. Nothing suits him - grumbles - Was "mistreated & misused" - Says patient (Blaney) who was sent down with him had nothing the matter with him but was sent down as a blind by the prison authorities to divert attention from his case.

Personal and Medical History of Edward Smith.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 6 1/2 in. WEIGHT, 124 lbs. NUTRITION, impaired.
WOUNDS OR ABNORMALITIES, Left hand deformed & clawlike from self-inflicted wound on wrist.
TONGUE, Tremors, Coatings, heavy yellowish coat. Promptness Movement, Slow.
PUPILS, Equality, Yes. Size, Normal.
Response Light, Yes. Accommodation, Sluggish.
SIGHT, Much impaired.
HEARING, Good.
COORDINATION, Arms, Fair
Legs,
TREMORS, Hands, Slight Tongue, None.
Facial Muscles, None General, None.
REFLEXES, Patellar, 9 equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating, Yes.
FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs.
Strength sounds good.
LUNGS,
Fair

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Says had syphilis, history doubtful. 7 yrs ago - Health failing since
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, One brother insane for a few months.

Personal and Medical History of Edward Smith.

1897

This patient was brought here from State Prison Stillwater, Minn by F.H. Lemon Sheriffs deputy, in fair physical health with the following history: No information concerning consanguinity, heredity or intemperance in parents or self: First symptoms manifested during past three years: Disease appears stationary, not variable, no rational intervals: Derangement manifested on subject of his health; claims that his eyes & digestive organs are diseased: Claims that he is being poisoned & otherwise mistreated: Not disposed to injure others: Attempted suicide by cutting left wrist: Propensity not active now: No filthy or destructive habits: No information concerning previous peculiarities, severe disease or injury to head: On May 3 1893 was sentenced to State Prison for burglary in the second degree, for a term of 8½ yrs. has been in sick cell at said prison for 3 yrs past. & has received ordinary treatment for sick cases. On personal examination is physically debilitated, has granulated eyelids. Delusions of persecution.

On admission put upon B³ (G.S.H. Dept. Complexion light: hair brown: eyes blue: Condition of skin good: Scar on inside of left wrist. Is clean. Behavior good.

Apr. 23 Summary to da Record by Dr Herzog:- Patient has improved slightly in physical health since admission. Has still hallucinations of hearing and delusions of persecution. Was on Elixir Iron, Quinine & Strychnia. But refused same after a few days. Was fairly quiet and well-behaved but hypochondriacal, occasionally refusing to go out, up to Apr. 22 when he made a disturbance in the dining room, thinking that people were talking about him. Trans. to B¹ today.

Apr. 30 Behavior has been good during past week: Complains of his eyes being weak: Appetite good: bowels fairly regular. May 31'97 Wt. 133# Health fairly good: Has delusions of persecution. Left limb somewhat deformed: Is quite obstinate, rebellious & troublesome in various ways: Is continually having trouble about his food. Jan 31'99 Patient about same in every way: At times very noisy & abusive: Manifesting however an intelligent manner & appearance of rightness rather than insanity. Feb 1 - July 31'99 Wt. 135# Noisy, troublesome, pugnacious: full of delusions: Is inclined to be noisy during night. Apr 3 Appeared very weak: refused nourishment. Trans. to Infirmary. Bruise on right knee & on right hand & arm caused by striking himself against bed & wall during violent spell.

Do 1900 Inclined to be profane & very vulgar. Aug 1 - Jan 31 1900 (Dr Chapple) Wt. 120# Oct 9 Has been in bed almost constantly altho not sick. Very noisy at times & pugnacious: Very deluded. Conversation extremely irrational. Taken up today.

Jany 31 Oct. 10. Burned hand slightly by hitting against radiator. Dressed. Right Hand swollen & circulation very poor: Treated daily - improved. Up each day but refuses to go out. Is very noisy & disagreeable: Health fairly good. Feby 1 1900, Wt 131# P Ey.

Feby 19 1900 Vaccinated: result negative - July 25. Transferred to annex.

Personal and Medical History of Edward Smith

1900

July 31 No change. Gain fairly good physical health: Eats & sleeps well. Has "delusions of persecution", and is very incoherent and irrational, and, at times, very noisy. Most of his talk expresses these delusions. Is quite tidy & clean in habits. Aug 1. 133½ lbs Sept 10. Transferred to D². Sept 13. To D³. Jany 31/901. Very little Change: gradually increasing dementia: nearly always noisy & haranguing to imaginary audience: Has delusions of persecution and hallucinations: does nothing: language abusive, and heis, at times, pugnacious -

Feby 1900 to Jany 31 Wt 140# May 31 Wt 138# Aug 1. 141# Nov 1. 132#. Jany 31/901. No Special change during year: health fairly good - Complains considerably, at times, of his crippled hand: very active. at times, very noisy, expressing his "delusions of persecution": frequently packs his ears full of chewed paper, Itrans to

" 31/03 Has Changed but little during year; sullen & noisy; harangues about his persecutions; does no work; is fairly tidy in habits. Dec 9 Tooth extracted.

Personal and Medical History of Albert Blanz.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4740

Residence, State Prison Stillwater Minn.

Date Admission, April 9' 1897.

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

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

Sex, Male.

Age, 29.

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, Shoemaker.

Degree Education, Common School.

Profession Religion, Lutheran.

Habits, Unknown.

Nativity, Germany.

Physicians Committing, B.J. Merrill - W.H. Pratt M.D.

Correspondents, None given in papers.

No. for Year, 273.

Insane Relatives, No information.

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form, Melancholia acute

Accompanying Bodily Disorder, Heart trouble?

Suicidal or Not, Not - Very homicidal

Date of this Attack, About Feb. 1' 1897.

Duration, over a month.

No. of Attack, 1st

No. of Admissions, 1st (Has been at States Prison)

Age First Attack, 29.

Time of Leaving, Dec. 19. 1897

Time in Hospital, 8-mo. 10 da.

Result, Died - Valvular Heart Disease

EXAMINATION ON ADMISSION.

Exam. by Dr Herzog 4/5/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Fair

Recent Events, Not so good

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Illusive at times

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State, Thinks something is wrong

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not, Somewhat.

Special Subjects, of persecution

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, Reticent

GENERAL DESCRIPTIVE REMARKS: Patient suffers somewhat from his heart lesion. Says has pains at night, is weak, incapable of exertion &c. Somewhat exaggerates his symptoms. Has somewhat vague ideas about someone throwing influences about him, particularly at night. Has also vague ideas about the Odd Fellows. Thinks this is an Odd Fellows prison. Says that these "influences" make his mind confused. Melancholia.

Personal and Medical History of Albert Blanz.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 6½ WEIGHT, 147. NUTRITION, Fair.

WOUNDS OR ABNORMALITIES, - Condition of skin - Somewhat greasy.

TONGUE, Tremors, Coatings, light yellow coat. Promptness Movement, Prompt.

PUPILS, Equality, Yes. Size, Normal.

Response Light, Yes Accommodation, Yes.

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms, Some impairment.

Legs,

TREMORS, Hands, Some. Tongue, Yes.

Facial Muscles, None. General, None.

REFLEXES, Patellar, Equal

Other

ARTICULATION,

Slurred,

Hesitating, Yes.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Blowing murmur - 2nd Aortic Sound. Pulsus paradoxus. Aortic regurgitation. Considerable hypertrophied displaced to left of nipple line Compensation fairly good.

LUNGS, Fair

EXAM. URINE,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Albert Blanz.

1897

This patient was brought here by Sheriff's deputy J. H. Lemon from State Prison Stillwater Minn. in fair physical condition, with the following history:- no information concerning consanguinity, heridity, previous peculiarities, severe disease or head injury or intemperance in parents or self: This is first attack + 1st Symptoms were manifested about February 1' 1897 by me Lauchlan: Disease appears increasing: not variable, no rational intervals. Derangement manifested on subject of his health: Has night visions + hears voices: Not disposed to injure others. Not filthy or destructive in habits: Patient was committed to State Prison for life, for murder in second degree on June 25' 1888. he has been confined in sick cell at said prison since Feb. 1' 1897: On personal examination no further facts learned. Concerning treatment - has been treated for his heart also given nux + sedatives + general tonics.

Apr 9 On admission put upon B3 (Q.H.S. Rpt. Complexion light: hair brown: eyes blue: condition of skin good: Is clean: behavior good)

Apr 10 Dr Herzog notes - Patient shows signs of degeneracy. He lacks in intelligence + is besides decidedly melancholic. His behavior so far has been fairly good except for his attempts to elope. Worries a good deal about his heart trouble. Very timid + shrinking in manner - probably due to prison discipline. Sexual perversion he states to have been of long-standing, consisting of membrorum hominum in ovum receptum. He acknowledges his perversion readily.

Apr 28 Patient became very ugly striking one of patients over head with a broom causing two small scalp wounds, was put in bay where he found a heavy, weighted floor-rubber + struck Mr Peterson on head inflicting scalp wound about 2" in. in length - Threatened to kill first man he had a chance at. Put in restraint straps at 9:30 A.M. Taken out at 8 P.M.

Apr 29 In restraint from 6:45 A.M. to 8 P.M. Seems more quiet today.

30 Still inclined to be ugly, threatens nurses + patients - In restraint all day. Wants to get away + says he will if he has to kill some one to do so.

May 3 Seems bound to take advantage of nurses + other patients, is continually looking for something which he can use as an instrument to kill some one - while out today attempted to steal first a pipe-wrench + later an ax but was discovered -

4 Tried to run away while out on lawn today was caught without difficulty -

May 13 Tries daily to injure those about him: kicks + strikes other patients + nurses at every opportunity - While out today tried to throw himself under a passing carriage.

19 Seems to have special grudge against F. Barth + Matt Peterson. While sitting in bay today jumped from his bench over to Barth + struck him in stomach + breast - Barth complains of lame neck + back. Patient is kept in restraint 13 hrs. out of every 24. May 25 Today found a piece of tin from a suspender buckle while out with crowd + attempted to Cut Mr. Peterson's throat as he lay on a

Personal and Medical History of

1897

bench. Wound inflicted was not dangerous. Was dressed by physician - May 26 Patient put in muff + straps + strapped to big chair. June 1 Wt. 147 Pulse 94. Attempts suicide daily - Is kept in muff + straps - This A.M. between 4 + 6 o'clock tried to kill himself by striking head against steam coil in room. Received a bad cut + a bruise on left side of head which bled quite freely. Head dressed by nurses Spillane + Smith. Later refused breakfast - ate light dinner + supper.

July 1 Daily notes of attempts at suicide + to injure others. Is always pugnacious + resistive - Wt. 133 Pulse 100. Eats very poorly: Sleeps fairly well: Bowels regular Has to be kept in restraint all the time + has to be watched while in restraint as he continually tries to bite + kick everyone who comes near.

July 25 One of ears swollen - looks like "crazy ear". July 27 Has trouble keeping food on stomach. Aug 1 Has to be kept in restraint all the time - muff during day + sheet during night. Tries to get nurses to give him a chance to kill himself. Has heart trouble, pulse often as high as 120 after he has been resting. Sept 1 Wt. 131. Pulse 76. No change of any kind in patient since last note. Oct 1 Has been fairly well behaved during last month - says he is going to get out of restraint - begs to be allowed to work in shoe-shop + kitchen. Wt. 129 Pulse 96. Nov 1 Wt. 134 P. 108. Has been quiet + fairly well behaved - Heart troubles him a great deal: Appetite fair: Bowels constipated Still in restraint. Nov 4 Allowed to sit in bay today restrained only with wristlets + strap - no muff. Nov 10 Is spitting blood also has difficulty in breathing. Nov. 11 Trans. to Infirmary + put to bed - Complains of heart. Nov 13 Lies quietly in bed says he does not feel well. Looks sullen + depressed - Says he will live too long if he is treated as well right along. Nov 16 Sits up in bed part of time. Says he feels about same as usual - Converses quite rationally. Still wears wristlets + strap Temp. subnormal - Visited by Father Riordan. Nov 19 Eats + sleeps well. Nov 17 restless + out of bed often says he is tired of staying in bed. 22 Seems fairly intelligent + brighter today. Seems gaining a little physically 23 Temp. subnormal. Nov. 30 Has worn wristlets since second ward - (Total hrs. 471) Improving physically - Expectorations not generally mixed with blood.

Dec 3 Very restless + out of bed often Dec 4 Quite melancholy again wishes he might be hung instead of being left in present condition. Dec 7 Has made several attempts to hurt M.W. Doubs + has threatened his life. Trans to C.

Dec 10 Physical condition poor - Seems to have a great deal of trouble with heart. Sleeps very little: appetite poor - Dec 18 Very restless all day - nauseated at supper time - seemed very weak when put to bed. Temp 96° P. 136 - Very restless until 2 A.M. Died at 2:50 A.M. Dr. Herzog notes - Patient had valvular heart disease, aortic insufficiency, hypertrophy enormous. Apex 1 in. to left of nipple line. Had tumor Tr. Dig. of Strophanthus in 5 drop doses 3x day. Compensation failed - was put on Digitalin (Merck) gr 1/10 every 2 hrs. at 9 P.M. Dec 19 Failed steadily + died at 2:50 A.M.

Died

Personal and Medical History of August Hensell.

HERBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4745.
Residence, Unknown.
Date Admission, Apr. 15th 1897.
Admitted by Dr. R.M. Phelps Hour, 6:45 P.M.
How Sent, J. Ullrich Jr of P. Ramsey Co.
Sex, Male.
Age,
Civil Condition,
Children,
Age Youngest Child,
Occupation,
Degree Education,
Profession Religion,
Habits,
Nativity,
Physicians Committing, J. Ohage + Walter Lucas
Correspondents,

No. for Year, 279.
Insane Relatives,
Cause Exciting,
Cause Predisposing,
Form, Melancholia Agitata
Accompanying Bodily Disorder,
Suicidal or Not,
Date of this Attack,
Duration,
No. of Attack,
No. of Admissions,
Age First Attack,
Time of Leaving, May 14. 1897
Time in Hospital, 29 d.
Result, Discharged Nov. 3. 1897- Improved

EXAMINATION ON ADMISSION.

Exam Apr. 16/97 by Dr Herzog.

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient is very dull + also depressed. Said at first people had been bothering him. Will volunteer no statements + it is very difficult to get anything by questions. Says name is Henkel: Says left Wisconsin a week ago, had been working on a farm there. Can't get the name of the town: Says he don't know his age: Says is single + has no relations in this country. Says was not drunk in St. Paul. Don't know when he was arrested nor for what reason.

Personal and Medical History of August Hensell.

INSANE AND UNKNOWN.

Police Have Trouble in Locking Up the Man.

An unknown man was found wandering on West Seventh street near the corner of Leech street at 8:30 o'clock last evening. Officer Zacher asked him who he was and what he was looking for. The man looked at the officer and answered in an incoherent manner. The officer called the patrol wagon, and when the wagon arrived the man attempted to break away, and it was with difficulty that the officers subdued him.

He was taken to the county jail and locked up. He tried to get away from Officer Bumgardner and McEllisterem, who went down with the wagon, and he pleaded with them to let him go. His eyes were wild, and he kept mumbling to himself.

"My mother marked me," he said, "and my father told me that I would not go to heaven." His pockets were searched and several scraps of paper and a much worn note book were found. The papers were covered with writing, a repetition of a name, which seemed to be August Hensell. He had two pocket books, one of which contained a $10 bill, and the other about $2.50 in silver. In his hip pocket was a large, cheap revolver.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

...in. WEIGHT, 131 lbs. NUTRITION, Fair
...ALITIES, has weak chin, lower part of face looks about 27 yrs. old, is prematurely bald. somewhat greasy.
Coatings, heavy yellow coat Promptness Movement, Slow.
...ual. Size, Slightly contracted.
... yrs. Accommodation, yes.
...ood.
COORDINATION, Arms, Fair
Legs,
TREMORS, Hands, Some Tongue, yes.
Facial Muscles, None. General, None
REFLEXES, Patellar, 9 equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating, yes.
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds fairly good.
LUNGS, Fair.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of August Hensell.

EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4745.

Residence, Unknown.

Date Admission, Apr. 15th 1897.

Admitted by Dr. R.M. Phelps Hour, 6:45 P.M.

How Sent, P. Wittrich Jr. of P. Ramsey Co.

Sex, Male.

Age,

Civil Condition,

Children,

Age Youngest Child,

Occupation,

Degree Education,

Profession Religion,

Habits,

Nativity,

Physicians Committing, J. Ohage + Haldor Lewis

Correspondents,

No. for Year, 279.

Insane Relatives,

Cause Exciting,

Cause Predisposing,

Form, Melancholia

Accompanying Bodily Disorder,

Suicidal or Not,

Date of this Attack,

Duration,

No. of Attack,

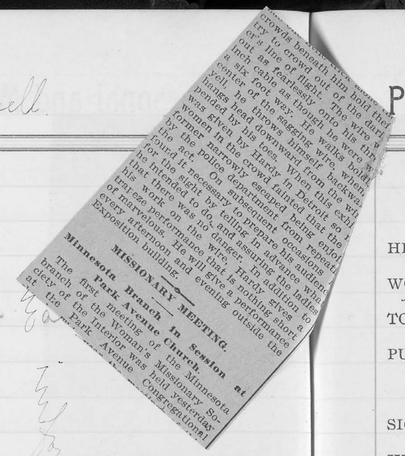
No. of Admissions,

Age First Attack,

Time of Leaving, May 14. 1897

Time in Hospital, 39 d.

Result, Discharged Nov. 3. 1897- Improved



EXAMINATION ON ADMISSION.

Exam Apr 16/97 by Dr Herzog.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Poor.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Illusive.

REASONING POWER:

Ordinary Subjects, Poor.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not, None

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent, Very reticent

GENERAL DESCRIPTIVE REMARKS: Patient is very dull + also depressed. Said at first people had been bothering him. Will volunteer no statements + it is very difficult to get anything by questions. Says name is Henkel: Says left Wisconsin a week ago, had been working on a farm there. Can't get the name of the town: Says he don't know his age: says is single + has no relatives in this country. Says was not drunk in St. Paul. don't know when he was arrested nor for what reason.

Personal and Medical History of August Hensell.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, 131 lbs. NUTRITION, Fair

WOUNDS OR ABNORMALITIES, has weak chin, lower part of face looks about 27 yrs. old. is prematurely bald. Condition of skin somewhat greasy.

TONGUE, Tremors, Coatings, heavy yellow coat Promptness Movement, Slow.

PUPILS, Equality, Equal. Size, Slightly contracted.

Response Light, Yes. Accommodation, Yes.

SIGHT, Seems good.

HEARING,

COORDINATION, Arms, Fair

Legs,

TREMORS, Hands, Some Tongue, Yes.

Facial Muscles, None. General, None

REFLEXES, Patellar, 9 equal. EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating, Yes.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Sounds fairly good.

LUNGS, Fair.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of August Hensell.

1897

This patient was brought hue by sheriffs deputy P.J. Missen, in fair physical condition, with the following history "Patient had nothing about him to identify him by + will not answer questions, only things he has said being "Oh, oh, oh" + "I want whiskey" + "I want water" "I live with my Grandfather". Was found wandering about streets in St. Paul. (See slip attached to preceding pages)

On admission put upon B.E. G.H.U. Rpt. Complexion dark: hair + eyes brown: Condition of skin good: Several moles on shoulders: Is clean: behavior stubborn + melancholy.)

Apr 28 Physicians Note: There has been very little change since admission Temperature was slightly elevated for 2 days, normal since. Sleeps well. Somewhat untidy. Is melancholic with tendency to stupor. Reticent + retiring, seldom speaks except in answer to questions.

Apr. 29 Patient seems very despondent: Talks very little, simply answering in monosyllables. Goes out daily for walk + seems strong + spry:

May 1 Seems very despondent: sits quietly in one place or bench all day: When spoken to sometimes responds but usually does not. Habits fairly neat + clean: Does not work: On regular diet: Appetite seems good: Bowels regular. Wt 135 Pulse 76.

May 4 Sent to Wisconsin with relatives not because he had improved: any but because he did not belong in the State.

Discharged.

Personal and Medical History of

Personal and Medical History of Joseph Labroix.

HERBERT, FIGLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4746
Residence, St. Paul, Minnesota.
Date Admission, April 15th 1897.
Admitted by Dr. R. W. Phelps. Hour, 6th P.M.
How Sent, G. Willrich Jap P. Ramsey Co.
Sex, male.
Age, 50.
Civil Condition, married
Children, 2.
Age Youngest Child, —
Occupation, Carpenter.
Degree Education, Common school.
Profession Religion, Catholic.
Habits, Intemperate.
Nativity, Quebec Canada (Parents Canada)
Physicians Committing, J. C. Markoe & P. Lamac-Margius.
Correspondents, Edith Labroix (daughter) 498 Marion St. St. Paul, Minn.

No. for Year, 280
Insane Relatives, None.
Cause Exciting, - fall?
Cause Predisposing, Excessive use of liquor.
Form, dementia alcoholic
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, not.
Date of this Attack, About 3 years ago.
Duration, About 3 years.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 47.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog 4/16/97

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient shows little wrong on first examination. Admits that he gets excited when he drinks but denies much drinking. Has not worked much at his trade this winter as there was little doing & he was ill part of the time. In regard to his inventions says he has completed the model for a carpet stretcher, ready for casting & has an idea in regard to the cable road but it is not worked out so as to be practicable. Denies having had any trouble at home more than one would ordinarily expect. Says got up one night at midnight & went down to get midnight lunch.

Personal and Medical History of Joseph Labroix.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7 in. WEIGHT, 127 lbs. NUTRITION, Somewhat impaired.
WOUNDS OR ABNORMALITIES, long ears, large lobule. Left hand mutilated by shot
TONGUE, Tremors, large, tooth marked. Coatings, heavy yellow. Promptness Movement, prompt.
PUPILS, Equality, √ yes. Size, Slightly contracted.
Response Light, √ yes. Accommodation, yes.
SIGHT, Fair.
HEARING,
COORDINATION, Arms, Good.
Legs, "
TREMORS, Hands, None noted Tongue, yes.
Facial Muscles, Slight General, None.
REFLEXES, Patellar, 9 equal EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL, EXPRESSION,
SENSIBILITY,
HEART, no murmurs.
Sounds fair.
LUNGS, Fair.
TAKEN,
Arteries very slight stiffness of temporals.
OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of Joseph La Croix.

Personal and Medical History of

1897

This patient was brought here by Sheriffs deputy A. J. Wride in fair physical health with the following history:- No history of consanguinity or heredity. First symptoms of disease appeared about 3 years ago; Disease appears increasing; is variable with irregular rational intervals: Derangement manifested by delusions of grandeur, & imagining that he has invented valuable mechanical devices - Is disposed to injure others: Not filthy or destructive: Previous peculiarity inclination to drink to excess: No severe disease but 3½ yrs. ago, while intoxicated, fell from car & probably hurt his head: Has not been confined or restrained: has received no systematic treatment. On personal examination no further information: the above opinion based on the statements of his family & attending physician, Dr. Grere.

On admission put upon B.T.E. (G.H.M. Rpt.) Complexion light: hair & eyes gray: condition of skin good: Scars on left elbow & on breast: Is clean: behavior good)

Apr. 21 Patient has been well behaved since admission, slept well from first night. Had a slight temperature for first few days but has since been normal. Shows no delusions, is fairly neat & tidy & shows nothing but a mild symmetrical dementia, possibly alcoholic

May '97 Patient in a quiet chronic state: Very demented: Is inclined to wander away when out of doors. Jan 31'99 No change of any kind during period: Drifts along in about the same slightly listless & demented manner.

Feb 1- July 31'99. (Dr Wanous) Wt. 108#. Behavior good: Talks fairly intelligently but appears
1900 quite defective. July 30 tried to elope. Aug 1- Jan 31'1900 (Dr Chapple): Wt. 105#. Not
-to- much change during period but is somewhat more quiet & contented.
Jan 31 Asks frequently for his discharge: Seldom disagreeable in manner: Sits
Feb 1 in room most of time: Habits tidy: Health good. Feb 1. Wt 105#. Pulse 68
July 7/27 July 17. Vaccinated: result negative. July 31. No change. Usually quiet & well-behaved. Does no work. Will talk readily & pleasantly. Is irrational, & at times, becomes much excited, angry and abusive. Threatens to do harm. Says "he is not insane & no one has any right to keep him here". Wt. 107#. Jany 31/1901. No change noticeable: Quiet, tidy patient, but very stubborn: will
Aug 1 1900
Jan 31 answer ordinary questions rationally & converse pleasantly: sometimes, becomes very angry & uses threatening & abusive language: Has "delusions of persecution" (that he is illegally held here &c). Never does any work: health quite good. Feb 1. 104½#
May 1 Wt 105#. Aug 1. Wt 110#. Dec 1. Jo D³. Jany 31/02. No change noticeable, during year.
Jan 31 1901 Sits quietly on ward: neat: well-behaved: at times, talks pleasantly & quite rationally and again is very surly & abusive. Says "his rights are taken away". Refuses to occupy himself at anything. Health good.

Jan. 31/03. (Dr. Chapple) Health has been fairly good. Is somewhat emaciated. Senile - has worked some on farm: is very threatening & abusive.

Personal and Medical History of Peter Bolt

EGBERT, FOLEAN & CHAMBERS, DAVENPORT, IOWA

Whole No. 4747
Residence, St Paul Minn
Date Admission, April 15th 1897.
Admitted by Dr. R. M. Phelps Hour, 6th P.M.
How Sent, G. Wellrich J. of P. Ramsey Co.
Sex, male.
Age, 66.
Civil Condition, widowed.
Children, 5.
Age Youngest Child, —
Occupation, Baker.
Degree Education, Good
Profession Religion, German Lutheran.
Habits, Not intemperate.
Nativity, Prussia (Parents Prussia)
Physicians Committing, E. Eugene Riggs & A.B. Aucker.
Correspondents,

No. for Year, 281
Insane Relatives, None.
Cause Exciting, Senility.
Cause Predisposing,
Form, ~~Senile~~ dementia organic
Accompanying Bodily Disorder, Paralysis of face & rt. arm.
Suicidal or Not, Not.
Date of this Attack, 3 or 4 yrs. ago.
Duration, 3 or 4 yrs.
No. of Attack, 1st
No. of Admissions, 1st (City & Co. Hosp. St. Paul)
Age First Attack, 66
Time of Leaving, Nov. 4. 1897
Time in Hospital, 5 mo. - 20 da.
Result, Died - Bright's Disease.

EXAMINATION ON ADMISSION.

Apr 16/97. Exam. by Dr Herzog.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Somewhat confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Fair
Recent Events, Much impaired.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly alert
Correct or Illusive, Correct.
REASONING POWER:
Ordinary Subjects, Slight impairment.
Own Mental State,
Special Subjects,

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

GENERAL DESCRIPTIVE REMARKS: Patient is jolly & good-natured - appreciates that he is failing. Walks somewhat in his walk & is somewhat unsteady. but Paralysis is not very marked - Senile dementia

Personal and Medical History of Peter Bolt.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 7½ WEIGHT, 150½ NUTRITION, Fair considering age.
WOUNDS OR ABNORMALITIES,
TONGUE, ~~Tremors~~, Condition of skin - scaly Careless about mouth, teeth, fangs, Coatings, - Promptness Movement, protrudes somewhat slowly
PUPILS, Equality, Yes. Size, Much contracted.
Response Light, No. Accommodation, No.
SIGHT, Impaired
HEARING, "
COORDINATION, Arms, Impaired
Legs,
TREMORS, Hands, None Tongue, Yes
Facial Muscles, Yes. General, No.
REFLEXES, Patellar, ?-8 about equal. EXAM. URINE,
Other
ARTICULATION,
Slurred, Somewhat.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. fairly strong
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Says had 2 paralytic strokes.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Peter Bolt.

1897

This patient was brought here by Sheriffs deputy J. W. Bolt in senile condition with the following history:- No history of consanguinity; heredity or intemperance in parents or self. (Patient smoked considerably) This is 1st attack. First symptoms manifested 3 or four years ago when he had apoplexy. about 2 weeks ago a second attack leaving paralysis of face + slight of right arm. Was in City + Co. Hospital St. Paul, last of March, result- unimproved. Disease not variable, no rational intervals. Derangement manifested on no particular subject: has gotten up at night + wandered around; has had clothes on fire a couple of times. Not disposed to injure others, is not destructive but is somewhat untidy in habits: No previous peculiarities shown; no severe diseases - injury to head "Sun". Has not been confined or restrained: Has received general treatment. On personal examination "has senile dementia". On admission put upon B.3.C. (Gth. Rpt. Complexion dark: hair gray: eyes brown: Condition of skin - Very dry. Is clean. behavior good)

Apr 28 Physician's Note Ordinary senile dementia, somewhat restless + uneasy during day. Sleeps well at night. Dissatisfied, wants to go home. Has considerable incoordination, is unable to go out with rest of men. No change since admission.

Apr 30 Marked loss of memory: Very childish: Habits slouchy. Is quiet + well behaved but refuses to go out for exercise claiming that he is too weak to walk: Appetite fair: Sleeps well. Wt. 150 Pulse 68.

May 26 Patient is growing weaker: Occasionally filthy in habits: On regular diet Trans. to Dr. June 1 Wt. 158 lbs June 28 Strolled away while at grove: Was found at barn: July 1 Wt. 160. Patients physical condition seems somewhat improved: Goes walking daily: Mental condition does not seem to change: Talks very irrationally + wanders about as if looking for something: Seems bewildered at times.

July 30 Has been quieter of late. Worries about his + is behaving better: Is clean in habits but untidy in dress.

Aug 1 Complains of severe pain in left side: More noticeable when he walks. Appetite good: Bowels regular: Sleeps well: Talks very irrationally, thinks he is in St. Paul - worries a great deal about his family. Physical condition does not improve. Sept 1 Wt 167 lbs. Physical appearance does not change: Does not complain of pain. Has frequent attacks of asthma: Habits are becoming dirty: Is destructive at times: Oct 1 Mental condition seems to be rapidly growing worse: Destroys clothing: Habits very dirty:

Oct 11 Has large boil on right buttock: Patients body, especially legs are swelling: Can scarcely bend legs: Oct 31 Is becoming quite helpless: Entire body swelling: Finds difficulty in breathing +

Personal and Medical History of Peter Bolt.

1897

also in passing urine: Very filthy: Seems to understand nothing:

Nov 1 Patient Transferred to Infirmary + put to bed: Is considerably bloated. Has quite a large ulcer on inner side of right thigh: also several small ones on legs: Is quite restless this evening + does not want to stay in bed: Has subnormal Temp. Hot Sand-bag applied: Medicine Every 4 hrs. P. Is quite weak: Tried to talk but only manages to articulate a few incoherent words or syllables: Slept none during night: Was out of bed often. On liquid diet: Nov 2 Very restless all day: Trying to get out of bed tho' scarcely able to help himself. Cannot talk distinctly Ulcers dressed: Night nurse reports - "would not stay in bed: Tried to get mattress on floor: Quite noisy. Slept 0 hrs." Nov 3 Temp. Subnormal this A.M. Normal in P.M. Restless + noisy all night: out of bed often:

Nov 4 Expired at 9:10 A.M. Failed gradually.

Died.

Personal and Medical History of Charles Olson Jr.

EGBERT, FICLAN & CHAMBERS, DAVENPORT, IOWA

Whole No. 4750
Residence, Weaver. Wabasha Co. Minn.
Date Admission, April 17' 1897.
Admitted by Dr A.F. Kilbourne Hour, –
How Sent, M. Kennedy & ofP. Wabasha Co.
Sex, Male.
Age, 35.
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Farmer.
Degree Education, Common school.
Profession Religion, Methodist.
Habits, Not intemperance.
Nativity, Wabasha Minn (Parents Norway)
Physicians Committing, T.H. Kelly W.H. Lincoln.
Correspondents, Swan Johnson, Weaver, Minn.

No. for Year, 284
Insane Relatives, Father.
Cause Exciting, "Disappointment" in love
Cause Predisposing, Hereditty.
Form, mania chronic
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, Dec. 25' 96.
Duration, nearly 4 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 35
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

Exam. 4/19/97. by Dr Herzog. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Somewhat confused -
Quick or Sluggish, At times sluggish.

MEMORY:
Past Events, Fair.
Recent Events, "
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Somewhat dull.
Correct or Illusive, In main correct.

REASONING POWER:
Ordinary Subjects, Unpaired
Own Mental State,
Special Subjects,

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

DELUSIONS:
Systematized or Not, None traced.
Special Subjects,
Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

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

GENERAL DESCRIPTIVE REMARKS: Patient shows no delusions on first examination. Is somewhat emotional. Cries on reference to his girl. Holds head down. is for the most part reticent will brighten up for a few moments & answer questions well. Talks somewhat disconnectedly about certain persons at home but never arrives at anything. Behavior is peculiar lips will move as if talking to himself restless, at times, depressed, at others singing. Has lived mostly at home, has done some work as a laborer. Do not think previous mental grade was very high.

Personal and Medical History of Charles Olson Jr.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7 in. WEIGHT, 132. NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, Ichthyosis simplex very well marked covers entire body - lower eyelids everted
TONGUE, Tremors, large Coatings, heavy yellow coat. Promptness Movement, Prompt.
PUPILS, Equality, Yes. Size, normal.
Response Light, Yes Accommodation, yes.
SIGHT, of right eye impaired Scar of right Cornea.
HEARING, Good
COORDINATION, Arms, fair
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, 1-2 equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating, somewhat.
FACIAL EXPRESSION,

SENSIBILITY,
Arteries - pulse small
HEART, blowing 1st mitral sharp 2nd pulmonary - Size enlarged. apex beat very forcible
LUNGS,
Expansion fair.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE, small.	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, Ole Olson #2 has been here 1st cousin has ichthyosis
Brothers or Sisters,

Personal and Medical History of Charles Olson Jr.

1897

This man was brought here by Sheriff's deputy DC. Mackenzie in fair physical condition with the following history:- No history of consanguinity: First symptoms of disease manifested December 25'96 when patient became unmanagable, broke furniture, etc. Disease appears increasing: not variable, no rational intervals: Deranged on no particular subject: Not disposed to injure others: no filthy habits but is destructive Patient's father was in the asylum in St. Peter in 1873: On Nov. 15'1896 was disappointed in a love affair & has since showed symptoms of derangement: No history of heredity: No severe disease or injury to head Has not been confined or restrained.

On personal examination is at times depressed & refuses to answer questions & is at others is exhilerated, sings loudly etc.

On admission put upon B³ C. (Gen. Rpt Complexion & hair sandy; eyes gray: condition of skin scaly: Has hernia: Ichthyosis: behavior good.

Apr 30 Physician's Note On admission there was a rise of temperature of about a degree which soon fell to normal & has continued so since. Little if any change since admission. Ichthyosis has improved slightly on warm bath & anointing 3× a week. Is quiet, well behaved, shows no delusions. works a little on ward, sits about in a depressed attitude but cheers up when spoken to. Seems contented. Is slightly feeble-minded. May 1'97 Wt. 134# July 29'97 Is rather demented in his ways. Throws water down his sleeves & does rather peculiar things:

Aug 11 Visited by friends Feb 1'98 Working in laundry: July 31 Is melancholy, quiet & dull - Feb 1-'99 to July 31'99. (Arrangements) Wt. 158# Apr 18. Got into trouble with another patient: received black eye. General condition good: Is depressed and melancholy Aug 1- Jan 31'1900. (Dr Chapple) Wt. 140# No change or improvement during period: Has been treated some for inflamed eyes, otherwise well

1900 Jan 31 Very Morose & stubborn: Will not talk to anyone: Is frequently pugnacious without provocation. Habits rather untidy: works on ward. Feby 1 Wt 139#. Pro. July 31 Vaccinated; result negative. July 31. No change during period. Aside from skin-trouble, appears to be in good health & works on ward. Habits untidy. Is well-behaved, but sullen and will fight, if molested. Aug 1 Does not talk unless angry. Aug 1 Wt 133# Sep 10. Transferred to D¹. Sep 13. Is D².

Oct 19 1901 Was visited by friend - Jan 31'1901. Works regularly on ward; when not at work, lies on bench. Jan 31 never speaks to anybody: very surly & irritable, but rarely has any trouble. Feby 1. Wt. 139# - May 1 1901 Wt 140#. Works regularly on ward: Condition unchanged. Aug 1. 142# - Nov 1. 144# Jan 31'02. No change Jan 31 mentally or physically: never speaks to anyone: Works on bed-flat: lies on bench with face to the wall: very pugnacious if his work is interfered with.

" 31/03 Works regularly on ward; makes beds & scrubs; rest of time usually sits with face to the wall; has nothing to say; will strike others who get in his way while at his work. Is somewhat untidy in habits.

Personal and Medical History of

Personal and Medical History of Martin W. Souls.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4754
Residence, Waltham, Minn.
Date Admission, April 21st 1897.
Admitted by Dr. R.M. Phelps Hour, 6 P.M.
How Sent, D.D. Washburn & Ft. Mower Co.
Sex, - Male -
Age, - 64 -
Civil Condition, - widowed -
Children, - 4 -
Age Youngest Child, -
Occupation, Farmer.
Degree Education, Common school.
Profession Religion, Methodist.
Habits, Not Intemperate.
Nativity, New York (Parents N. Y.)
Physicians Committing, J.E. Daigman & A.W. Allen.
Correspondents,

No. for Year, 287.
Insane Relatives, Not Known.
Cause Exciting, not defined but there seems to be
Cause Predisposing, some trouble at base of brain.
Form, Dementia organic
Accompanying Bodily Disorder, none mentioned.
Suicidal or Not, Not
Date of this Attack, Mar. 3 '97.
Duration, 1 mo. 18 da.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 64
Time of Leaving, July 1. 1898
Time in Hospital, 1 yr. 2 m. 10 da.
Result, Died - Valvular Heart Disease

EXAMINATION ON ADMISSION.

By R.M. Phelps 8/21/97

MENTAL CHARACTERISTICS.

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

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

GENERAL DESCRIPTIVE REMARKS: Patient came here with very strong aphasic condition & a partial hemiplegia. Mental condition very confused. Hardly seemed to have any power of attention tho. could sometimes catch it vaguely. Was very deaf. Mumbled our same things monotonously. Stumbled at words excessively. In fact could say but few. Has improved considerably but same condition exists in lesser degree. Except of face & speech it is hard to find paralysis. The limbs show a general weakness. Heart is so generally impaired as to suggest a heart clot following the Brain lesion.

MARTIN W. SOULS.

NOTE. Son-in-law, E. J. Markham, of Waltham, Minn., writes that after the attack of March 3rd, they could make patient understand a little at times by signs and by writing, but not at all times. That for about three weeks before the attack he complained of being dizzy, thought he had the grippe. That at times he would be violent and at other times quiet and sleepy. We presume this means after the attack.

HEARING,
COORDINATION, Arms, Considerably impaired but more senile than Paralytic
TREMORS, Hand
Facia
REFLEXES, Pat
Other
ARTICULATION
Slurred,
Hesitating,
FACIAL EXPRE
SENSIBILITY,
HEART, No mu
Very irregular & reduplication
LUNGS,
Nor
Arteries
OPHTHALMOSC
HABITS, Dirty,
BOWELS, Normal
APPETITE, Good
SLEEP, Good,
PULSE,
CRANIAL MEAS
HISTORICAL, Ca
LENGTH OF INVASION,

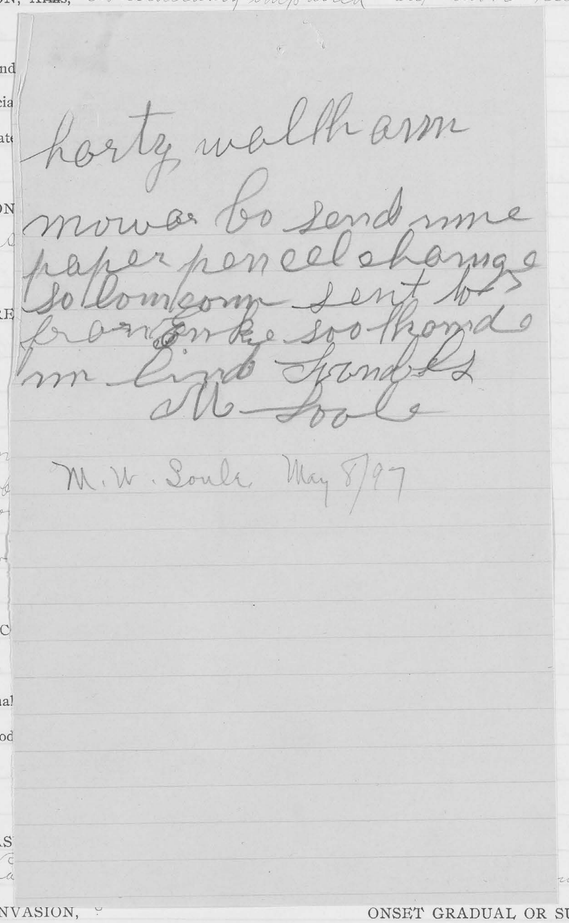
EXAM. URINE,

Careless,
Irregular,
Poor,
Irregular,
Temp.,

renclusions at time of Paralysis

ONSET GRADUAL OR SUDDEN, Sudden

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,



Personal and Medical History of

Whole No. 4754
Residence, Waltham, Minn.
Date Admission, April 21st 1897.
Admitted by Dr. R.M. Phelps Hour, 6:45 P.M.
How Sent, D. D. Washburn Supt. Mower Co.
Sex, - Male -
Age, - 64 -
Civil Condition, - Widowed -
Children, - 4 -
Age Youngest Child, -
Occupation, Farmer.
Degree Education, Common school.
Profession Religion, Methodist
Habits, Not Intemperate.
Nativity, New York (Parents N. Y.)
Physicians Committing, J. E. Dargman + A.W. Allen
Correspondents,

No. for
Insane Relatives,
Cause Exciting, not.
Cause Predisposing, some trouble
Form, Dementia.
Accompanying Bodily Disorder, none known.
Suicidal or Not, Not
Date of this Attack, Mar. 3 '97.
Duration, 1 mo. 18 da.
No. of Attack, 1st

EXAMINATION

By R.M. Phelps 8/25/97 MENTAL CH

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

GENERAL DESCRIPTIVE REMARKS: Patient can... partial hemiphlegia. Mental condition very confused: hardly seemed to have any power of attention tho. could sometimes catch it vaguely. Was very deaf. Mumbled over same things monotonously. Stumbled at words excessively. In fact could say but few. Has improved considerably but same condition exists in lesser degree. Except of face + speech it is hard to find paralysis tho limbs show a general weakness. Heart is so generally impaired as to suggest a heart clot following the Brain lesion.

Personal and Medical History of Martin W. Souls.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 1/2 WEIGHT, 156 NUTRITION, Fair for age.
WOUNDS OR ABNORMALITIES, None noted. Skin fair condition.
TONGUE, Tremors, Coatings, No notable. Promptness Movement, Sluggish + uncertain.
PUPILS, Equality, Equal Size, Slightly small.
Response Light, Fair. Accommodation,
SIGHT, ? Slight arcus senilis.
HEARING, Very poor.
COORDINATION, ~~Arms~~, Appreciably impaired but more senile than Paretic
Legs,
TREMORS, Hands, No special tremors - Nervous Tongue,
Facial Muscles, Undecided motions. General,
REFLEXES, Patellar, Normal. EXAM. URINE,
Other
ARTICULATION,
Slurred, Slow } Aphasic
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs - Rather weak
Very irregular beats with intermittancy + reduplication
LUNGS,
Normal
Arteries Poor.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Can't give any information History of probable convulsions at time of Paralysis
LENGTH OF INVASION, ? ONSET GRADUAL OR SUDDEN, Sudden
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Martin W. Souls

1897

This patient was brought here by Sheriffs deputy, John C. Johnson, in fair physical condition (senile) with the following history. Nothing known as to consanguinity or heredity: First symptoms of attack manifested March 3rd '97 when patient was unconscious for a short time, then he attempted to wander off. Became unconscious again with Cheyne Stoker respiration from which he gradually recovered. Disease is variable with partially rational intervals he seems more rational in the early afternoon: Derangement manifested by hebitude of mind & wanting to wander away. Not disposed to injure others No filthy or destructive habits: No previous peculiarities: No severe disease or head injury: Has been confined past three weeks to prevent him from wandering off. Sedatins have been given with good effects; He improved somewhat under their use. On personal examination mental powers dull & speech hesitating, requires restraint at times. Commitment recommended as his disease is of such a nature or in such a stage as to require for his recovery Care & treatment while under legal restraint.
On admission put upon B³ E (Journ Rpt Complexion dark: hair gray: eyes blue: Condition of skin good: Has hernia: Behavior good: hearing poor.)

May 4 Physician's Note Patient has had slight rise of temperature - highest 100 2: Bowels somewhat constipated. Oedema of legs noted on first day has disappeared. Has been on Sat. Sol. K.I. increasing up to 3ss tid.
No change in condition since admission. Behavior slightly better Stays in bed better. May 5 '97 Patient has slight rise of temperature: Seems to show considerable mental impairment & dullness: Asphasic condition still continues. May 31 '97 Now able to be up & about a good deal: Goes out walking some. Oct 29 Is at times rather confused: Talks very little: Is very deaf: Ankles are becoming oedematous: Trans to Infirmary Chief symptoms The oedema. Pulse as low as 44 at times. Oct 30 Examination of urine showed considerable albumen. January 1 '98 Patient still lying quietly in bed. Is kept in bed: Temp, pulse & respiration about normal. Patient quite mat. Seems to drift along with little change May 1 '98 Still in bed: Had a convulsion at 2 P.M. July 1 '98 Patient has been quite oedematous Pulse weak & patient gradually failed in coma to death

Died.

Personal and Medical History of

Personal and Medical History of Ole Kallum.

ROBERT, FISLAR & CHARLES, DAVENPORT, IOWA.

Whole No. 4756
Residence, St Paul, Minn.
Date Admission, April 26th 1897.
Admitted by Dr. L. & B. Eby Hour, 6th P.M.
How Sent, J. Ulrich J. of P. Ramsey Co.
Sex, Male.
Age, 44.
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Waiter on Dining Car.
Degree Education, None.
Profession Religion, Lutheran.
Habits, Unknown.
Nativity, Norway (Parents Norway)
Physicians Committing, P.A. Kanter & Arthur Swaney.
Correspondents,

No. for Year, 289
Insane Relatives, Unknown.
Cause Exciting, Unknown.
Cause Predisposing, Unknown
Form, Dementia paranoid
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, —
Duration, —
No. of Attack, 1st
No. of Admissions, 2nd (City Hospital St Paul)
Age First Attack, —
Time of Leaving, Sept. 22. 1897.
Time in Hospital, 4 mo. 27 d.
Result, Died - Epileptiform attack in General Paresis

EXAMINATION ON ADMISSION.

By Wm. Phelps 5/23/97

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Mildly
Depressed,
DELUSIONS: No definite - but many delusive ideas.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Denies syphilis but denial is of little value as he is not accurate about anything. Mildly maniacal in behavior. Somewhat garrulous. Shows mildly the sense of well-being. No very active delusions - some incoherence & exaggeration of facts. Had convulsions & was very wild for a few days some time ago.

Personal and Medical History of Ole Kallum.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ WEIGHT, 152 NUTRITION, Normal.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, some Coatings, normal. Promptness Movement,
PUPILS, Equality, Right slightly smallest. Size, normal
Response Light, Very sluggish Accommodation,
SIGHT, Normal
HEARING,
COORDINATION, Arms, Somewhat poor
Legs,
TREMORS, Hands, Some Tongue,
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred, Fairly good.
Hesitating,
FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs - a trifle weak.
LUNGS, Normal
Arteries - Slight atheroma -
OPHTHALMOSCOPIC EXAM.,

TAKEN,

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

CRANIAL MEASUREMENTS,
HISTORICAL, Denies syphilis - Does not drink much - tended bar for 10 yrs. also Cooked on dining car.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Living
Father or Pat. Relations,
Brothers or Sisters, 1 ✓

Personal and Medical History of Ole Kallum.

1897

This patient was brought here by Sheriffs Deputy C. L. Missen attended by A. Weidel, in fair physical condition, with the following history.- Nothing known as to Consanguinity, heredity, intemperance in parents or self. Previous peculiarities, severe disease or head injury:- The first symptoms of attack were manifested by stealing from pawnshops & delusions of persecution: Disease appears stationary: Derangement manifested by delusions of persecution & tearing clothing: Not disposed to injure others: Is filthy & destructive in habits: Has been at County Jail for four days & was at City Hospital for one month for some unknown disease (Latter fact learned on personal examination)

Apr 26 On admission put upon B.3 E. Y.S.H. & R.T. Complexion light: hair brown: eyes blue: Condition of skin good: large vein on left leg: Is clean: behavior good)

May 9 Dr. Hyzog notes. On admission appeared maniacal & was quite ugly- refusing to allow examination. Slight rise of temperature apparently from digestive disturbances. Later became more quiet but showed signs of paresis. Treatment consisted of Peptonyme with divided dose of calomel.

May 16 Seems improving some: Is not quite as nervous as when received on ward: Is still very irritable & talks of & over bearing way to other patients. May 25 Is more quiet: behavior quite good: Quite nervous & apt to use profane language.- Trans. to B.3.

June 1 Wt. 166 Pulse 78. Quite well behaved: gets quite excited at times: & uses profane language. Does quite a little work on ward: Is neat & clean: June 14 Mental condition remains about same: Works well. June 22 Patient had epileptic fit at 5.20 A.M. Remained unconscious.- Trans. to Infirmary. In comatose condition all day: Perspires freely: Pulse strong: Takes no nourishment. Habits filthy: slept none: June 23 very restless during night, talking & singing: also during day- out of bed often: Stupid: will take no nourishment. Slept 1 hr.

25 No change: Had to be held in bed part of afternoon: Talks incoherently. Slept 1 hr.

26 Some bruises on legs: Requires constant attention of nurse during day: Perspires freely Slept 0 hrs.

27 Violent & destructive: Voice hoarse: Had to be held in bed most of day: eats ravenously. Temp. 102.4 this PM. June 28 Quieter for a while this A.M. & slept some: On protection sheet in PM. Bowels constipated: Temp. up to 100.6. June 29 Slept most of A.M. Restless & maniacal in P.M. had to be held in bed: Quieter toward evening. S. 8 hrs. Temp. 100.2.

30 No. change. July 1 Wt. 150 lbs. Violent & destructive. Appetite good: July 2 Up & dressed this PM, much quieter. July 3 Behaves better & mind is clearer. Trans. to B.3. July 5 very troublesome & noisy, also very destructive. July 6 Shut himself in room & barricaded door with Beds. Trans. to 6. July 9 Tried to escape. July 20 Has been quiet & well behaved since on ward. Is slightly irritable at times also nervous. Talks continually about his work on dining car: Appetite fair: Bowels regular: Does not sleep well: Works on ward.

Personal and Medical History of Ole Kallum.

Trans. B.3. Very noisy & irritable: Has been in restraint several times.

Aug 1 Patient Paretic: Very much confused & generally irritable: Memory poor. Tells stories of his past life over & over: Complains of quantity & quality of food: Appetite voracious. Aug 6 Very noisy & quarrelsome this A.M. Refused breakfast & dinner.

Sept 1 Wt. 156½ lbs. Pulse 78. Sept 6 Taken with convulsions at 5.30 P.M. Had three. Trans. to Infirmary Temp. 101°. Was unconscious & limp. Revived at 4 A.M. Restless until morning. Sept 7 Very restless & badly confused. On liquid diet. Sept. 12 There has been very little change since last note: Sleeps very little: Is noisy & restless Talks irrationally. Is more quiet today however. Sept 15 Given clothes today: Behaved fairly well, but is still restless & confused. Sept 16 Up on ward. Regular diet.

20 Has been up & dressed since last note. Very ill-natured today, restless & destructive put to bed: 5 Bm. Complains of pain in abdomen. Fairly quiet during day.

21 Abdomen swollen & hard: Noisy & violent during night: Temp. 5 Bm. 101

22 Temp. 100.2. P. 130 R 36. Patient was quite restless this A.M. Complained of pain in abdomen: Ill natured & stubborn. Filthy in habits: At noon took 2 glasses of milk at 1 PM. became unconscious. Breathing became very heavy as if in convulsion.- Continued in this condition until 1.30 PM. when he died.

Died.

Personal and Medical History of Gustaf Anderson.

EGBERT, FICLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4757

Residence, St. Paul, Minn.

Date Admission, April 27th 1897.

Admitted by Dr. C.B. Eby Hour, 6.45 P.M.

How Sent, P. Willrich Jap. P. Ramsey C.

Sex, Male.

Age, 29.

Civil Condition, Married.

Children, None.

Age Youngest Child, –

Occupation, Brakeman & Conductor. RR.

Degree Education, Self educated. Can read & write.

Profession Religion, None.

Habits, Int temperate.

Nativity, Norway (Parents Norway)

Physicians Committing, E.W. Bentley & Wm. Davis.

Correspondents,

No. for Year, 290.

Insane Relatives, Parents & 1 sister committed suicide. One sister has been here.

Cause Exciting, –

Cause Predisposing, Heredity.

Form, Melancholia acute

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, about 1 week ago.

Duration, About 1 week.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 29.

Time of Leaving, June 7. 1897

Time in Hospital, 1 mo. 10 da.

Result, Discharged Nov. 5. 1897. Improved

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Gustaf Anderson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ WEIGHT, 142 NUTRITION,

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT,

HEARING,

COORDINATION, Arms,

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Gustaf Anderson.

1897

This patient was brought here by Sheriffs deputy J. P. Flandrake attended by Mrs G Anderson. in fair physical condition with the following history:- No history of consanguinity: First symptoms manifested about a year ago by restlessness, insomnia, religious delusions but has not been right for 6 mo. past Disease appears increasing: not variable: no rational intervals: Derangement manifested by delusions, chiefly religious,- sees god- Imagines physical strength is increasing: Not disposed to injure others: No disposition to filthy or destructive habits: Parents & one sister committed suicide, one sister was here in Rochester asylum spring of 1891- now cured- No previous peculiarities: No history of intemperance in parents- patient has used intoxicants & tobacco to excess: No severe disease or injury to head: Has not been confined or restrained: Has received no treatment. No further particulars noted on Personal examination. On admission he put upon 2nd E (Gust's Ept. Complexion Light: Hair brown: Eyes blue: Condition of skin good. Scar on left leg just above ankle & on right knee: Pimple pimples on back: Is clean: Behavior good.)

May 10 Physicians Note." Ate nothing first 2 days, being commanded by the Lord to eat nothing. 3rd day was fed with tube, after that ate freely & improved very much in health, mentally & physically. Talks freely & rationally, behavior good, Says feels better than for 7 years past. Realizes that he was not right before but says has no such ideas now." May 14 Patient seems perfectly rational: Had delusions on admission but has not alluded to them for some time - Says he was insane when he came.

15 More religious of late: Seems to be relapsing into former state. May 24 Seems rather stupid & sleepy today Has made some irrational remarks.

25 Is somewhat maniacal this A.M. became irrational & later became limp & stupid. Trans. to Infirmary: Habits filthy, Refuses to eat.

26 Has rallied considerably from stupid state. Appetite good.

27 Fairly rational this A.M. Stupid in P.M. Habits filthy. May 28 Received letter from home & answered it - Seems brighter. May 29 Still quite stupid Refuses to talk: Visited by friends yesterday. May 30 Fairly quiet in bed. Bowels constipated: T. 97.8. May 31 Temp. normal. Quiet most of day. Eats fairly well.

June 1 Wt. 127. No change in condition June 2 Talks rationally & freely today. Up part of afternoon. June 4 Up most of day: Visited by wife, seemed very glad to see her. June 7 Has been up. every day since 4th Says he feels the best he has since he has been here. Taken home by wife.

Discharged.

Personal and Medical History of

Personal and Medical History of James Simpson

BIBBERT, PIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. H 7558
Residence, St. Paul, Minn.
Date Admission, April 30th 1897.
Admitted by H. H. Herzog, MD Hour, 645 PM.
How Sent, G. Willrick & Jos. Ramsey Co.
Sex, Male.
Age, 24.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Plumber.
Degree Education, Common school.
Profession Religion, Catholic.
Habits, Intemperate.
Nativity, Minn. (Father Ireland, Mother Winnipeg)
Physicians Committing, A. W. Dunning & C. F. Graney.
Correspondents, Johanna Simpson (sister) 144 E 3rd St. St. Paul Minn.

No. for Year, 291
Insane Relatives, None.
Cause Exciting, Drink.
Cause Predisposing, Epilepsy.
Form, mania a potu
Accompanying Bodily Disorder, Epilepsy.
Suicidal or Not, Yes. propensity active
Date of this Attack, about 1 yr. ago.
Duration, about 1 year.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 23.
Time of Leaving, June 25. 1897
Time in Hospital, 1 mo 26 days.
Result, Discharged Aug. 11. 1897 Improved.

EXAMINATION ON ADMISSION.

Exam. by Dr. Herzog May 1 '97

MENTAL CHARACTERISTICS.

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

EMOTIONAL STATE:
Normal, Calm, Normal.
Indifferent,
Exalted,
Depressed,
DELUSIONS: None brought out.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Fairly voluble & coherent
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient denies epilepsy. Has been a hard drinker & only recently was released from a year in workhouse. Then he became intoxicated & was locked up. While in jail became maniacal. Is still sufferings from effects of his debauch but does not seem to be insane & degenerate with low moral sense. Speech & demeanor indicate desire to be considered "tough." Complains of pains in legs & has no patellar reflexes but does not convey idea of having Tabes dorsalis.

Personal and Medical History of James Simpson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 9½ WEIGHT, 138 lbs. usually 155 NUTRITION, Considerably impaired anaemic - eyes sunken.
WOUNDS OR ABNORMALITIES, 0
TONGUE, Tremors, Coatings, slight coat on edges. Promptness Movement, prompt.
PUPILS, Equality, Yes. Size, Normal.
Response Light, Excessive Accommodation, do.
SIGHT, Some impairment.
HEARING, Good.
COORDINATION, Arms, slight impairment
Legs,
TREMORS, Hands, None. Tongue, Yes.
Facial Muscles, None General, Slight
REFLEXES, Patellar, 0 EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs - Strength sounds weak: pulse feeble: rate irregular
LUNGS, Chest contracted - slight dullness right apex.

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of James Dimpson.

1897

This patient was brought here by Sheriff's deputy J. P. Flandrake, in fair physical condition, with the following history:- No history of consanguinity heredity or intemperance in parents. First symptoms manifested within a year, by depression: Disease appears increasing: In progression: No rational intervals: Derangement manifested by general depression & tendency to commit suicide: Is not disposed to injure others: No filthy or destructive habits: No previous peculiarities noted: Has epilepsy: Has been in work house one year, in jail 3 times: Has received no treatment. No further information obtained on personal examination.

On admission put upon B³ E (Q.V.M. Rpt. Complexion light: hair black: eyes brown: Condition of skin good: Scar on right knee: Is clean: Behavior good: Talk rational.)

May 13 Physician's note Patient has lost his despondency & has gained in flesh markedly: Now talks perfectly rational in all respects - Says he feels better than he has for years - The "numb" feeling of legs has in a large measure disappeared. (H.H.A.)

14 Is neat & clean in habits & dress: Does a great deal of work

Bowels regular: Appetite good: May 16 Changed to A -

21 Patient is rather sullen & quiet for first few days on ward but at present is more agreeable & talkative: Is somewhat of a bully & rough in speech & behavior: June 2 Wt. 145 Pulse 84.

June 25 To Went Home - Dr. Herzog notes - "Showed no delusions. Had slight incoordination but did not consider him as having locomotor ataxia. Had no epileptic convulsions while here"

Discharged

Personal and Medical History of

Personal and Medical History of

EBBERT, FISLAR & CHARLERS, DAVENPORT, IOWA

Entered in error.
Patient sent back under new papers.
Had not been discharged.
Papers filed under No. 4575.

Whole No. See No 4575. Feb. 93
Residence, Minnesota
Date Admission, May 3rd 1897.
Admitted by Dr. Kilbourne Hour, 6 45
How Sent, G. Willrich Jap? Ramsey
Sex, Male.
Age, 32.
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Laborer.
Degree Education, —
Profession Religion, unknown.
Habits, Very intemperate.
Nativity, Scotland (Parents Scotland)
Physicians Committing, J. B. Brimhall & O. L. Pine.
Correspondents, none given.

Date of this Attack, Found intoxicated May 1st 97.
Duration, 2 days
No. of Attack, 2nd
No. of Admissions, 2nd
Age First Attack, 31
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

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

MEMORY:
- Past Events,
- Recent Events,
- Special Subjects,

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

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

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

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION,

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT,

HEARING,

COORDINATION, Arms,

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of James Dmith.

HERBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. See No 4575. Feb. 93 this Volume.
Residence, - Minnesota
Date Admission, May 3rd 1897.
Admitted by Dr. Kilbourne Hour, 6 45 PM
How Sent, G. Willrich J. of P. Ramsey Co.
Sex, - male.
Age, - 32 -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, Laborer.
Degree Education, —
Profession Religion, unknown.
Habits, Very intemperate.
Nativity, Scotland (Parents Scotland)
Physicians Committing, J. B. Brimhall & O. D. Pine.
Correspondents, none given.

No. for Year, - -
Insane Relatives, unknown.
Cause Exciting, Probably aggravated by drink
Cause Predisposing, Previous attack.
Form,
Accompanying Bodily Disorder, none mentioned.
Suicidal or Not, Has attempted it. Propensity not active now.
Date of this Attack, Found intoxicated May 1st 97.
Duration, 2 days
No. of Attack, 2nd
No. of Admissions, 2nd
Age First Attack, 31
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

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

of

...TION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

WEIGHT, NUTRITION,
...RMALITIES,
...nors, Coatings, Promptness Movement,
..., Equality, Size,
Response Light, Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of James Smith.

1897

This patient was brought here by Sheriff's deputy Gust A. Winkler in fair physical condition, with wound on face. With the following history: Nothing known as to Consanguinity, heredity or previous peculiarities, or severe diseases or head injuries. Was found intoxicated in November '96 & sent to this (Rochester) hospital. Found in same condition May 1st '97. Disease appears increasing: Is variable with rational intervals. Derangement manifested by delusions that 9 men are conspiring to take his life. Has illusions of various kinds, is violent a portion of the time. Not disposed to injure others. Tried to hang himself in November: propensity does not seem active just at present. Tries to destroy his clothing. Confined & received treatment at Rochester hospital from Nov. '96 to Dec. '96 (See folio 93 No. 1575. this volume) sent out on trial & returned this day May 3 '97. with new papers. which are filed under old number with former papers.

Personal and Medical History of

Personal and Medical History of Frank Grub.

EGBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4759
Residence, Vagrant.
Date Admission, May 3rd 1897.
Admitted by Dr. R. M. Phelps Hour, 6:45 P.M.
How Sent, J. Ullrich Jr. & P. Ramsey Co.
Sex, male.
Age, 26
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Stone cutter
Degree Education, None.
Profession Religion, None.
Habits, Not intemperate.
Nativity, Switzerland (Parents Switzerland)
Physicians Committing, A. W. Whitney & J. Ohage.
Correspondents,

No. for Year, 292.
Insane Relatives, Unknown
Cause Exciting, Masturbation
Cause Predisposing,
Form, imbecile
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not.
Date of this Attack, 2 Mo. ago.
Duration, 2 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 26 yrs.
Time of Leaving, June 29. 1897
Time in Hospital, 2 mo 2 da.
Result, Transferred to Fergus Falls.

6/6/pm

EXAMINATION ON ADMISSION.

Exam. May 4/97 by Dr. Herzog. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Somewhat confused.
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Fair.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly alert.
Correct or Illusive, Correct.
REASONING POWER:
Ordinary Subjects, Poor.
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Patient is feeble-minded - a vagrant. Has served numerous terms in workhouses - Hangs head; is surly in his answers & irritable. Denies masturbation. Probably a congenital degenerate.

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

Personal and Medical History of Frank Grub.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 8 WEIGHT, 140 NUTRITION, fairly good - face pinched.
WOUNDS OR ABNORMALITIES, High arched palate.
TONGUE, ~~Tremors~~, Small, pointed Coatings, Clean Promptness Movement, Prompt.
PUPILS, Equality, Yes. Size, Normal
Response Light, Yes Accommodation, Yes.
SIGHT,
HEARING,
COORDINATION, Arms, Fair
Legs,
TREMORS, Hands, Slight Tongue, Slight
Facial Muscles, None General, None
REFLEXES, Patellar, 9 equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No Murmurs.
Somewhat weak. Slightly irregular.
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of Frank Opus

1897

This patient was brought here by Sheriffs deputy P.J. Nieces in fair physical condition, with the following history:- Knows nothing concerning consanguinity or heredity: First symptoms manifested 2 months ago by melancholic symptoms: Disease appears stationary: not variable: no rational intervals: Derangement manifested by mental depravity + stupidity + general lack of intellect: Not disposed to injure others: Filthy + destruction in habits: Nothing known as to previous familiarities: Intemperance in parents or self: No severe disease or head injury: Has been confined in work-house several times: Has received no treatment. On personal examination shows personal uncleanliness. Lack of memory. Refuses to answer questions.

May 5 On admission put upon B' E (9th Rpt Complexion dark: hair dark brown: eyes black: Condition of skin good: Is dirty: behavior good.

May 6 Physician's Note: "Is a defective: perfectly satisfied as long as he is cared for." HHH.

10 Appetite good: Bowels regular: Behavior fairly good: At times somewhat restless - walking hall if allowed: but will always mind when spoken to. Is stubborn + lazy refusing to work. Talks very little: Habits clean. June 1 Wt. 158 P. 104. Physical condition Apparently good: Works a little on hall. June 2 Trans. to Annex.

June 29 Eats + sleeps well - Physical condition seems good. Behavior restless Talks only when spoken to: Does no work: Habits clean: Transferred to Fergus Falls.

Discharged.

Personal and Medical History of

Personal and Medical History of A. W. Mortenson

ESSERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4765

Residence, St. Paul, Minn.

Date Admission, May 12, 1897.

Admitted by Dr. R. M. Phelps Hour, 6:45 P.M.

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

Sex, Male.

Age, 53 yrs.

Civil Condition, Married

Children, 3

Age Youngest Child,

Occupation, Clerk, Board of Public Works.

Degree Education, good.

Profession Religion, yes Congregational.

Habits, Not intemperate.

Nativity, Denmark (Parents Denmark.

Physicians Committing, G. Stanton & Talbot Jones.

Correspondents,

No. for Year, 298

Insane Relatives, None Known. (Father intemperate)

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form, Melancholia acute

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Threatened - possibly attempted it

Date of this Attack, About 10 days ago.

Duration, About 10 days.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 53.

Time of Leaving, Aug. 10. 1897

Time in Hospital, 2 mo. 29 da.

Result, Discharged Jan. 19. 1898 Recovered.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

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 A. W. Mortenson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 WEIGHT, 116 NUTRITION,

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Size,

Response Light, Accommodation,

SIGHT,

HEARING,

COORDINATION, Arms,

Legs,

TREMORS, Hands, Tongue,

Facial Muscles, General,

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of A. W. Mortenson

1897

This patient was brought here by Sheriffs deputy Jules Leabanne in fair physical condition with the following history: Nothing known as to consanguinity: First symptoms manifested about 10 days ago by various delusions of persecution & self-accusation: Disease appears increasing Not variable, no rational intervals: Derangement manifested by delusions concerning loosing papers belonging to the Masonic & Druids lodges which he thinks will bring disgrace upon himself & family: Not disposed to injure others: Not certain as to attempts at suicide; has threatened to jump out of window: Not filthy or destructive in habits: No previous peculiarities: No head injury. Has suffered from severe sick headaches for many years: Has not been confined or restrained. Has received no treatment. No further particulars learned on personal examination.

May 13 On admission (sent upon B³C (Govt. Dept. Complexion dark: hair brown: eyes brown: Condition of skin good. Tattoo marks on right arm - 2 flags Eruption on back: Is clean: behavior quiet.)

13 Summary Nurses record - Slept ½ hrs. during night: Quiet when awake: Trans. to Infirmary at 11 AM. & put to bed - Melancholy & depressed: Answers questions but does not talk of his own accord - Is weak & says top of head feels very sore: Feet cold: Hot applications applied to feet & cold ones to head. May 14 Applications continued first part of night. Seems brighter & talks more readily - Says that cause of condition is worrying & loss of sleep - Says he lost valuable papers belonging to society & worried so about it that he could not sleep & at times would not recognize his friends about him. Says he is not insane. only depressed. worries about his wife etc - May 15 Feels better this morning: Very quiet & apparently does not care to talk - May 16 Did not rest well last night. during morning complained of head. Habits clean: Bowels regular: Talks quite rationally: May 18 Up & out with crowd today May 19 Walks about ward: Realizes where he is & talks rationally. May 20 No change: Does neat: Very agreeable: Bowels regular: Appetite fair: takes milk between meals. May 22 Visited by son-in-law. Very much depressed after he left. Thinks he will never see family again.

June 1 Talked to himself greater part of night. June 3 Massage given. June 6 Seems to be a little better both mentally & physically. June 7 Visited by wife & daughter

15 Has been talking to himself greater part of day. June 26 Despondent & depressed. Thinks that he will not get well - up this p.m. for a while. June 28 Visited by wife & daughter. Seemed pleased to see them - Still complains of head being sore. July 1 Wt. 135 P. 72. July 17 Played on violin for amusement of patients today. July 21 Visited by friends July 25 Visited by wife & daughter

July 31 Has improved considerably during past month: Pain in head has not troubled him of late & he is more cheerful & ambitious & thinks he will soon be well. Is neat & tidy & well-behaved. Takes a lively interest in all kinds of sport.

Personal and Medical History of A. W. Mortenson.

1897

Aug 1 Wt. 127 Pulse 78. Appetite good: Bowels regular: Neat & clean in habits: Talks freely & intelligently & is very cheerful & pleasant: Assists with work: goes out with crowd: reads & plays on violin & is quiet & well-behaved.

" 4 Visited by friend. Aug 10 Visited by wife & taken home.

Discharged.

Personal and Medical History of John Mahoney

For No. 4766 See page 381 - omitted -

EGBERT, FIDLAR & BRAMBERG, DAVENPORT, IOWA.

Whole No. 4767.
Residence, St. Paul, Minn.
Date Admission, May 14th 1897.
Admitted by Dr H. H. Herzog Hour, 6 45 P.M.
How Sent, G. Willrich J. of P. Ramsey Co.
Sex, - Male.
Age, - 60 -
Civil Condition, - Single -
Children, -
Age Youngest Child, -
Occupation, Laborer
Degree Education, - None -
Profession Religion, Catholic.
Habits, Unknown.
Nativity, Ireland (Parents Ireland)
Physicians Committing, Jas. L. Mayor - Haldor Dieru
Correspondents,

No. for Year, 300
Insane Relatives, - Unknown.
Cause Exciting, Unknown
Cause Predisposing, "
Form, Dementia senilis
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, About 1 yrs. ago.
Duration, About 1 years.
No. of Attack, Probably Not 1st.
No. of Admissions, Unknown
Age First Attack, "
Time of Leaving, Xfer. 26. 1900
Time in Hospital,
Result, Transferred to Hastings.

DK Fox

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

Exam. by Dr. Herzog 5/15/97.

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, Correct.
REASONING POWER:
Ordinary Subjects, Slow + defective.
Own Mental State,
Special Subjects,

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

GENERAL DESCRIPTIVE REMARKS: Patient is a senile dement. Quite feeble with quite marked atheromatous changes. Has probably been always of low mental grade. Has no recollection of relations. Has been at Little Sisters of the Poor at St. Paul

Personal and Medical History of John Mahoney.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 Ft. 6 in. WEIGHT, 138½ NUTRITION, Somewhat impaired.
Skin. Some roseola blight
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, None Coatings, Clean Promptness Movement, Slow.
PUPILS, Equality, Irregular in outline Size, Small, immobile
Response Light, ~~Impaired~~ No Accommodation, No.
SIGHT, Impaired
HEARING, "
COORDINATION, Arms, Impaired
Legs, "
TREMORS, Hands, Tongue,
Facial Muscles, General, Some - on standing
REFLEXES, Patellar, Q equal. EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries Stiff.
HEART, Impulse strong -
1st mitral sound soft murmur.
LUNGS, No marked disease - small expansion -

TAKEN,

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

Personal and Medical History of John Mahoney.

1897

This patient was brought here by Sheriffs Deputy P. J. Misen: in fair physical condition with the following history:- No history of Consanguinity:- First symptoms of this attack (probably not first) Manifested about a year ago came to "Little Sisters of the Poor" Excitable & irritable: Disease appears progressive: Disease not variable, no rational intervals: Derangement manifested by trying to cut foot to fit shoe, is excitable at times & tries to strike other patients with chairs etc. Memory is bad: Patient is disposed to injure others Not Suicidal: Destroys clothing & bedding: No previous peculiarities shown: No severe disease or head injury: Has not been confined or restrained: Has received no treatment: On personal examination appears dull & stupid: Says he is 100 years old & has been in St. Paul 90 yrs. On admission put upon 3° C (G.t.n Pat Complexion light: Hair gray: eyes blue: Condition of skin Good: Is clean: Stoops slightly: Behavior quiet.)

May 27 97 Physician's Note. Patient has slept well & had no rise of temperature since admission, Appetite good: bowels regular: Is feeble & scarcely able to keep up with the others while walking. Wanders aimlessly about the ward. Habits & personal appearance slouchy, spits on floor etc. Simple senile dementia with loss of memory for recent events well marked (H.H.H.)

(Summary Note Rec'd July 1st 97 Wt. 145# Seems to be getting along quietly; rather demented: Wanders about rather aimlessly Apr 1 98 Condition about same: Sits about ward: does nothing: Rather filthy in habits: Jan 31 99 At present on A[2]. Is dull, quiet & demented: Has been occasionally slightly violent:

Feb 1 - July 31 to July 31 99. (Dr. Mahoney) Wt. 153#. Mental condition does not change: Seldom talks unless spoken to. Neat in habits & dress: Bowels regular. Appetite good. Aug 1. No apparent change in patient. Sept 26. Has trouble with patient Hoffman, and received scratch on hand. Oct 1. Wt 149# - Nov 30. Appetite good: bowels regular: Habits cleanly: Sleep regular. Is easily irritated. Feb 1 1900. Patient is generally well behaved: Does no work. Apl 1/26 Wt 142#. P 79. April 26. Transferred to Hastings Hospital.

Personal and Medical History of

Personal and Medical History of Martin J. Meade

HERBERT, FOLAN & CHAMBERS, DAVENPORT, IOWA

Whole No. 4768

Residence, St. Paul, Minn.

Date Admission, May 14th 1897.

Admitted by Dr. H.H. Herzog Hour, 6.55 P.M.

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

Sex, Male.

Age, 41.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Painter.

Degree Education, Can read & write.

Profession Religion, None.

Habits, Very intemperate.

Nativity, Born on Shipboard in Indian Ocean (Further Inland, Brixham Eng.)

Physicians Committing, C.L. Crise & R.D. Bale.

Correspondents,

No. for Year, 301

Insane Relatives, Unknown

Cause Exciting, Alcohol & perhaps lead poison.

Cause Predisposing,

Form, Manic Insanity

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Not given

Duration, —

No. of Attack, 4th?

No. of Admissions, 5th Gen. (One on Ires. Warrant) 2. St Peter

Age First Attack, —

Time of Leaving, Dec. 28. 1898

Time in Hospital, 1 yr. 7 m. 14 d.

Result, Discharged Feb. 8'99.

Improved.

Dec 28/98. Taken out by agent Gates to New York for deportation to Ireland — O.K. Dr.

EXAMINATION ON ADMISSION.

Exam. 3/15/97 by Dr. Herzog.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Slightly confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Slightly impaired.

Recent Events, More impaired.

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive, Correct.

REASONING POWER:

Ordinary Subjects, Fair.

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,✓

DELUSIONS: None noted.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Fairly coherent

Voluble or Reticent, Voluble

GENERAL DESCRIPTIVE REMARKS: Has been in hospitals numerous times, beside admissions here, was twice in St. Peter. Formerly had paranoiac ideas of persecution. Does not show them so plainly now. Is slightly more demented, loss of memory more marked. Is now tremulous, weak & unsteady after a debauch

Personal and Medical History of Martin J. Meade

Pioneer Press Mch 3'97

Premonition of Insanity.

Martin J. Mead, aged forty years, surrendered himself to the police yesterday. He complained of being sick. During the day he developed symptoms of insanity. In the evening he asked Jailer Staufield for a revolver with which to shoot himself. He ruffled about the condition of the poor and he said that he would call upon the governor to-day and request him to provide work for all the unemployed in the city. He was removed to the county jail on the order of Dr. Brimhall. Mead has been in the insane asylum before.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Considerably impaired.

Condition of Skin Greasy

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Marked. Coatings, heavy brownish yellow Promptness Movement, Large, prompt.

PUPILS, Equality, Equal. Size, Normal

Response Light, Yes. Accommodation, Yes.

SIGHT, Fair.

HEARING, Good.

COORDINATION, Arms, Considerably impaired

Legs, "

TREMORS, Hands, Marked. Tongue,

Facial Muscles, General, Some general

REFLEXES, Patellar, Equal. EXAM. URINE,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Bounds feeble, weak — irregular

LUNGS, Some bronchitis

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

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

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Martin J. Meade.

1897

This patient was brought here by Sheriffs deputy J. P. Flandrake, in fair physical condition with the following history: No history of consanguinity: Has been here in this (Rochester) hospital 4 times before this (See note[x]) No information in papers concerning present attack - (See newspaper clipping attached to previous page) Disease worse while drinking: Derangement manifested by alcoholic insanity: Tremor of muscles, aversion to talking, melancholy: Not disposed to injure others: No information concerning heredity, habits or previous peculiarities: Has been confined here -+- at St. Peter as above stated: No further particulars noted on personal examination.

[x] Note Patient was here the 1st time from May 23'90 to May 9'90 (See Vol. 14 p. 6 or No. 3102)
" " 2nd time. Oct 28'90 to Mch 19'94 (" 20 " 225 " 3164)
" " 3rd time. May 26'94 " Oct 8'94 (" 27 " 249 " 3732)
" " 4th time. July 24'95 " May 26'96 (" 32 " 5 No. 4169) on Mch. Warrant.
Has been at St. Peter since leaving here last.

On admission put upon B³ E (O.P.D. Rpt Complexion dark: Hair gray: eyes blue: Condition of skin good: Vaccination scars on left arm: Varicose veins on inside of right thigh + leg: Behavior good: Complains of being cold, + shaking.)

May 27'97. Physicians Notes Patient has had no rise of temperature since admission: Appetite good after the first week, slept well: Bowels constipated at first, now good, on 10 gtt. Fl. ex. Casc. Sag. t.i.d. Took strych. Nit. gr 1/60 up to xxx. Has been quite well behaved for him, this last time. Few complaints. Has suffered from gastritis + the nervous symptoms due to a debauch. Mental state is a blending of paranoea, with delusions of persecution + a vague egotism with a dementia, probably alcoholic. He has apparently given up the idea of trying to make his way outside for a time. Was glad to get in + wants to stay.

Oct 7'97 Summary notes by Dr Phipps.
Patient driping along quietly. Surly in appearance. Complains frequently of being weak, shaky + nervous, same as on previous occasions:
Apr 15'98. Left today. May 24'98 Returned: Says his head hurts him: Talks to himself: Complains of not sleeping well. May 28 Kept in bed on several days, but now up + about. Complains of not sleeping; says he worries over his troubles. Dec 7'98 Sent away to Island: Mr. Gates accompanying him to Newyork. Had been out at work + behavior was about same as on previous stays.

December ? Discharged

Personal and Medical History of

Personal and Medical History of Richard A. Arnison

4M
EBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4766
Residence, Clarmona, Minn.
Date Admission, May. 13th 1897.
Admitted by Dr. R. M. Phelps Hour, 6 PM.
How Sent, C. Farrington J. of P. Fillmore Co.
Sex, Male.
Age, 63
Civil Condition, Married.
Children, One.
Age Youngest Child,
Occupation, Farmer & Miner.
Degree Education, Academic.
Profession Religion, None.
Habits, Intemperate.
Nativity, Rhode Island (Father N.Y. Mother R.I.)
Physicians Committing, Geo. A. Low Hy. Jones MD.
Correspondents,

No. for Year, 299.
Insane Relatives, one uncle & one aunt.
Cause Exciting, Intemperance.
Cause Predisposing, –
Form, Dementia senilis.
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, Has had trouble with head several years
Duration, not stated.
No. of Attack, Several.
No. of Admissions, 1st
Age First Attack, 60 yrs old
Time of Leaving, July 22. 1897
Time in Hospital, 3 mos. 26 da.
Result, Discharged Nov. 3. 1897.
Much Improved.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

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

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

Personal and Medical History of Richard A. Arnison

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, 120 NUTRITION,
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,

TAKEN,

OPHTHALMOSCOPIC EXAM.,

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

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

Personal and Medical History of Richard A. Minnor.

1897

This patient was brought here by Sheriff's deputy E. H. Bronnd in fair physical condition with the following history: No history of consanguinity: Has had trouble with head for several years: First attack manifested 3 yrs. ago: duration short: Disease appears increasing: Variable with irregular, rational intervals: Derangement manifested by being intensely jealous of his family: Is disposed to injure others: Not suicidal filthy or destructive: No previous peculiarities shown: No severe disease or injury to head: Patient very intemperate: Has not been confined or restrained: No treatment pursued.

No information obtained on personal examination:

On admission put upon D 3 E (7th & 8th Rts.) Complexion light: hair slight gray: eyes blue: Condition of skin good: Vaccination scar on left arm: Scar above left knee & on right leg & small scar on back: Left hand injured & fingers stiff: Behavior good.)

May 26 97. Physician's Note Patient has had normal temperature, fair general health & has been very quiet & well behaved since admission. He is not so hypochondriacal as at first & seems to think his medicine (Arsenauro gtt.x tid.) is doing him good. Seems to be constituted. Talks quite well on ordinary subjects - Is still slightly demented & is probably one of those who are very troublesome at home, particularly if drinking.

June 1 Wt. 175 lbs. Pulse 72. Is quiet & well behaved: Does a little work on ward: Talks quite rationally: June 30 Complains of being troubled with Asthma: Trans: to A 3. July 4 Wt. 170½ Pulse 64. Patient is of good behavior: habits neat & clean: Physical condition good: Appetite good: Sleeps well: Goes for walk each day - is on parole: Does no work beyond caring for his own room: July 22 Went Home.

Discharged.

Personal and Medical History of

Personal and Medical History of Dennis Tracy

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EBBERT, FIDLAR & CRAMER'S, DAVENPORT, IOWA.

Whole No. 4769

Residence, St. Paul, Minn. 396 Farguier St.

Date Admission, May 15th 1897.

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

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

Sex, Male.

Age, 77.

Civil Condition, Married.

Children, 9

Age Youngest Child, —

Occupation, Laborer.

Degree Education, None.

Profession Religion, Roman Catholic.

Habits, Moderate drinker

Nativity, Ireland.

Physicians Committing, A. W. Dunning & J. A. Dunn

Correspondents, Wife Mrs. D. Tracy 588 Farguier St., St Paul. Minn.

No. for Year, 202.

Insane Relatives, None.

Cause Exciting, Age, infirmity occasioned by

Cause Predisposing, surgical injury

Form, Dementia senilis

Accompanying Bodily Disorder, —

Suicidal or Not, Not.

Date of this Attack, Several years ago.

Duration, Several years.

No. of Attack, 1st

No. of Admissions, 1st to Hospital for insane (in St Paul Hosp. 5 mo.)

Age First Attack, 77

Time of Leaving, Died Sept. 7.

Time in Hospital, 2 yr. 3 m. 23 d.

Result, Died in Gen. Paresis.

EXAMINATION ON ADMISSION.

MENTAL CHARACTERISTICS.

By Phn. Phelps 5/25/97.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Confused.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Incorrect.

REASONING POWER:

Ordinary Subjects, Poor

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient a markedly senile case. Is rather active yet & thoroughly demented.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Slightly.

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not, Transitory.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Dennis Tracy.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7 in. WEIGHT, 155 lbs. NUTRITION, Fair for age.

WOUNDS OR ABNORMALITIES, Skin fair for age.

TONGUE, Tremors, Coatings, Brown coat. dry. Promptness Movement,

PUPILS, Equality, Equal. Size,

Response Light, Accommodation,

SIGHT, ?

HEARING, Some trouble.

COORDINATION, Arms,

Legs,

TREMORS, Hands,

Facial Muscles, Tongue,

REFLEXES, Patellar, Normal General, Somewhat trembling & feeble.

Other EXAM. URINE,

ARTICULATION,

Slurred, Fairly normal.

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART,

Sounds very weak

LUNGS, Normal.

Arteries grossly atheromatous.

OPHTHALMOSCOPIC EXAM.,

TAKEN,

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

CRANIAL MEASUREMENTS,

HISTORICAL, Used to drink hard. Says had Vertigo 4 or 5 yrs ago. Headaches rarely.

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 Dennis Tracy.

1897

This patient was brought here by Sheriff's deputy P.J. Mixsa, in fair physical condition with the following history:- No history of consanguinity, or heredity: This is first attack, first symptoms manifested several years ago by partial dementia. Disease appears increasing: Not variable, no rational intervals: Imagines he is persecuted by those trying to gain control of his property: Not disposed to injure others Is filthy & destructive in habits: No previous peculiarities shown: No severe disease, nor head injury excepting scalp wound. - & broken leg received last December: Has been in Hospital for 5 months.

On personal examination is well-nourished & a pleasant old gentleman.

May 16 On admission put upon B³ E (G.T.M. Rpt. Complexion light: hair gray: eyes blue: Scar on right elbow & on knee: Coarse veins on right leg: behavior good)

Summary Notes R.M. Phelps May 15'97 Received on ward & put to bed: Rather dull & restless: Says Bishop Ireland ran over him with engine, breaking both of his legs, which is probably not true. May 31. Has been up recently: Seems quite exhausted & weak: June 1. Wt. 140#. In bed again; seems to be more easily cared for there. Temperature recently slightly elevated July 1'97 Wt. 151#. Gth 154#. Patient rather irritable. Has been up & about a good deal of the time of late. Nov. 1 Put to bed: Troubled with diarrhoea. Apr 1'98 Wt. 146#. Still in bed; dirty & demented. October 1. Still lying quietly in bed: No change in any respect. Feb 1'99 Still in bed. No change of importance.

1899 Feb. to July 31'99 (Dr Wanous) Patient remains about the same from day to day: lies quiet in bed: Troubled with constipation & gives frequent enemata

July 6. Fell from bed. no bruises noticed. Aug 1/99. Patient lies helplessly in bed; Aug 1 is very filthy: Sep 1/99. Patient is growing weaker: Has sacral bed sores on back and hips: Sep 1/ These sores are dressed daily. Sept 2. Patient is steadily failing: Sep 4. Continues to fail rapidly, " 4/ Breathing is labored: Patient lies in a semi-comatose state. Sep 7. Continued so; failed rapidly, and died at 7³⁰ P.M. —

— Died —

Personal and Medical History of

Personal and Medical History of Ingwald C. Johnson.

EBERT, PIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 4770

Residence, Minnesota.

Date Admission, May 26th 1897.

Admitted by Dr. C.B. Eby Hour, 6:45 P.M.

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

Sex, Male.

Age, 30.

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, Laborer.

Degree Education, Can read & write.

Profession Religion, none.

Habits, unknown.

Nativity, Norway (Parents Norway)

Physicians Committing, Alex Donald & Haldor Sucov

Correspondents,

No. for Year, 305

Insane Relatives, None so far as known.

Cause Exciting,

Cause Predisposing, Phys. degeneration.

Form, Paranoia

Accompanying Bodily Disorder, none mentioned.

Suicidal or Not, yes. propensity active.

Date of this Attack, unknown

Duration, unknown

No. of Attack, unknown

No. of Admissions, "

Age First Attack, "

Time of Leaving, Sept. 9. 1897

Time in Hospital, 3 mo. 14 d.

Result, Discharged Feb. 9. 1898 Improved.

EXAMINATION ON ADMISSION.

By Rev. Phelps 8/23/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Poor apparently.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Dull

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Talks in a dull, confused, uncertain way. Thinks was crazy when arrested tho can't tell what he did except to run out on the streets of Minneapolis. Seemingly the boy has been normally quite dull & drank heavily making his condition & behavior worse. No physical symptoms noted.

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,

Medical History of Ingwald C. Johnson.

TRIES TO HANG HIMSELF.

An Insane Prisoner Has a Narrow Escape.

I. C. Johnson, who was adjudged insane Tuesday by Judge Willrich, attempted to hang himself in the county jail yesterday morning. He was found suspended from the door of his cell by means of his suspenders. Johnson had nearly accomplished his purpose when discovered. A colored boy named Moore saved Johnson's life by raising his body from the floor until assistance arrived. Johnson was sent to the Rochester hospital yesterday afternoon.

Have memorandum put in Case book to notify M. L. Hutchins - 141 E 9½ St. St. Paul when Ingwald C Johnson leaves here.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

NUTRITION, Good.

Promptness Movement, Normal.

odation,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Normal

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal

LUNGS, Good condition

TAKEN,

EXAM. URINE,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, No severe diseases. Got drunk sometimes - Vertigo after eating. Family had headaches.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Don't Know

Mother or Mat. Relations, ? heard from home last 7 yrs. ago.

Father or Pat. Relations, ? heard last 7 yrs. ago

Brothers or Sisters,

Personal and Medical History of

EBERT, PIDLAR & CHAMBERS, DAVENPORT, IOWA

Whole No. 477 w

Residence, Minnesota.

Date Admission, May 26th 1897.

Admitted by Dr. L. B. Eby Hour, 6:45 P.M.

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

Sex, Male.

Age, 30.

Civil Condition, Single.

Children, -

Age Youngest Child, -

Occupation, Laborer.

Degree Education, Can read & write.

Profession Religion, none.

Habits, unknown.

Nativity, Norway (Parents Norway)

Physicians Committing, Alex Donald & Haldor Dueo

Correspondents,

No.

Insane k

Cause Excitin

Cause Predisposing

Form,

Accompanying Bodily Disor

Suicidal or Not, yes. fre

Date of this Attack, unknow

Duration, unknown

No. of Attack, unknown

No. of Admissions, "

Age First Attack, "

Time of Leaving, Sept. 9. 1897

Time in Hospital, 3 mo. 14 d.

Result, Discharged Feb. 9. 1898 Improved.

EXAMINATION ON ADMISSION.

By Rev. Phelps 8/23/97

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Poor apparently.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Dull

Own Mental State, "

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Talks in a dull, confused uncertain way. Thinks was crazy when arrested. Can't tell what he did except to run out on the streets of Minneapolis. Seemingly the boy has been normally quite dull & drinks heavily making his condition & behavior worse. No physical symptoms noted.

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,

TRIES TO HANG HIMSELF.

An Insane Prisoner Has a Narrow Escape.

I. C. Johnson, who was adjudged insane Tuesday by Judge Willrich, attempted to hang himself in the county jail yesterday morning. He was found suspended from the door of his cell by means of his suspenders.

Johnson had nearly accomplished his purpose when discovered. A colored boy named Moore discovered. A colored boy named Moore cut Johnson's life by raising his body from the floor until assistance arrived. Johnson was taken to the Rochester hospital yesterday after-

Medical History of Ingwald L. Johnson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good.

SOUNDS OR ABNORMALITIES, Normal

TONGUE, Tremors, Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Normal. Accommodation,

SIGHT, Good?

HEARING, "

COORDINATION, Arms, Normal

Legs,

TREMORS, Hands, Fairly Steady Tongue,

Facial Muscles, General,

REFLEXES, Patellar, EXAM. URINE,

Other

ARTICULATION,

Slurred, Normal

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal

LUNGS, Good condition

TAKEN,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, Irregular,

APPETITE, Good, Medium, Poor,

SLEEP, Good, Poor, Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, No severe diseases - Got drunk sometimes - Vertigo after eating. Fairly hard headache.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify — "Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Don't Know

Mother or Mat. Relations, ? Heard from home last 7 yrs. ago.

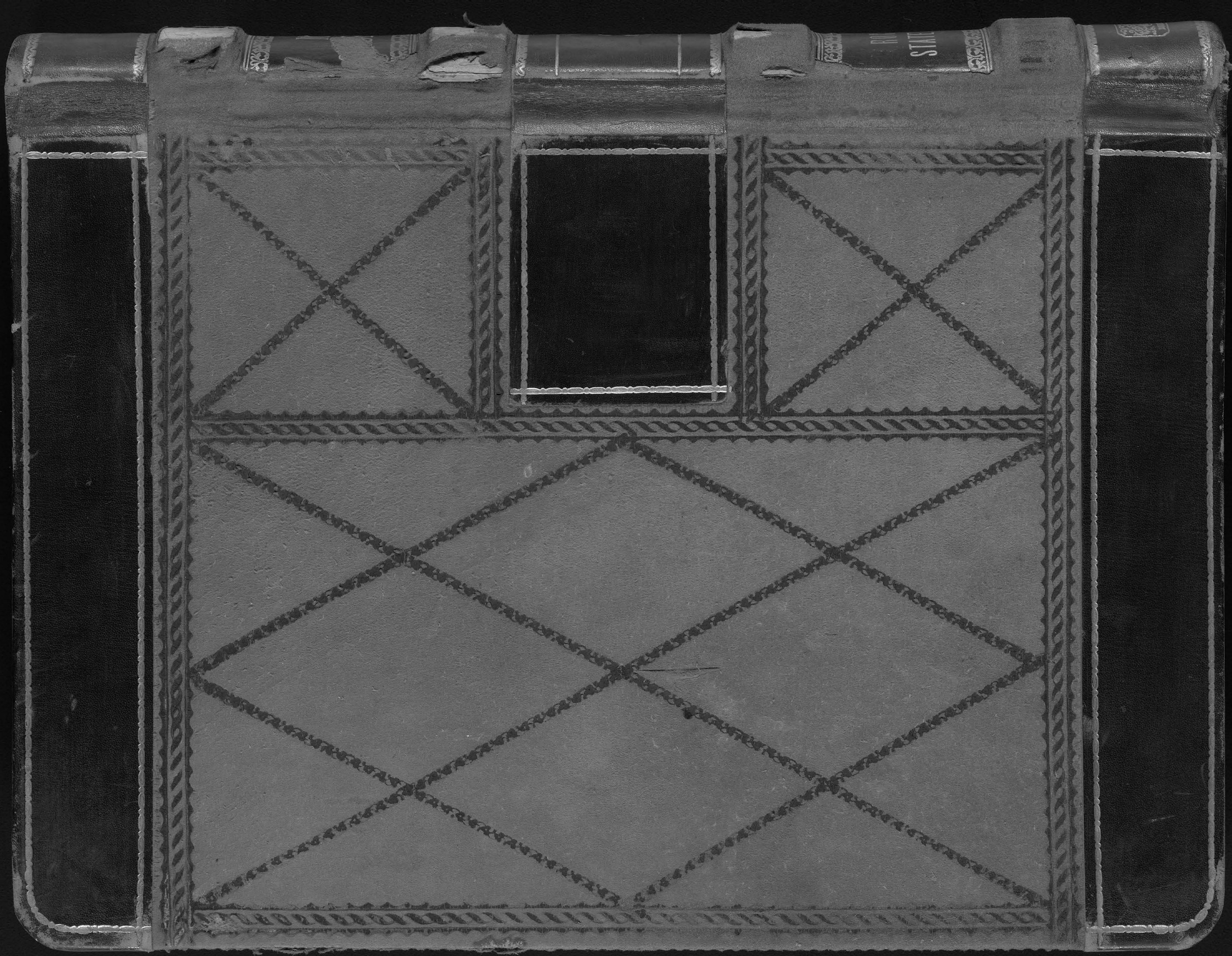
Father or Pat. Relations, ? Heard last 7 yrs. ago

Brothers or Sisters,

Personal and Medical History of Sigwald C. Johnson.

1897

This patient was brought here by Sheriffs Deputy P.J. Nissen attended by C. J Watson in fair physical condition with the following history:- No history of consanguinity noted. No information concerning number of attack or duration. Disease seems increasing: Is variable with irregular rational intervals: Derangement manifested by mental confusion - afraid that he will be hung - thinks people are pursueing him in order to kill him. Has attempted suicide by hanging: Disposed to filthy & destructive habits: No information concerning previous peculiarities. Intemperance in parents or self: Has had head injury: was confined one day in jail: Has received no treatment. On personal examination - memory poor: Appears stupid & preoccupied: Has hallucinations of hearing; thinks he is being persecuted. Masturbates openly.

May 26 Admission put upon B³ E (Q.Hy. Rpt. Complexion light: hair light: eyes blue: Condition of skin good: Is dirty: behavior good.)
Reed on ward & put to bed. Talks very irrationally. Thinks he is to be killed - Confesses to masturbation. May 28 Still believes he is to be killed - Is quiet & well-behaved.
29 Habits fairly tidy: Does some work when asked. Temp. pulse & resp. normal. Appetite good.
30 Has given up idea that he is to die - & is very contented here - Sleeps well.
June 1. Is looking much better physically. June 2 Makes no complaints - Is good natured & agreeable. June 3 Seems somewhat exalted mentally. Physical condition good.
6 Walks hall part of time swinging arms & talking loudly to himself.
7 Complains of pain in head today - medicine given June 8 Says head is better; is feeling good & enjoys medicine: Bowels regular - July 1 Wt. 158 Pulse 72.
July 14 Has been very stupid of late. Today had a very maniacal spell: Stood before mirror in washroom. Dancing, yelling & laughing foolishly to himself.
July 30 Still remains very hilarious, laughing & talking to himself in a very foolish manner & at times breaking out into songs & loud laughter - usually standing before mirror. Is slouchy in dress & habits: Appetite good. bowels regular. Aug 1 Wt. 165½ Pulse 90. Confused & irrational most of time - at times forgets what he is doing & stands stupidly in one place until spoken to. Sept 1 Wt. 173½ Pulse 74. Has improved some mentally: Goes about his work with more energy than at any time since admission. but is at times somewhat demented still laughing & talking foolishly to himself. Physical condition excellent.
Sept 9 Patient eloped at noon & efforts to find him of no avail.

Discharged.