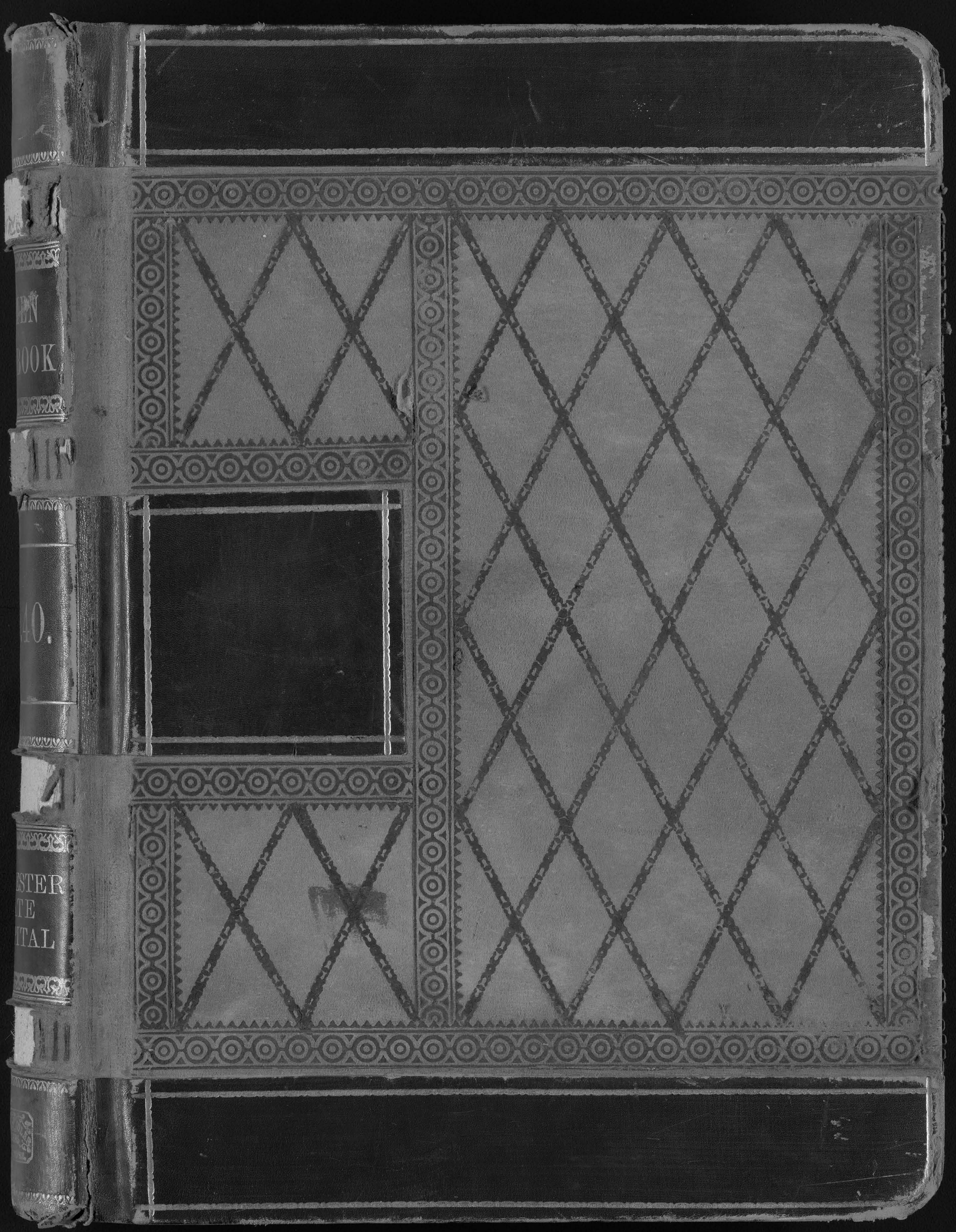


Rochester State Hospital (Minn.). Patient Case Books.

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Version 3
August 20, 2018


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PLEASE TAKE NOTICE.

THIS BOOK is made of first-class material and by first-class workmen. In order to insure a good book until used up observe the following: Do not open in the center, but from either the front or back, running the leaves over until you come to the place you want; and in closing it do just the reverse, running the leaves back to the cover. All new books will be more or less stiff in the back until used a while, and this manner of using will make them limber and still not strain them. When the book is not in use, and at night, keep another book or weight on it so that the covers will not curl, as all new books are liable to do, especially if kept in a very warm room.

Respectfully,

Egbert Gideon & Chambers.

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Allen	Wm. Minerva	21	(See Minerva Campbell)
Ameigh	Elizabeth J	49	
Adams	Catherine	113	
Arndt	Wm Emma	137	
Aalen	Wm Mary	165	
Artt	Mary	257	
Andrews	Olive	397	2nd ad

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Bredahl	Alvilda	33	(Sister Hattie Bredahl)
Byrnes	Kate	61	
Ballard	Candace A	85	
Burgess	Lillie	141	
Bean	Mrs Ella J	277	3rd Ad.
Bork	Augusta	297	2nd ad.
Blase	Elizabeth M.	393	(Transferred from Western Hospital of Tacoma)

Campbell	Mrs Minnie	21	(See Minnie Allen)
Canham	Lillie	25	2nd ad. (at Hudson & Wauwatosa also)
Clement	Mary	117	3rd ad.
Cameron	Ida M.	205	
Casti	Magdalena	349	2nd ad.
Casy	Lizzie	341	2nd ad. here. Has been at St. Peter & Fergus.
Cursy	Estella	377	

Faulhaver	Maggie	337	2nd ad	Rev. Maggie Berry
Flynn	Johanna	349		

Gatzlaff	Adelmie	53
Griffin	Delia	179
Graf	Mary	209

Hartung	Hulda	17
Harmel	Mari	89
Haggerty	Mary	101
Haberkorn	Mary	173
Hay	Mrs Hagar	157
Hognason	Katie	265
Hallus	Gertrude	385

Johnson	Anna	73	245

Kochler	Alvina	45	
Kettle (or Kittle)	Ida	109	2nd Ad.
Kregar	Juliana	133	
Kunz	Katie	301	
Kallak	Inge	305	2nd ad.
Krotcher	Nellie	381	

Leeson	Agnes	1	
Lynch	Mary #4	9	
Le Mieux	Malvina	29	
Luborwicka	Monica	93	(See also Tom Luborwicka)
Larsen	Mary #2	145	
Lynch	Catherine	189	
Lynch	Mary #3	193	
Lind	Emily	229	
Lattmann	Christine	293	
Licka	Rose	329	

Morn	Jane O.	73	3rd ad.
Miller	Kate	77	
Melby	Ellen	175	
Mladow	Annie	169	
Mack	Ellen	181	
Miller	Minnie	237	
Murphy	Eliza	333	
Moody	Ida S.	369	
Major	Jane A.	389	2nd ad.
Maas	Emma	401	

McGonigle	Sarah	353.	has been at Fergus Falls.

Newman	Minnie	5
Nelson	Betsy	149
Neidentrauer	Theresa	201
Nelson	Anna	233

O'Neill	Sarah	69
O'Hara	Nora	185

Paul	Ella	81
Peterson	Louisa	253
Porraro	Alvina	285

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Rhode	Hannah C.	177	
Rybka	Rasa	225	3rd ad.
Risser	Catherine	325	

Shank	Edith	13	
Stenehjem	Emma	37	
Stewart	Rachel	65	
Sio	Frances	105	
Stewart	Hattie	153	(at St Joseph's St Paul. 5 mos)
Schmidt	Adolphine	161	
Stumvoll	Mary	213	
Sinivano	Sarah A	221	2nd ad.
Sullivan	Laura B	261	
Siwarts	Sarah	269	5th ad. (See Sarah Morano)
Storley	Mrs. Anna	273	2nd ad.
Snow	Amelia	281	
Secord	Grace	309	
Saam	Elizabeth	317	
Segar	Jane	361	
Schumacher	Emma	357	

Savage	Emily	373	3rd ad.

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Tillischie	Annie	41	
Tecke	Augusta, Louise	57	
Tubbessing	Annie M.	97	
Tessmer	Pauline	197	
Thornton	Catherine	289	
Tschida	Anna	315	(Crista Theresa Tschida)

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Von Lubowiecka	Monica	93	
Van Slyke	Ella Maud	321	
Valois	Hattie	365	

Wagner	Emma	121	
Worth	Minnie	217	
Wagner	Mrs Wanda	241	
Wilson	Jessie E	245	

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Personal and Medical History of

Personal and Medical History of Agnes Liesen

Whole No. 5148
Residence, St. Paul, Minn.
Date Admission, October 5th 1898.
Admitted by Dr. R. M. Phelps hour, 6 PM.
How Sent, Gilfillan & Co. & Pt. Ramsey Co.
Sex, Female Age, 34 yrs.
Civil Condition, married.
Children, Six
Age Youngest Child, 15 months
Occupation, Housewife. (husband a blacksmith)
Degree Education, Common school.
Profession, Religion, Roman catholic.
Habits, Not intemperate.
~~Nationality~~ Nativity Minn. (Parents born in Germany)
Physicians Committing, Gustav A. Peiz & C. J. Maloney.
Correspondents, husband.

No. of Years, 4 yrs.
Insane Relatives, None. (Father drank heavily - suicided 5 yrs ago)
Cause Exciting, Unknown.
Cause Predisposing, —
Form, Paranoia
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, December 1897
Duration, 10 months
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 33 yrs
Time of Leaving, 12th May 1902
Time in Hospital, 3 yrs 7 mos 7 ds
Result, Improved: Discharged Nov 8/1902.
(Cared for by relative)

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 10/6/98

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events,

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

DELUSIONS, Systematized, Transitory, Special Subjects,

Says got queer ideas last December. Was not well after birth of baby (Jan 98) Head troubled her at times - Top of head pained her - when she was worried that place hurt her.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 2 yrs.
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father D. Drank excessively. Suicided - Not insane that thinks
Paternal Relatives,
Mother, D. When patient was young - died when 2nd pair of twins were born.
Maternal Relatives,
Brothers and 3 Sisters, (Brother dead)
6 Children + 1 miscarriage (oldest 17 yrs)
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had injury to head - Man fell from veranda + struck his heel on her scalp. Had scalp wounded - doubtful if any more was unconscious for a time - 15 yrs ago. Had measles + scarlet fever.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, Dizziness + Confusion not very severe but real
OCCUPATION, Healthy or not, Housewife.
Detail Date, Duration, and Character of Previous Attack, if any,
2 yrs ago had miscarriage + at that time head troubled her some.
Sleep, Appetite, and Bowels, Some constipation.

Personal and Medical History of Agnes Liesen.

10/1

5148

M^rs Agnes Liesen

Copy of Order for Hearing Petition of Michael Liesen for appointment of a guardian for said Agnes Liesen — insane; served and service admitted 19th October 1900 —

(Papers filed with commitment papers.)

ACTERISTICS.

SUAL WEIGHT, 135 - 145 NUTRITION, fair.

luggish

ize normal. Response to light sluggish.

of special incoordination

TREMORS, Hands, Tongue, Facial Muscles, General, None of note.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Fairly good.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal.
ARTERIES,
Normal
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

10/7/98 EXAMINATION URINE, Quantity, Sp. g. ℥j xxx ℥j Reaction, neutral Color and Appearance, Yellow - fleaky deposit
Albumen, Trace by Heat + HNO3 # by Tanrets Sugar, —
Casts and Crystals, Amor. urates # all kinds of epith - many overlapping mucin bands + a few pus Corp.

10/18 GYNECOLOGICAL EXAMINATION, External genitals normal except laceration of perineum. Mucous Membranes surrounding urethra + vagina hypertrophied + lacerated - irregular laceration of os - lips everted - cervix offensive leucorrheal discharge - uterus retroflexed.
MENSTRUATION, irregular, at times — dysmenorrhea. Pain in epigastric + ovarian regions subject to headache. pain present about one week before, disappears + returned when flow commences
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient quite pleasant + intelligent - Slight hint of vagueness + of ideas held back - No delusions expressed. They seem to come + go prominent at times, at other times can reason them away - Suspicious of her husband + sexual ideas seem to be the usual form.

Personal and Medical History of Agnes Lieser

Whole No. 5148

Residence, St. Paul, Minn.

Date Admission, October 5th 1898.

Admitted by Dr. R. M. Phelps hour, 6th (Pm.

How Sent, Gilfillan & Co. of St. Paul Ramsey Co.

Sex, Female Age, 34 yrs.

Civil Condition, married.

Children, Six

Age Youngest Child, 15 months

Occupation, Housewife. (husband a blacksmith)

Degree Education, Common school.

Profession, Religion, Roman catholic.

Habits, Not intemperate.

~~Nativity~~ ~~Nationality~~, Minn. (Parents born in Germany)

Physicians Committing, Gustav A. Peug & C. J. Mooloway.

Correspondents, husband.

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No. of Attack,

No. of Admission, 1st

Age First Attack, 33 yrs.

Time of Leaving, 12th May 1902

Time in Hospital, 3 yrs 9 mos 7 Ds

Result, Improved: Discharged Nov 8/1902. (Cared for by relative)

EXAMINATION ON ADMISSION BY DR. R. M. Phelps Date of 10/6/98

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events,

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

DELUSIONS, Systematized, Transitory, Special Subjects,

Says got queer ideas last December. Was not well after birth of baby (July) Head troubled her at times. Top of head pained her - when she was married that place hurt her.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 7 yrs.

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father D. Drank excessively. Suicided - Not insane at times

Paternal Relatives,

Mother, D. When patient was young - died when 2nd pair of twins were born.

Maternal Relatives,

Brothers and Sisters, 3 (Brother died)

6 Children + 1 miscarriage (Catholic)

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, ~~Head Injuries, and Surgical Operations~~),

Had injury to head - Man fell from veranda + struck his heel on her scalp. Had scalp wound - doubtful if any unconscious for a time - 15 yrs ago. Had measles + scarlet fever.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Dizziness + confusion not very severe but much

OCCUPATION, Healthy or not, Housewife.

Detail Date, Duration, and Character of Previous Attack, if any,

9 yrs ago had miscarriage + at that time head troubled her some.

Sleep, Appetite, and Bowels, some constipation.

Personal and Medical History of Agnes Lieser.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 7 PRESENT WEIGHT, 128½ USUAL WEIGHT, 135 - 140 NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, fair.

TONGUE, Coatings or Promptness of Movement, Whitish coat - sluggish

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal. Response to light sluggish.

SIGHT, says poor.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Fair.

COORDINATION, ~~Arms, Legs~~, Slight hint of imp coordination, None of special incoordination ~~Gait~~

TREMORS, Hands, Tongue, Facial Muscles, General, None of note.

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, fairly good.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Normal.

ARTERIES,

Normal

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

10/21/98 EXAMINATION URINE, Quantity, Sp. g. 3/xxx ± Reaction, neutral Color and Appearance, Yellow - flaky deposit

Albumen, Trace by Heat + HNO_3 # by Tanrets Sugar, -

Casts and Crystals, Amor. cerates # all kinds of epith - many overlapping mucin bands + a few pus corp.

10/18 GYNECOLOGICAL EXAMINATION, External genitals normal except laceration of perineum. Mucous Membrane surrounding urethra + vagina hypertrophied + lacerated - irregular laceration of os - lips everted - whitish offensive leucorrheal discharge - uterus retroflexed.

MENSTRUATION, irregular at times - dysmenorrhea. pain in epigastric + ovarian regions subject to headache. pain present about one week before, dizzy + retained when flow commences

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient quite pleasant + intelligent - Slight hint of vagueness + of ideas held back. No delusions expressed. They seem to come. + to prominent at times, at other times can reason them away - Suspicious of her husband + sexual ideas seem to be the usual form.

Personal and Medical History of Agnes Lieser.

1898

This patient was brought here by J.B. Arend attended by her husband, in fair physical condition, with the following history: No history of consanguinity or heredity: First symptoms of insanity manifested in December 1897, by delusions of persecutions: Disease appears increasing: Is variable: Derangement now manifested by delusion of persecution by neighbors: Not disposed to injure others: No filthy nor destructive habits: No previous peculiarities noted: No severe diseases but sustained injury to top of head: Not confined nor restrained. Has been under care of nurse & has had complete rest: On personal examination, no further particulars noted.

Oct 5 On admission put upon Infirmary (5th Apt. Complexion dark: Hair black: eyes brown: Skin normal condition: Is clean: Behavior quiet. Has delusions) Summary Notes by Dr. Phelps. Oct 5 Received on ward. Aug 8 Imagines that her people are talking about her, in general, however, talks sensibly - is paranoiac.

Nov 30 Trans. to B3. Is agreable & talks fairly well: Delusions not prominent.

Jan 30/99 Still on good ward: Delusions somewhat more prominent of late.

Mch 1 - Sept 1899. By Dr Bliss General health good. Appetite fair: bowels regular: sleeps well. Takes outdoor exercise. Mch 31. Threatened to elope: Takes gym. treatments: Cries a great deal. Has many delusions (persecutory in nature) which seem to trouble her. Appears very melancholy & worries because people are talking about her. Mch 31 Transferred to B3. Occasionally refuses to eat. Quarrels with Mrs. McGrath & thinks she appropriates clothing & money sent to her. May 10 Is more agreeable, assists some with work & does not express her delusions so freely. July 3 & 4 Visited by husband: Aug. 25 Trans. to A2. Is becoming more quiet: Is neat in habits: Assists with work on ward & is not quite so irritable. Sept 1. Feb 28 1900. (Dr Heywadel) Neat: Appetite good: Takes out door exercise: expresses delusions: Thinks people are talking about her: Does some work: Jan 17 Wt. 136#. Note by physician Nov 30 '99 Patient complained that she did not menstruate regularly: said she had been regular recently but that previous to that had only menstruated a few times in several years. Nurse has made no record but says she thinks she has been regular since on A2. Mch 1 - Nov 30, 1900 Neat: Very irritable at times & disagreeable: Scolds a great deal: Occasionally takes food from others: Is very suspicious: Appetite good: Sleeps well: Says she is not insane but expresses many delusions about attentions of men: Apr 21 Leaves out of windows Trans. to B3. June 18 Trans. to A2. July 7 Vaccinated Aug 29 Becoming very disagreeable & abusive in language. Trans. to B2. Finds she is kept here for wrong doing of other patients. Dec 1 - Feb 28 1901 General health fairly good: Takes out door exercise: Expresses delusions of persecution Assists with work. Feb 28 Wt 107#

Mar. to June General health good, takes out door exercise, attends amusements, talks in very disagreeable manner, expresses delusions of persecution, assists with ward work and also does some fancy

Personal and Medical History of Agnes Lieser

Mar. to June 1901 work, at times objects to doing anything at all, May 30 Wt. 131#.

June to Sept. No change in mental or physical condition, Aug. 27 Wt. 126#. Sept. to Dec.

Sept. 27 Patient became very much disturbed and noisy, used vulgar language and was taken to D.I. West for the day. Oct. 8 patient became suddenly ill with pain in abdomen and sides, condition only temporary, remained in bed couple of days, Nov. 22 Wt. 128#.

Dec. to Mar. Dec 27. menstruating: Feb. 28 Wt. 127#: general health good: assists with the ward and fancy work: May 27 visited by husband is unoccupied: shows no change either mentally or physically.

May 12 went home.

Personal and Medical History of Minnie Newman.

Whole No. 5149
Residence, Blue Earth City, Minn.
Date Admission, October 6th 1898.
Admitted by Dr. C. B. Eby hour, 7.40
How Sent, S. F. Winship Asst. Faribault Co.
Sex, Female Age, 56 yrs.
Civil Condition, married.
Children, 2
Age Youngest Child, 15 years.
Occupation, Housewife (Husband Farmer)
Degree Education, Common school.
Profession, Religion, German Evangelical.
Habits, Not intemperate.
Nationality, Germany. (Parents also born there)
Physicians Committing, F. N. Hunt & J. E. Cooper.
Correspondents, Lewis Newman Blue Earth City Minn.

No. of Years, 42
Insane Relatives, None
Cause Exciting, Child birth.
Cause Predisposing, —
Form, Melancholia (with mild agitation)
Accompanying Bodily Disorder, Uterine prolapsus of uterus
Suicidal or not, Yes.
Date of this Attack, 12 yrs. ago.
Duration, 12 yrs.
No. of Attack, 1st continuous
No. of Admission, 1st
Age First Attack, 44 yrs.
Time of Leaving, Feb. 28. 1899
Time in Hospital, 4 m. 22 d.
Result, Died Exhaustion in Acute Melancholia.

EXAMINATION ON ADMISSION BY DR. F. N. Phelps. Date of 10/8.

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,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Very depressed - mildly agitated

DELUSIONS, Systematized, Transitory, Special Subjects,
Full of delusions of depression -

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, (2 mos. quite bad - Previously for 16 yrs. has been ailing

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption), Can't get any full information.

Father, Dead.

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

Brothers and Sisters, Thirteen in all - oldest 18 youngest 1 yr

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of Minnie Newman

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft. 11 PRESENT WEIGHT, 83 lbs. USUAL WEIGHT, NUTRITION, Very poor.

WOUNDS, Abnormalities and condition of Skin, Skin somewhat dry - low

TONGUE, Coatings or Promptness of Movement, Fairly good condition

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Slightly dilated

SIGHT, Says poor.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING,

COORDINATION, Arms, Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Nervous & agitated - no marked tremors -

PATELLAR REFLEX, Normal. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal to a rather superficial examination as she was agitated

ARTERIES,
Slight atheroma.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Seems normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binaurucular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

10/7/98 EXAMINATION URINE, Quantity, 3 XLV Sp. g. 1016 Reaction, Alkaline Color and Appearance, Pale yellow. Cloud. Mucus flecks, deposit.

Albumen, None Sugar, None.

Casts and Crystals, Amor. urates. * Triple phosphates & a few pus corp.

GYNECOLOGICAL EXAMINATION, External genitals normal. Extensive laceration - laceration of cervix also hyperaemia. Uterus atrophied

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Weakly - depressed Physically rather slight.

Personal and Medical History of Minnie Newman.

1898.

This patient was brought here by Sheriff Sandy McDonald, attended by husband, in fair physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in parents nor self: First symptoms of attack manifested twelve years ago by walking about most of time both night & day talking to herself: Disease appears increasing: Is variable: Derangement now manifested by talking about her troubles & walking aimlessly about, talks of committing suicide: No disposition to injure anyone else: Has attempted suicide by drowning: No filthy nor destructive habits: No previous peculiarities manifested: No severe diseases nor injuries to head sustained: No confinement nor restraint employed: No particular treatment pursued. On personal examination has had a severe prolapsus of uterus for several years.

Oct 6 On admission put upon Infirmary (Sth. Ct.) Complexion dark: hair black: eyes brown: skin normal condition: No marks, scars nor bruises noted: Is dirty: Behavior maniacal: Has delusions)

Summary Notes by Dr. Phelps. Oct 6 Received on ward: Very emaciated: Awake & moaning most of night. Oct 12 Patient has been fairly quiet & temperature about normal. General condition fair. No prominent symptoms: Is easily excited, complaining & melancholy. Oct 19 Has talked about committing a murder & has been very agitated & depressed. Oct 26 Patient for the last week has had a fairly normal temperature: no other prominent physical symptoms: looks pale & rather weak: does not, however, seem to be failing. Nov 2 Appetite very poor: general condition not favorable. Is profoundly melancholy. Nov. 24 Patient restless & excited: In a state of agitated melancholia: Has occasionally a slight rise of temperature.

Dec. 8 Is at present being fed by tube. Is still rather restless & extremely melancholy. Jan 5 At times very restless but is somewhat more quiet. Also at times she moans & is rather noisy. Feb 15 Seems quite weak: Has been failing very much. Feb 19 Now has diarrhoea: is growing weaker. Feb 21 Patient died at 2:30 AM. Had not only diarrhoea but one or two haemorrhages, which in her weakened condition were very exhausting.

Died

Personal and Medical History of

Personal and Medical History of Mary Lynch #✓

Whole No. 5153

Residence, Winona Co., Minn.

Date Admission, October 12th 1898.

Admitted by Dr. R. M. Phelps hour, 10 a.m.

How Sent, H.L. Buck J. of P. Winona Co.

Sex, Female Age, 94.

Civil Condition, Widowed.

Children, 4

Age Youngest Child, 45 yrs.

Occupation, Farming (?) housewife.

Degree Education, None.

Profession, Religion, Catholic.

Habits, Not intemperate.

~~Nativity~~ Nationality, Ireland. (Parent also born there.)

Physicians Committing, ~~H.P.~~ Mc Geughey & B McGaughey.

Correspondents, Thos Lynch, Utica (2 mi. east.)

No. of Years, 46

Insane Relatives, None

Cause Exciting, Age & arterial degeneration.

Cause Predisposing,

Form, Senile Dementia (with occasional excitement

Accompanying Bodily Disorder, Senile Trembling.

Suicidal or not, Threatened.

Date of this Attack, About 2 mos ago.

Duration, 2 mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 94 yrs.

Time of Leaving, Oct. 22. 1898

Time in Hospital, 10 d.

Result, Discharged Feb. 6. 1899 Unimproved.

EXAMINATION ON ADMISSION BY DR. ..... Date of .....

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quick - Confused.

MEMORY, Past Events, Impaired -

Recent Events, " Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Alert - Illusive -

REASONING POWER, Ordinary Subjects, Impaired.

Special Subjects, "

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Very restless - & in constant fear -

DELUSIONS, Systematized, Transitory, Special Subjects,

Fears that she will be hung - or otherwise harmed -

HALLUCINATIONS, Cannot determine -

ILLUSIONS, " "

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Brief

ONSET, Gradual or Sudden, Gradual & incoherent talk & wandering for days.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother, Cannot determine

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Is too disturbed to secure any information from her.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

First attack.

Sleep, Appetite, and Bowels, Appe. fair. Sleep often disturbed.

Personal and Medical History of Mary Lynch #✓

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1 in. PRESENT WEIGHT, not Taken USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Hands bruised. Skin warm, dry & flabby.

TONGUE, Coatings or Promptness of Movement, ?

PUPILS, Equality, Size, Response to Light, and Accommodation, ?

SIGHT, Fair -

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Arcus Senilis -

HEARING, Fair -

COORDINATION, Arms, Fair Legs, Fair. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Too restless to test.

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

10/15 GYNECOLOGICAL EXAMINATION, External genitals normal except laceration of perineum. Laceration of cervix. Uterus atrophied - retroflexed - adherent to left -

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Seems to be in constant fear of impending danger & whenever anyone enters room attacks them as tho' in self defense. At times talks incessantly - again may be quiet for hours - Mental cond. is prob. due to senile changes in arterial system.

Personal and Medical History of Mary Lynch.

1898

This patient was brought here by Sheriff: A.W. Fehrmann attended by son Thos. Lynch, in fair physical condition, with the following history:- No consanguinity heredity nor intemberance in parents nor self noted: First symptoms of disease manifested two weeks ago by incoherent talk + by wandering away. Disease appears increasing: Is variable: Derangement now manifested by idea that son is going to hang her. Tries to get away from home + wanders about: Is disposed to injure others: No filthy nor destructive habits: No information concerning previous peculiarities: No severe diseases nor injuries to head: Has been kept at home for last three days: Has received no treatment: On personal examination shows senile trembling talks of fear of being hung: Considerable excitement.

Oct 12 On admission put upon Infirmary Gen. Rpt. Complexion dark: Hair gray: eyes gray: Skin hot + dry: Hands tremid: Is very dirty: 2 small nodules on left side of chest at juncture of ribs with sternum: Behavior quiet: Talks of being abused by relations/

Summary Notes by Dr Phelps. Oct 12 Received on ward. Is rather destructive: Thinks she is going to be hung. Is noisy Oct 18 Patient visited by son: has been rather noisy + restless. Oct 22 Visited by daughter + taken home as they expressed a wish to try to care for her.

Discharged.

Personal and Medical History of

Personal and Medical History of Edith Shank.

1898

Whole No. 5158

Residence, Morristown Rice Co. Minn.

Date Admission, October 20th 1898.

Admitted by Dr. A. F. Kilbourne hour, 3 P.M.

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

Sex, Female Age, 24 yrs.

Civil Condition, Married (husband a hackman)

Children, None

Age Youngest Child, —

Occupation, Housewife

Degree Education, Common school.

Profession, Religion, Congregationalist

Habits, Not Intemperate

~~Nationality~~ Nativity, Wis - (Parents also born there)

Physicians Committing, J. Sargent + J.S. Seeley

Correspondents,

No. of Years, 51

Insane Relatives, Maternal uncle.

Cause Exciting, Unknown

Cause Predisposing, Previous attacks - + possibly, Heredity

Form, Melancholia (acute)

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Not.

Date of this Attack, 2 mos ago

Duration, About 2 wks.

No. of Attack, Rev.

No. of Admission, 1st

Age First Attack, 1-2 yrs

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. R.A. Bebb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quick - Confused.

MEMORY, Past Events, Cannot determine as she refuses

Recent Events, to talk. Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Alert - illusive.

REASONING POWER, Ordinary Subjects, Probably impaired

Special Subjects, "

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

Cannot determine. expresses none but probably has some.

HALLUCINATIONS, ?

ILLUSIONS, ?

Melancholia usually very irritable if disturbed - The gross signs above being lacking, specify concerning Power Refuses to speak - except occasionally to say a few words.

of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness,

Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Two weeks.

ONSET, Gradual or Sudden, Gradual. Over a years ago first, for about two weeks - a number of attacks since.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Hereditary insanity.

Father, Living

Paternal Relatives,

Mother, ?

Maternal Relatives, Mother's brother insane

Brothers and Sisters,

Children - none.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,

See above.

Sleep, Appetite, and Bowels, quite good.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 9 in PRESENT WEIGHT, 141½ lbs. USUAL WEIGHT, NUTRITION, Quite good.

WOUNDS, Abnormalities and condition of Skin, Small scar above right eye. Skin in normal condition

TONGUE, Coatings or Promptness of Movement,

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal.

SIGHT, Good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Apparently no trouble.

HEARING, Good.

COORDINATION, Arms, Good Legs, good. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None

PATELLAR REFLEX, Other Reflexes, Exaggerated.

ARTICULATION, Slurred, Hesitating, Slow, Distinct - prompt.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, No Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Normal - regular.

ARTERIES,

normal.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical

Expansion good.

B. Sounds normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

10/10/98 EXAMINATION URINE, Quantity, 3½ V½ Sp. g. 1014 Reaction, neutral Color and Appearance, Yellow - clear - heavy white flaky deposit.

Albumen, None Sugar, None.

Casts and Crystals, # Amor. urates - # mucin bands, a few epith. cells + pus corp.

11/ GYNECOLOGICAL EXAMINATION, Hymen intact. External genitals hyperaemic otherwise normal Uterus retroflexed - leucorrhea, whitish - tenacious.

MENSTRUATION, no history of.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, good

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Extremely sarcastic + disdainful in manner + carriage. Sometimes cries + is much depressed. Very untidy in habits. Is stubborn + disagreeable in manner. inclined to listen - + seem reticent at times. Father says that at onset she began to neglect home duties + herself. + was greatly worried + troubled over family affairs. Has a suspicious distrustful expression when addressed. at other times is apt to sit mute + motionless.

Personal and Medical History of Edith Shank.

1894

This patient was brought here by Sheriff Moshier attended by Mrs Shank and Fred Lockenberg, in poor physical condition, with the following history:- First attack occurred about a year ago (Summer of '93) & lasted about two weeks. Since then has had a number of attacks: First symptoms of present attack manifested about two weeks ago, refused to recognize her friends & behaved in every way the reverse of her ordinary behavior - refusing to eat dress, go to bed etc. Disease appears increasing: Is variable, but no rational intervals: Derangement manifested on almost every subject: Not disposed to injure others: Habits filthy & destructive No history of consanguinity, one brother of her mother is insane: No intemperance in parents nor in patient: Previous peculiarities - very religious & very eccentric about every undertaking: No severe diseases nor injuries to head: No confinement nor restraint employed: Would accept no treatment. On personal examination no further particulars noted. On admission put upon Infirmary Ward Best

Oct 20 (Gen'l Rep. Complexion dark: hair black: eyes brown: Skin normal condition: Small scar above right eye: Is rather dirty: Behavior quiet: will not talk.)

Summary Notes by Dr. Phelps. Oct 20 Received on ward. Rather quiet: Is rather stubborn. Oct 26 Patient still very stubborn & says very little: has had a slight rise of temperature. Is inclined to resist. Nov 2 Rather untidy Is stubborn & disagreable in manner.

Mch. to August 1899. General health good: Appetite good: Bowels usually constipated: given laxatives regularly: Is untidy in habits & careless in appearance. Quite violent & destructive at times. Trans. to 6'. Takes outdoor exercise: Remains inactive. July 22 Visited by father. Sept 1 - Feb 28 1900 (Dr Heyndale) Very untidy: Seldom talks: appetite good: Sleeps well: Menstruates regularly: Bowels somewhat constipated: Feb 7 - Mch 1 - In bed with attack of pleurisy in left side: Not very sick at any time: Took medicine well: Highest temp, about 100. Feb 28 Irritable & violent at times: Still confined to bed. Mch 1 - Nov 30 1900 very irritable Indifferent to surroundings & appearance: Appetite good: Bowels constipated: Sleeps well: Trans. to 6'' May 1 - Does a little work in dining room May 22 Takes outdoor exercise: answers questions occasionally

June 10 Attacked nurses: attempted to escape While on lawn: July 6 Vaccinated. Oct 20 Taken sick & put to bed: Menstruating: Complained of sore throat. Temp. 100.8 on 29th Temp. still up. trans. to Infirmary & there until Dec 9th Highest temp. 104.6 - Pulse 115 Resp 26. On milk diet & eggnogs. Cathartics & stimulants given: Developed pleurisy of left side that gradually absorbed ~~without~~ by use of adhesive strips. did not require paracentesis: Slept fairly well: untidy &

Personal and Medical History of

disagreeable. Left Inf. Dec 9. Bowels regular: appetite fair: Refused medicine. Trans. to 6'. Much more agreeable after leaving Infirmary & improved mentally. Habits cleanly Trans. to B 3 but remained there only 2 weeks, when she became disturbed & was trans. to 6 3 & later to 6'. Wt March 160 lbs.

March - June 1901 Does no work. No change in mental or physical condition. May 31 Wt. 166 #. June to Sept. June 19. July 17 Aug. 7 menstruated, Aug. 15 visited by lady friends, at times destructive and violent, does no work, takes out door exercise Sept. 1 Wt 165 lbs.

Sept. to Dec. No change during quarter, Nov. 30 Wt. 158½ #.

1/2 to Feb. 1, 1903 General health good: bowels good: sleeps well: attends no amusements: does no work: exercises: does not converse: as a rule does not answer questions: at times untidy and generally careless. Dec. 1st. Wt. 146 #.

Personal and Medical History of Hulda Hartung.

Whole No. 5161
Residence, Stillwater, Minn.
Date Admission, October 22nd 1898
Admitted by Dr. Bobs. Eby hour, 6:30 P.M.
How Sent, F. J. Wilson Dep. Sh. Washington Co.
Sex, Female Age, 28 yrs.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, None (Father a butcher)
Degree Education, Common school.
Profession, Religion, Not a church member.
Habits, Not intemperate.
~~Nativity~~ Nationality, Illinois (Germany, nativity of Parents.)
Physicians Committing, W. D. Pratt + B. J. Merrill.
Correspondents,

No. of Years, 54.
Insane Relatives, None.
Cause Exciting, Unknown
Cause Predisposing,
Form, Subacute (Dec. Dem.)
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, 3½ yrs ago
Duration, 3½ yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 25 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Bobs. Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Sluggish - Confused.
MEMORY, Past Events, Poor
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull.
REASONING POWER, Ordinary Subjects, Poor
Special Subjects,
Own Mental State, Demented
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent.

DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any.
So slow, dull, silly, some loss of will power
HALLUCINATIONS, Probably none.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 3½ yrs before admission
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Cannot obtain history from patient.
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
?
HABITS, Drinking and Smoking, ?
HEADACHES, VERTIGO, OR CONVULSIONS, ?
OCCUPATION, Healthy or not, ?
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2½ PRESENT WEIGHT, 117 USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin,
TONGUE, Coatings or Promptness of Movement, Clear.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - slightly dilated
SIGHT, apparently good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Right eye turned outward.
HEARING, apparently good
COORDINATION, Arms, will not test well Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, none
PATELLAR REFLEX, diminished Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Seldom speaks - articulation indistinct.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, diminished
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal.
ARTERIES,
Normal.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion good
B. sounds normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

11/23/98 EXAMINATION URINE, Quantity, Sp. g. 1004 Reaction, neutral Color and Appearance, Pale yellow - clear.
Albumen, none Sugar, none.
Casts and Crystals, Amor. urates. a few epith. cells + uric acid crystals.

11/18/98 GYNECOLOGICAL EXAMINATION, Labiae hypertrophied. hymen intact - very close + firm.

MENSTRUATION, Could secure no history
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, good.
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Conversation thoroughly unreliable. Seldom tries to speak - usually mutters. Appearance of an imbecile. Gen. health very good.

Personal and Medical History of Hulda Hartung

1898

This patient was brought here by Sheriffs deputy Oscar Anderson, attended by Mrs. Hartung, in fair physical condition, with the following history:- First symptoms of insanity manifested 3½ years ago, by delusions: Disease appears increasing: Not variable: Derangement now manifested by dementia: Not disposed to injure anyone: ~~Neither~~ filthy and destructive in Habits: No previous peculiarities manifested: No injuries to head nor severe diseases: Has never been confined nor restrained:
General treatment received:
On personal examination seems demented.
Oct 22. On admission put upon Infirmary (2/4th Apt. Complexion dark: Hair & eyes brown: Skin in normal condition: No marks, scars or bruises noted: Is clean: Right eye slightly crossed: Behavior quiet: Talks incoherently.)
Summary Notes by Dr. Phelps. Is quite dull & quiet. Oct 28 Has been dull & quiet ever since coming. Feeble Seems rather developmental in character: Is feeble-minded & obstinate in all behavior. Nov 28 Patient exercises some but usually sits about ward in a dull demented way. Is continually complaining. Mch 1 to Aug 31 99 General health & physical condition good. Appetite good. Sleeps well. Bowels quite regular: Is untidy in Habits: Menstruation regular. Destructive to clothing. Practices self abuse: Is silly in manner. April 5 Threw dishes. May 15 Talks. to B:
Sept 1- Feb 28 1900. (Dr. Heyerdale) Dirty: Eats & sleeps well. Very quiet in behavior: Occasionally strikes others: Seldom speaks: General health good: Menstruates regularly: Jan 1 Wt. 150 #. Mch 1- Nov 30 1900 (Dr Newton) Untidy & careless: Very destructive: Does not converse: Often laughs: Is aggressive: Is fed on tray: Eats & sleeps well: Bowels regular: Takes daily outdoor exercise: menstruates regularly: July 16. Vaccinated. Is very abusive, kept in restraint almost constantly to correct habits also to keep her from striking other patients: Is destructive: Does not converse: In restraint jacket at day. Nov 16 Wt. 146 #. Dec 1- Feb 28 1901 Appetite good: Bowels regular: Not intelligent: does not converse or answer questions: Kept in restraint jacket most of time: Not noisy & seldom resistive: Mch 1. Wt. 139 #.
Mar 1- June 1- 1901 menstruates regularly. Does no work. General condition unchanged. May 29 Wt. 137¼ #. June to Sept. Indifferent, destructive and unclean, take out door exercise, does no work. Sept. 2 Wt. 112 #.
Sept. to Dec. Nov. 23. Wt. 125 # no change mentally.
Up to Feb. 1, 1903. Appetite good: sleeps well: menstruates regularly: bowels regular - exercises: does no work: is very destructive most of the time: sometimes violent but usually quiet: untidy and careless: does not converse or answer questions: Nov. 29 Wt. 138 #.

Personal and Medical History of

Personal and Medical History of Mrs. Minnie Campbell
(Name is Minnie Allen)

Whole No. 5162

Residence, She says Ramo Mich

Date Admission, October 29th 1898.

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

How Sent, P.A. Mott Supt Pine Co.

Sex, Female Age, 35 years.

Civil Condition, married (2) (a widow)

Children, 1.

Age Youngest Child, 12 yrs.

Occupation, Housewife (

Degree Education, Good Common school.

Profession, Religion, Disciples.

Habits, Not intemperate.

~~Nativity~~, ~~Nationality~~, Canada. (Parents birthplace unknown)

Physicians Committing, Wm. Greaves & W.A. Hunt.

Correspondents,

Sheriff Edwards - East Hainsville, Alcona Co, Mich

No. of Years, 55

Insane Relatives, Unknown.

Cause Exciting, Unknown.

Cause Predisposing, —

Form, Melancholia (defective & hysterical element from.)

Accompanying Bodily Disorder, None stated.

Suicidal or not, Attempted it with Laudanum.

Date of this Attack, During month of or previous to Oct 8/98.

Duration, Unknown

No. of Attack, ?

No. of Admission, ? Has been in City Hospitals in St. Paul, Detroit, Duluth, & Stillwater.

Age First Attack, ?

Time of Leaving, Jan. 9. 1899

Time in Hospital, 2 mo. 11 d.

Result, Discharged Feb. 8. 1899 Improved

EXAMINATION ON ADMISSION BY DR. R. A. Babb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quick - slightly confused at times.

MEMORY, Past Events, Fairly good

Recent Events, Fair Special Subjects, Confused.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Alert.

REASONING POWER, Ordinary Subjects, Good

Special Subjects, Fair & very set

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Unstable - Excitable & often depressed

DELUSIONS, Not Systematized, Possibly Transitory, Special Subjects,

HALLUCINATIONS, Probably none

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

Rapid changes abruptly from one subject to another

Marked at times

often Threatens suicide

HISTORICAL.

LENGTH INVASION, Says about 6 weeks but it was

ONSET, Gradual or Sudden, probably gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Claims none.

Father, Died - typhoid fever - 27 yrs. ago.

Paternal Relatives,

Mother, Living 75 yrs. quite well.

Maternal Relatives,

5 Brothers and 4 Sisters, One sister & one brother died Diphtheria.

1 child - 13 yrs.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Typhoid at 15 - Always came back.

HABITS, Drinking and Smoking, probably good.

HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo at times.

OCCUPATION, Healthy or not, Housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,

Says had similar attack when child was very ill - years ago.

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4½ PRESENT WEIGHT, 112½ lbs. USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, Scar on neck. Skin fairly normal.

TONGUE, Coatings or Promptness of Movement, Red - clean - rather flabby.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size medium - responses good.

SIGHT, Quite good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good.

COORDINATION, Arms, Good Legs, good. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands - slight twitching of muscles & movements of head & face when she talks.

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Not slurred.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical.

Expansion fair

B. Sounds normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

11/22/98 EXAMINATION URINE, Quantity, Sp. g. 1017 Reaction, Acid Color and Appearance, Yellow - clear - white flaky deposit.

Albumen, Trace by Tannets Sugar, None.

Casts and Crystals, Amor. urates - a few fat droplets & few corpuscles. all kinds of Epith cells.

11/18/98 GYNECOLOGICAL EXAMINATION, External genitals normal, except laceration of perineum: irregular laceration & inflammation of cervix. hyperaemia of vagina: uterus adherent slightly to right. Cervical tenderness - anteflexion leukorrhea - chocolate colored discharge - ?

MENSTRUATION, Always regular. not painful except pain in back - has always had mat. backpains at times

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Says she is excitable & really may be insane at times. She menstruates. Hysterical element prominent. Is emotional, erratic, excitable, impatient & shows marked defects of will power & some mental defects. Very melancholy at times. Has suicidal impulses. Probably always of nervous temperament & unstable. Says she was really insane once when her child was very ill.

Personal and Medical History of Mrs. Minnie Campbell- (or Allen)

1898

This patient was brought here by sheriff's deputy Frank L. White attended by Mrs. F. L. White, in poor physical condition, with the following history: Patient wandered into Northfield on Oct. 26th 1898, evidently insane: + information given was incoherent + uncertain: Says no history of consanguinity: dont know as to heredity: Has been in City Hospitals in St. Paul; Detroit, Duluth and Stillwater: No satisfactory information concerning number of attacks. Derangement now manifested by brooding continually over domestic troubles: Shows no disposition to injure anyone: Attempted suicide by taking laudenum: Destroys clothing: No knowledge of previous peculiarities manifested nor of history of severe diseases upon injuries to head: Supposed cause of disease domestic troubles + high nervous organization. Nothing known as to treatment pursued. On personal examination the above facts learned. Accompanying warrant + certificate of jury was a letter from Wm. J. F. Jackson authorizing commitment.

Patient says her name is Minnie Allen.

Oct 29 On admission put upon Infirmary West. G.H.M. Rpt- Complexion fair: Hair red: Eyes brown: Skin in normal condition: Scar on right side of neck: Small bruise on left arm: Is clean: Behavior quiet: Talks intelligently.

Summary Nurses Notes Oct 29 Talks quite freely. Thinks in a vague sort of way that she ought not to have been sent here + that there is some conspiracy against her. Oct 11 Mental condition about same. Shows some feebleminded-ness, irritability + mildly hysterical behavior. Nov 30 Has been fairly cheerful + has drifted along in a quiet way. Has recently threatened suicide + been hysterical. Gives an account of herself as follows: Says she ran away from home with a man + married him: She afterwards found out that he had another wife + left him in Albany. She started for Nebraska where she had an uncle: She claims she was sick + did not know what she was doing" + was arrested four or five times on the road for her strange + insane behavior. She thinks she was only sick, not insane. Letters, however, from her relatives state that she was always nervous + peculiar at time of her menstrual periods. + her account is, in fact, not to be depended upon in any way

Dec 30 No change in patients behavior or condition. She talks of suicide at times in a hysterical way: writes letters + poetry: tells her troubles + history in a very confidential way to anyone whom she can interest. Tells fortunes + reads + plays games - but causes a good deal of trouble on ward among the patients by quarrelling with them + by stirring them up in various ways. Jan 9'99 Patient was taken to Michigan

Personal and Medical History of

to her relatives today by State agent Gates + his sister.

Discharged.

June 17- Telegram received to day from Chester, Ill. asking for address of relatives. Patient under arrest at that place.

Personal and Medical History of Lillie Louhaim

Whole No. 5166
Residence, St. Paul, Minn.
Date Admission, November 2nd 1898.
Admitted by Dr. C. B. Eby hour, 6¼ PM.
How Sent, J. Ullrich & of P. Ramsey Co.
Sex, female Age, 23 yrs.
Civil Condition, single.
Children, —
Age Youngest Child, —
Occupation, None. (Father in tobacco business)
Degree Education, Common school. Good musical education.
Profession, Religion, Not a church member.
Habits, Not intemperate.
~~Nationality~~ Native, Minn. (Parents born in Poland.)
Physicians Committing, J. Storing & C. E. Riggs
Correspondents, Father. M. Louhaim St Paul.

No. of Years, 5 9
Insane Relatives, Mother
Cause Exciting, ?
Cause Predisposing, Heredity & previous attack.
Form, Subacute Insanity (Mel.)
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, Not.
Date of this Attack, 2½ months ago.
Duration, 2½ mos.
No. of Attack, 2nd.
No. of Admission, 2nd Here (has been at Winnebago & Hudson)
Age First Attack, 20 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. R. A. Bebb *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Sluggish & confused.
MEMORY, Past Events, Good.
Recent Events, Fairly good. Special Subjects, ?
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull & illusive.
REASONING POWER, Ordinary Subjects, Fairly good
Special Subjects, Poor.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Much depressed.

Many
DELUSIONS, Systematized, Transitory, Special Subjects,
Of special nurses. Thinks there are many sinful people who punish others & she suffers in this way. Thinks electricity is used to make her sleep.
HALLUCINATIONS, Of hearing & smell.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 2½ years before admission
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Mother & father first cousins.
Paternal Relatives,
Mother, dead insane
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Asst book keeper in father's store.
Detail Date, Duration, and Character of Previous Attack, if any,
Previous attack duration 18 mos. - acute mania
Sleep, Very Appetite, Poor and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4½ in. PRESENT WEIGHT, 116½ lbs. USUAL WEIGHT, NUTRITION, Fair
WOUNDS, Abnormalities and condition of Skin, Skin cool - circulation impaired.
TONGUE, Coatings or Promptness of Movement, Yellow coating - hesitating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - responses fair.
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, do.
COORDINATION, Arms, Fair Legs, Good Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Very fine of hands. of tongue - at times of facial muscles - Frequent nervous twitchings of different groups of muscles.
PATELLAR REFLEX, Diminished Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Below normal
HEART, No Murmurs, Strength, Sounds, Size, 2 Sounds over Aortic area - weak.
Apex Beat, Regularity,
Apex Beat normal position
ARTERIES, n.
Pulse weak & irregular
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair
B. Sounds abnormal -
Percussion note normal. Vocal fremitus normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

Nov 17 EXAMINATION URINE, Quantity, Sp. g. 1012 Reaction, Neutral Color and Appearance, Yellow - Cloudy
Albumen, Trace by Tsuretz. Sugar, None.
Casts and Crystals,
Nov 8 Quantity 3 XXXIV. Sp. gr. 1030 - Uric Acid - Colorete. Reddish yellow. clear flaky deposit. Amor urates - epith. cells - few corp. uric acid crystals & mucus casts.
GYNECOLOGICAL EXAMINATION, External genitals normal. hymen intact. uterus.

MENSTRUATION, Sometimes irregular but free from pain. - see previous Exam - Vol. 30. Fol 81
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleeps poorly
BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment) Thoughts appear to be largely introspective. Partially appreciates her condition & grieves over it. Realizes that her mind is affected That she has not the ability to (in person) that she once had. and has little hope of improvement & ultimate recovery. Does not sleep or rest well at night. Thinks Dr Eby & others are in her room & may harm her. Says she sees & hears them. At times of it manner is depressed - nervous with anxious expression. Occasionally is brighter talks more - sometimes in a fully incoherent way. Stands most of time. Probably always somewhat defective mentally. Probable cause heredity - Form melancholia with some dementia.

Personal and Medical History of Lillie Cochrane.

1898

This patient was brought here by Sheriff Deputy Frank J Egan, attended by Mrs. Phankuch, in fair physical condition with the following history:- Parents were first cousins, mother insane: First symptoms of insanity manifested in January 1896 when patient was taken to Hudson Sanitarium & was afterward in this hospital from Jan. 31' 1896 to June 7' 97 for further particulars see Vol. 30 Fol 8. No. 4315.) First symptoms of present attack manifested about 2½ months ago, by delusions of special senses. Disease appears increasing: Not variable: Derangement now manifested by hallucinations of hearing & smell: persons annoying her: Not disposed to injure anyone: Neither filthy nor destructive in habits: No previous peculiarities mentioned: There is no history of intemperance in parents nor in patient, nor of any severe diseases etc nor injuries to head. Patient has been at Wauwatosa for past 3 months:

No further particulars noted upon personal examination.

Nov 2. On admission put upon Infirmary (G.H.W. Pf.) Complexion dark: hair brown: Eyes brown: Skin in normal condition: No marks, scars nor bruises noted: Is clean: Behavior quiet: Talks very little but answers questions intelligently.)

Summary Notes by Dr. Phelps Nov 2 Patient received on ward: Rather dull & quiet in behavior & rather melancholy Nov 8 Drifts along in the same quiet, dull, melancholy, rather feebleminded way: Seems to appreciate what is said & can answer questions in a dull way. Nov 9 No change in any essential respect. Does not sleep well: Is somewhat melancholy. Feb 26 No change. At times appears to be brightening up a little but on the whole has changed little or none. March - Nov. 30' 1899. General health improved: Appetite poor: Bowels constipated requiring laxatives regularly & frequent enemata. Is untidy in habits at times Laughs to herself & is quite silly: Receives massage: Occasionally takes outdoor exercise.

June 3. Seems very weak & pale - muscles & extremities cold. Temp. 98 Pulse 80. Complains of fever & pain in head again June 22 Had similar spell. Cries a great deal. Bowels very constipated: Appetite poor: Aug. 23 Trans. to Infirmary. Augs Remained in bed. Sept - Dec. 99. Is becoming very untidy in habits & careless in appearance: Is quiet & depressed indifferent to surroundings: Conversation incoherent & is inclined to be silly: Appetite poor: sleeps quite well. Nov. 26 Trans. to B 3 W.

Dec 1- Feb. 28' 1900 (Dr Keyesdale) Much disturbed: expresses many delusions: Attempts to strike other patients: Is very melancholy: Very constipated & requires frequent enemas & cathartics: Feb 27 Operated upon by Drs. J Mayo. plastic operation on illeo caecal valve to relieve constipation allowing free passage from small to large intestine: Vermiform appendage also removed. Patient passed through operation well & made an uneventful recovery upon ward May 30. There was a slight suppuration from upper part of abdominal

Personal and Medical History of

for a short time: a stitch abscess: which gradually healed. March 9 to May 18 visited by uncle: Cathartics occasionally given: Constipation much improved since operation: While in bed was irritable at times & assaulted some: behavior about same as when up: June 30 At times irritable & attacks nurses: Appearance untidy: Takes outdoor exercise: Sleeps well: given massage: July 31 Vaccinated: Aug. 31 Given regular electrical treatments. Oct. 19. Slightly constipated. Sometimes violent. Nov 24 Wt 125 lbs.

Dec 1- Feb 28' 1900 General health fairly good: appetite good: Takes outdoor exercise: Bowels somewhat constipated requiring occasional laxatives. Feb 26 Wt. 107 lbs.; March to June 1901. Mar. 29 visit by uncle, April by lady friend. General health good, bowels constipated, takes out door exercise, has many delusions, is incoherent in speech, neat in habits and appearance May 29. Wt. 112 lbs.

June to Sept. June 18 visited by uncle, no change in either mental or physical condition, Augs. 30 Wt. 116 lbs. Sept. to Dec. Nov. 7 visited by uncle, at times becomes somewhat disturbed is then very quarrelsome and violent and attacks nurses, Nov. 25 Wt. 124 lbs.

Dec to Feb 1903. No change. Wt. 124 lbs.

Personal and Medical History of Malvina LeMieux

Whole No. 5167
Residence, Rice County, Minn.
Date Admission, November 3rd 1898.
Admitted by Dr. A.T. Herzog hour, 3 P.M.
How Sent, R.R. Matt J. agt. Rice Co.
Sex, Female Age, 24 yrs.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Dressmaker (Father Farmer)
Degree Education, Common school.
Profession, Religion, Catholic -
Habits, Not intemperate.
~~Nativity~~ Nationality, Minn (Russ) (Parents born in Quebec)
Physicians Committing, R.R. Jackson & P.A. Smith.
Correspondents, Thos. LeMieux (Father) Faribault, Minn

No. of Years, 60
Insane Relatives, None.
Cause Exciting, Unknown
Cause Predisposing, Unknown.
Form, Acute Mania (adolesc.)
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, Oct. 30. 98.
Duration, 4 days.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 24 yrs.
Time of Leaving, June 6. 1899
Time in Hospital, 7 m. 3 d.
Result, Discharged Dec. 27. 1899 Improved

EXAMINATION ON ADMISSION BY DR. R. A. Bibb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Very quick but confused.
MEMORY, Past Events, Poor.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert - illusive.
REASONING POWER, Ordinary Subjects, Poor.
Special Subjects, Poor.
Own Mental State, Acute manical condition.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Usually bright & exalted. Sometimes irritable.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 4 days on admission.
ONSET, Gradual or Sudden, Sudden.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Living Can obtain no history from her
Paternal Relatives,
Mother, Living.
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Dressmaker.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 10 PRESENT WEIGHT, 95 lbs. USUAL WEIGHT, NUTRITION, Fair.
WOUNDS, Abnormalities and condition of Skin, N.
TONGUE, Coatings or Promptness of Movement, ?
PUPILS, Equality, Size, Response to Light, and Accommodation,
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good
COORDINATION, Arms, Inco disturbed in by tests Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, N.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, N Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
ARTERIES,
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

11/29/98 EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, acid Color and Appearance, Yellow - cloudy - no sediment.
Albumen, Trace by Tsuretz Sugar, None
Casts and Crystals, Amor. urates - a few epith. cells. + uric acid crystals -

12/25/99 GYNECOLOGICAL EXAMINATION, External genitals normal. Hymen intact: Uterus slightly retroverted:

MENSTRUATION, Cannot obtain history of menstruation.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment) Acute mania - cause unknown. Previous mental condition probably fairly good. Appears childish & not well developed for her age. Is usually laughing, gay, cheerful - singing etc. Very quick in movements. Liable to strike others but in a rather playful way. Very destructive. Removes clothing & disarranges hair. Is at times cross & irritable, especially if not allowed her own way. Typical case of acute mania. Violent motion of limbs & body. Talks incessantly & incoherently.

Personal and Medical History of Malvina LeBrieux.

1898

This patient was brought here by Sheriff's Deputy J.B. Thompson attended by Thomas LeBrieux, in fair physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor in parents. First symptoms of insanity manifested on Sunday, October 30'98 by destructive tendencies: Disease appears increasing, is not variable: Derangement now manifested on subject of religion: Not disposed to injure anyone: Not filthy in habits: No previous peculiarities manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued: On personal examination is in constant motion, laughs, sings, plays piano, etc. Temperature 100.

Nov 3 On admission put upon Infirmary (G.H.& H. Dpt.) Complexion dark: hair black, eyes gray: Skin in normal condition: No marks, scars nor bruises noted: Is clean: Behavior very maniacal: Remarks incoherent. Summary Notes by Dr. Phelps. Nov 3 Received on ward: Rather noisy, restless & somewhat maniacal in behavior. Nov 9 Restless noisy & maniacal. a quite typical case of acute mania. Has a slight rise of temperature at times. Nov 16 Still noisy: Has ~~not~~ been in restraint at times. Is destructive. Nov 30 Was visited by relatives on the 28th. Most of the time so far has been quite maniacal & at times difficult to manage

Dec 1 Patient very troublesome, in restraint part of time: Dec 2 Visited by Mother. Feb 28 Patient is quite noisy still but has, however, improved considerably Is now upon 6s. Mch 1 Apr 1 99. Patient's appetite good: sleeps well part of night. Habits untidy. Very noisy most of time also violent & destructive: Strikes & kicks nurses & patients: Usually kept in seclusion in morning until work is done also at meal times Apr 28 Trans to C3. Has improved: sleeps better & appetite improved: Neat in habits

1899 Apr 3 Trans. to B3. Visited by sister from Apr. 18-25. Is quiet in behavior: Converses freely. Trans to A2. Physical condition much improved. June 6'99 Has continued to improve. Allowed to go home on trial

Discharged.

Personal and Medical History of

Personal and Medical History of Alvilda Bredahl.

Whole No. 5169
Residence, St. Paul, Minn.
Date Admission, November 7' 1898
Admitted by Dr. A. F. Hilbourne hour, 6 1/2 P.M.
How Sent, Gwillick & Ofp. Ramsey Co.
Sex, Female Age, 25 yrs.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Laundress.
Degree Education, Common school.
Profession, Religion, Lutheran.
Habits, Not intemperate.
Nationality, Norway (Parents also born there)
Physicians Committing, Drs Sohlberg & Haldor Evens
Correspondents, Odin Bredahl (Brother) 871 Lawson St. St. Paul, Minn.

No. of Years, 61
Insane Relatives, Sister here - Brother at home-melancholia
Cause Exciting, Unknown.
Cause Predisposing, Heredity.
Form, Melancholia (Adolescent) acute
Accompanying Bodily Disorder, Insomnia
Suicidal or not, Attempted to jump out of window.
Date of this Attack, 3 Wks. ago.
Duration, 3 Wks.
No. of Attack, 2nd
No. of Admission, 1st
Age First Attack, 20 yrs. (5 yrs. ago in Norway 5 mos. here)
Time of Leaving, Mar. 27. 1900
Time in Hospital, 1 yr. 4 mo. 15 d.
Result, Died. Tuberculosis Pul.

EXAMINATION ON ADMISSION BY DR. R. A. Bell *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Usually confused & sluggish.
MEMORY, Past Events, Fair
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull - illusive.
REASONING POWER, Ordinary Subjects, Poor
Special Subjects, Poor
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks - brothers & mother are in radiators - She hears them. Probably has many others
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation, With delusions

HISTORICAL.

LENGTH INVASION, Says brief - 2-3 wks before admission
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Died - 2 years ago.
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says none -
HABITS, Drinking and Smoking, Drank beer & brandy some
HEADACHES, VERTIGO, OR CONVULSIONS, Says - no -
OCCUPATION, Healthy or not, Working in laundry 2 1/2 yrs.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Poor Appetite, Good and Bowels, Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in PRESENT WEIGHT, 120 1/2 lbs. USUAL WEIGHT, NUTRITION, Poor.
WOUNDS, Abnormalities and condition of Skin, Skin fairly good condition
TONGUE, Coatings or Promptness of Movement, Clean.
PUPILS, Equality, Size, Response to Light, and Accommodation, equal. response to accom. slow. to light v.
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, Fair Legs, Fair Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Hands fairly steady - Slight tremor of tongue
PATELLAR REFLEX, Exaggerated on right side. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Hesitating & somewhat slurred.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, Size, Nor. Mark
Apex Beat, Mark Regularity, regular.

ARTERIES,
Radial mak. fairly regular - 70.

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical.
Expansion limited
B. Sounds shallow Resp. 22

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

11/29/98 EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, acid Color and Appearance, Reddish yellow clear White flaky deposit
Albumen, Trace Sugar, none.
Casts and Crystals, Amor. & sodium urates - mucin bands a few pus corpuscles - & all kinds epith cells. & uric acid crystals.
11/14 GYNECOLOGICAL EXAMINATION, Hymen intact. adhesions across lower part of vagina - uterus adherent far to left side - external genitals normal.
MENSTRUATION, irregular. Says ceased for 8 mos. when 16-19 yrs. was working very hard & sick at the time - Excessive
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleepless - restless & noisy at night
BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Memory fairly good - Form of insanity - Melancholia agitans. Attempted suicide in different ways - A few weeks after admission became far more demented. extremely untidy & attempted to injure herself in various ways. After leaving against radiator - burning herself on one occasion quite badly. Obliged to use restraint part of time.

Personal and Medical History of Alvilda Bredahl.

1899

This patient was brought here by Sheriffs deputy Frank J. Egan attended by Odin Bredahl with the following history: No history of consanguinity: One sister (Nettie Bredahl) here, one brother at home, has melancholia: First attack occurred five years ago in Norway, lasted about five months: First symptoms of present attack manifested three weeks ago by insomnia, kept by herself: Laughs to herself: Disease appears increasing: Is variable with irregular rational intervals: Derangement now manifested by restlessness, sleplessness, incoherence. Gets on her knees & prays: Not disposed to injure anyone: Has attempted suicide by jumping out of window, propensity active: Is destructive: Previous peculiarity, was very nervous: No history of intemperance in parents nor in patient: No severe diseases or nor injuries to head: Has been confined at home: No treatment pursued: On personal examination is restless, incoherent, prays, picks at her nose - On admission put upon Infirmary (6th Ward Rpt. Complexion dark: hair brown: eyes gray: Bruises on left arm & back: Is clean: Behavior maniacal Talks incoherently.)

Nov 7/99

Summary Notes by Dr. Phelps Nov 7 Received upon ward: Rather restless & agitated & somewhat noisy. Nov 13 Has been in restraint. Some on account of her melancholy condition & suicidal tendencies. Temp. has been recorded as high as 100.6°. Is, however, at present, about normal. Nov 21 Patient still restless & agitated rather incoherent in talk & will not lie still in bed, or rest well. Dec 15 Patient struggling more than usual in behavior. Will undress herself & tries to choke herself. Seems to have active suicidal tendencies. At times tries to burn herself.

1899

Feb 21 Seems quieter now, but still unreliable in behavior. Does not have to be held but has to be continually watched. (Cont. by Dr. A. K. Bell.) Mar 13. Patient very untidy: appetite generally good, bowels constipated Mar. 16 Does not appear as well: circulation poor: pulse weak: limbs cold. Mar 18 Temp. 95.6° 98° P. 56-76

Mar 20 Temp. 102. In restraint to keep in bed. Sleeps well. Mar 27 Emesis: Mar 30 Appetite impaired: refused food. Fed mechanically for about five days:

Apr. 13 Appetite improved: circulation poor: Pulse short & weak: Apr. 2 Has been fed mechanically again: very untidy: Apr. 16 Got out of bed: cut her hand. Is very pale: eyes swollen: Stimulants & laxatives given: Apr. 29-30- Lavage of stomach: contents very green: complained of pain in abdomen: urine: Temp. & Resp. more normal: May 16: Fed mechanically since last note: Has been up & dressed part of day: taken out of doors: June 1 continues untidy & destructive: Fed much. much of time: June 8: Put piece of wire in upper right arm: wire removed & wound dressed.

June 12 Put wire in lower left arm: removed & wound dressed. Aug 99 Notes: appetite good: takes outdoor exercise: Nov 28 Put to bed because weak: complained of head ache & coughed: appetite fair: bowels constipated:

Personal and Medical History of

1899

Usually answers questions, otherwise seldom speaks: quiet and depressed worries a great deal: cries quite often: appears lonely & appreciates attention Very conscientious & kind hearted: often speaks of her relatives & is quite fond of them: Has many delusions which she expresses quite freely at times. Dec 1- Feb 28 1900 Is depressed & irritable: occasionally noisy: Conversation incoherent: Is untidy: Kept in bed: Coughs some: Bowels moved by cathartics: Sleeps quite well: Gradually failing with tuberculosis pulmonalis. Mch 1- 20. Depressed at times: noisy & cried a good deal: Failed gradually: appetite poor: Bowels regular: slept poorly Mch 21. Died at 6 P.M.

Died.

Personal and Medical History of Emma J. Stenehjem.

Whole No. 5170
Residence, Houston Co. Minn.
Date Admission, Nov. 8' 1898.
Admitted by C. B. Eby hour, 4.45 PM.
How Sent, Thos. Ryan J. of P. Houston Co.
Sex, male Age, 21 yrs.
Civil Condition, Single
Children, none.
Age Youngest Child, —
Occupation, Housekeeper (Father farmer)
Degree Education, Good -
Profession, Religion, Lutheran
Habits, Not intemperate.
~~Nationality~~ Native, Norway (Parents born in Norway)
Physicians Committing, T. Jenson & J. Stabo.
Correspondents, Ole Stenehjem, Black Hammer, Minn.

No. of Years, 62
Insane Relatives, Two paternal aunts & one uncle.
Cause Exciting, Love affair.
Cause Predisposing, Heredity
Form, sub-acute mania
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, One month ago.
Duration, One month.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 21 yrs.
Time of Leaving, Jan. 16'99
Time in Hospital, 2 m. 8 da.
Result, Discharged July 16'99 Recovered.

EXAMINATION ON ADMISSION BY DR. ..... *Date of* .....

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick - Confused.
MEMORY, Past Events, Impaired.
Recent Events, " Special Subjects, Fair.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert - illusive.
REASONING POWER, Ordinary Subjects, Imp -
Special Subjects, "
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Mildly exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Talks about having been a bride - how she was dressed &c.
HALLUCINATIONS, Can determine none.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives, Too disturbed to obtain history
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
?
HABITS, Drinking and Smoking, ?
HEADACHES, VERTIGO, OR CONVULSIONS, ?
OCCUPATION, Healthy or not, Housework.
Detail Date, Duration, and Character of Previous Attack, if any,
First attack.
Sleep, Appetite, and Bowels, Disturbed

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. 5½ PRESENT WEIGHT, 97 lbs. USUAL WEIGHT, NUTRITION, Not good.
WOUNDS, Abnormalities and condition of Skin, Bruises on arms & legs - eruption on face & body
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation,
SIGHT, Quite good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Quite good
COORDINATION, Arms, fair Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, General nervousness.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Slow - unusually distinct.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
ARTERIES,
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

11/16/98 EXAMINATION URINE, Quantity, ℥ xxxv ¼ Sp. g. 1039 Reaction, acid Color and Appearance, Reddish-yellow. White flaky deposit
Albumen, Trace by Heat & Nitric Acid Test Sugar, None.
Casts and Crystals, Amor. urates - a few pus corp. Several epith. cells, a few oxalate of lime crystals granular casts.
GYNECOLOGICAL EXAMINATION,
MENSTRUATION, irregular - often every 3 wks. has much pain in back & limbs previous to menstruation.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Extremely noisy & mildly maniacal. Talks a great deal in a high pitched peculiar tone. Remarks incoherent & expresses delusions. Physical condition not good, not fully developed - very slender. Excess of albumen in urine. Has timid embarassed manner, is very easily excited.

Personal and Medical History of Emma J. Stenehjem.

1898.

This patient was brought here by Sheriffs deputy A.O. Stenehjem attended by Lars N. Johnsrud & Miss Jane Suldahl, in fair physical condition, with the following history: No history of consanguinity. Has aunts & one uncle insane. First attack. first symptoms manifested one month ago, by restlessness & crying at night. Disease appears increasing. So variable. Derangement now manifested on subject of love affair. Not disposed to injure anyone. So destructive of clothing. No previous peculiarities manifested. No severe diseases nor injuries to head. No history of intemperance in patient nor in parents. Has been in confinement during past month. has been given narcotics, with little benefit. On personal examination is wild & excited.

Nov. 7 On admission put upon Infirmary (4th Rpt. Complexion dark. hair light brown. Eyes gray. Condition of skin normal. Eruption on face & body. Bruises on legs & arms. So dirty. Behavior maniacal. Talks incoherently.) Summary Notes by Dr. Phelps. Rest on ward Nov 7th Was extremely noisy & wildly maniacal. would not stay in bed. Nov 14 Very obstinate, wildly maniacal. has to be watched, at times struggles. has been in restraint somewhat.

Nov 25 somewhat improved. Has quieted down some. Gneral character of behavior, however, is about the same. Dress trans. to R3. Has become much quieter. Is still, however, slightly excitable, easily agitated & rather emotional.

Jan 16 Went home very much improved but was still easily excited. Can be put down as fairly well recovered.

Discharged.

Personal and Medical History of

Personal and Medical History of Annie Pellicchi

Whole No. 517.
Residence, Ivanco (Carmen Douglas Co.)
Date Admission, November 9th 1898
Admitted by Dr. H. H. Herzog hour, 6.45 P.M.
How Sent, G. Willich & Co. agts. Ramsey Co.
Sex, Female Age, 26 yrs.
Civil Condition, ~~married~~ (single)
Children, None
Age Youngest Child, –
Occupation, Housework
Degree Education, None.
Profession, Religion, Lutheran.
Habits, Not intemperate.
~~Nationality~~, Nativity, America (Parents born in Norway.
Physicians Committing, G. Brimsdal & A. W. Dunning
Correspondents,

No. of Years, 64
Insane Relatives, One brother.
Cause Exciting, Disappointment.
Cause Predisposing, Heredity.
Form, Melancholia (Acute) with suicidal tendencies.
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Attempted drowning herself 4 yrs. ago. Attempted to open radial artery 3 days. ago.
Date of this Attack, 4 yrs. ago.
Duration, 4 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 22 yrs.
Time of Leaving, Feb. 14. 1899
Time in Hospital, 3 mo. 5 d.
Result, Transferred to Fergus Falls. Okpm

EXAMINATION ON ADMISSION BY DR. ..... *Date of* .....

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
fairly clear - not sluggish.
MEMORY, Past Events, Quite good.
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Slightly dull. Fairly correct.
REASONING POWER, Ordinary Subjects, Fair
Special Subjects, "
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
depressed.
DELUSIONS, Systematized, Transitory, Special Subjects,
religious delusions.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Living.
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters, 1 bro. insane.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
?
HABITS, Drinking and Smoking, ?
HEADACHES, VERTIGO, OR CONVULSIONS, ?
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3½ PRESENT WEIGHT, 139 lbs. USUAL WEIGHT, NUTRITION, Anaemic.
WOUNDS, Abnormalities and condition of Skin, Scar on neck & left wrist. cut herself with knife -
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation,
SIGHT, Quite good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Quite good.
COORDINATION, Arms, fair Legs, fair. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, hesitating.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
ARTERIES,
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

11/29/98 EXAMINATION URINE, Quantity, Sp. g. 1038 Reaction, acid Color and Appearance, reddish yellow. cloudy, heavy, quick deposit.
Albumen, none Sugar, none -
Casts and Crystals, Amor. urates - a few epith cells & uric acid crystals.
11/18 GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact - uterus normal position.
MENSTRUATION, too frequent - usually every 3 wks. Sometimes pain in back - nausea before menstruation formerly subject to headaches. does not have them so often now.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Quite good.
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Probably of average mental ability previous to present attack. Condition now quite advanced since first symptoms were noticed 4 yrs. ago. At present is very quiet & depressed. just before brot to hospital cut arteries in left wrist with suicidal intent. She is very reserved & seems to prefer to be alone. rarely speaks unless addressed & then only to answer questions briefly.

Personal and Medical History of Annie Tillischie

1898

This patient was brought here by Sheriffs Deputy W. P. Standrake attended by Tina Lindgren, in fair physical condition, with the following history:-
No history of consanguinity: one brother insane: First symptoms manifested four years ago: Insane appears increasing: Is variable: Derangement now manifested by melancholia, suicidal tendencies & religious delusions: No disposition to injure anyone: No filthy nor destructive habits noted: No previous peculiarities, nor severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued. On personal examination appears very morose & depressed:

Nov 9. On admission put upon Infirmary list (Gen. Rpt. Complexion fair: hair light: eyes light blue: Skin in normal condition: Scars on neck & on left wrist from knife cut. Is rather dirty: Behavior quiet: Talks very little & only in answer to questions.)

Summary Notes by Dr. Phelps. Nov 9 Received on ward. Behavior fairly quiet put to bed: Is rather depressed & dull. Nov 15 Has been in restraint since second day: chiefly because of fear of suicidal tendencies, altho she has been quiet & has made no attempts. Nov 21 Visited by sister & father. Nov 23 Visited by father & sister. Dec 19 Became more active to day, refused to keep clothes on: Became violent & was put in restraint. Jan 3 99 Still refuses to keep clothes on: 3rd with tube: Has been violent & resistive. Feb 16 Has been quieter of late altho somewhat sullen in manner. To day transferred to Fergus Falls hospital at the request of some relatives who live near there

Transferred to Fergus Falls Hospital.

Personal and Medical History of

Personal and Medical History of Alvina Koehler.

Whole No. 5178
Residence, Winona, Minn.
Date Admission, November 17 1898.
Admitted by C. B. Eby hour, 4:20 PM.
How Sent, H.L. Buck Dep. Sh. Winona Co.
Sex, Female Age, 46 yrs.
Civil Condition, married.
Children, 6.
Age Youngest Child, -
Occupation, Housewife.
Degree Education, Good- German.
Profession, Religion, Not a church member.
Habits, Not intemperate.
~~Nationality~~ Nativity, Germany (Parents also born there)
Physicians Committing, W. J. English + L.H. Engelken
Correspondents, Carl Koehler, 711 E. Howard St, Winona, Minn.

No. of Years, 71
Insane Relatives, Father odd. Sister insane.
Cause Exciting, —
Cause Predisposing, Heredity.
Form, Melancholia (mixed with delusions of persecution)
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, 1 wk ago.
Duration, One week.
No. of Attack, 2.
No. of Admission, 1st.
Age First Attack, 45 yrs.
Time of Leaving, Dec. 12. 1898
Time in Hospital, 25 d
Result, Discharged May 3. 1899 Improved

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 11/19/98

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, fairly clear- not sluggish
MEMORY, Past Events, Quite good. Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive, not dull- incorrect.
REASONING POWER, Ordinary Subjects, fairly good. Special Subjects, Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, restless - mild depression
DELUSIONS, Systematized, Transitory, Special Subjects, Thinks she is persecuted + wants to leave home
HALLUCINATIONS, None apparent.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Dead
Paternal Relatives,
Mother, Dead.
Maternal Relatives,
3 Brothers and 1 Sisters, left in Germany
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
0
HABITS, Drinking and Smoking,
HEADACHES, (common) VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework most of time.
Detail Date, Duration, and Character of Previous Attack, if any,
Can get her to speak of none.
Sleep, (restless) Appetite, (irregular) and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4 PRESENT WEIGHT, 145 USUAL WEIGHT, NUTRITION, Fair
WOUNDS, Abnormalities and condition of Skin, Enlarged vein. Skin fairly good.
TONGUE, Coatings or Promptness of Movement, Moist, coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Size normal. Response to light.
SIGHT, Thinks about normal.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, No special note.
HEARING, Normal.
COORDINATION, Arms, Slight tremor Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Action irregular Sounds largely normal.
ARTERIES,

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION,

MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient fairly well nourished + claims no very especial disease. Think has some heart trouble. Heart palpitates + stops a good deal but go upstairs sometimes. No cause nor indeed any very good history can be obtained from her.

Personal and Medical History of Alvina Koehler.

1908

This patient was brought here by Sheriff's deputy, attended by Carl Koehler, in fair physical condition, with the following history:- No history of consanguinity ~~heredity~~, nor intemperance in patient nor in his parents. First attack occurred about one year ago, lasted three mos. First symptoms of insanity manifested about one week ago, became afraid to stay in house. Disease appears increasing, is variable, patient is better in morning. Derangement now manifested by being very restless - thinks she is persecuted. Talks incoherently. wants to leave home. Has shown disposition to injure others. Not suicidal. No filthy nor destructive habits. Father is odd, one sister insane. Patient has acted queer for a long time. No severe diseases nor injuries to head. Patient has been confined at home, no treatment pursued as she refused to take any.

On personal examination appears depressed, says she wants to leave home, is in a dazed condition.

Nov. 17 On admission put upon Infirmary (6th Ft) Complexion dark. Hair brown part gray. Eyes blue. Skin in normal condition. No marks, scars nor bruises noted. Is dirty. Varicose veins extending the entire length of legs. Behavior quiet. Answers questions intelligently.

Summary Notes by Dr. Phelps. Nov 17 Received on ward. Was very quiet & quite rational in manner. Slept well. Nov 30 Still quiet & rational in manner. Has had vague delusions at times & has at times been rather active. Dec. 1st Visited by husband & taken home. He states that she has been subject at times to the delusions of the kind described at home, & even before that had symptoms of mild mental trouble.

Discharged

Personal and Medical History of

Personal and Medical History of Elizabeth S. Amnigh.

Whole No. 5179
Residence, Rochester, Minn.
Date Admission, November 18, 1898.
Admitted by Dr. A. J. Kilbourne hour, 4 30 PM
How Sent, J. A. Leonard S. of P. Olmsted Co.
Sex, Female Age, 63 yrs.
Civil Condition, widowed.
Children, none.
Age Youngest Child, —
Occupation, nursing
Degree Education, Quite extended.
Profession, Religion, Episcopalian
Habits, Good.
Nationality, Newyork. Parents unknown.
Physicians Committing, H. W. Witherstine + C. J. Granger
Correspondents, Mrs. F. Brown, City.

No. of Years, 7
Insane Relatives, Sister.
Cause Exciting, Influenza
Cause Predisposing, ?
Form, Senile Dem. (mild depression with maniacal outbursts)
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, Two years ago.
Duration, 2 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 61 yrs.
Time of Leaving, Dec. 22. 1898
Time in Hospital, 1 m. 4 d.
Result, Discharged Feb. 8. 1899
Unimproved.

EXAMINATION ON ADMISSION BY DR. P. M. Phelps *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Very confused + sluggish.
MEMORY, Past Events, poor.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,

REASONING POWER, Ordinary Subjects, Poor.
Special Subjects, Poor
Own Mental State, Poor.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Decidedly depressed.
DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 2 yrs.
ONSET, Gradual or Sudden, Gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, No history given.
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No history
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, rather poor.
WOUNDS, Abnormalities and condition of Skin, normal. Skin about normal for age.
TONGUE, Coatings or Promptness of Movement, Very slight coating
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Size normal
SIGHT, uses glasses.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Fairly near normal.
COORDINATION, Arms, Normal. Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Rather slight of hands.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Fairly normal.
ARTERIES,
No atheroma noted - Has clear fluble pulse
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

11/vm/98 EXAMINATION URINE, Quantity, 3 XXXV Sp. g. 1035 Reaction, acid Color and Appearance, Reddish-yellow Cloudy, copy deposit
Albumen, none Sugar, trace. by Fehlings.
Casts and Crystals, Amor. + sodium urates - Triple phosphates - a few pus corp. + epith cells.

GYNECOLOGICAL EXAMINATION,

MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin, F
SLEEP, Present Amount and Character, Irregular 6 hrs. last night.
BOWELS, Present Condition, Very constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient very silly. Is physically quite weak. Is very mixy in mind. Quite silly in talk. Seems mildly senile.

Personal and Medical History of Elizabeth J. Amigh.

1898

This patient was brought here by Sheriff Stewart attended by Drs A.G. Brown (Victor) in very poor physical condition, with the following history:- No consanguinity known: One sister insane: No intemperance in patient nor parents: First symptoms manifested two years ago, became very melancholy: Disease appears increasing: Is variable, with irregular rational intervals: Derangement now manifested by irrational conversation & obscenity. Not disposed to injure anyone: No filthy nor destructive habits manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: Has received general treatment only. On personal examination is excited & talks incoherently. On admission but upon Infirmary Ward. {E.H.N.Pat

Nov 18 Complexion dark: Hair grayish brown: Eyes blue: Skin in normal condition: No marks, scars nor bruises noted: Is clean: Behavior maniacal: Is rather silly}

Summary Notes by Dr. Pebbs. Nov 18 Received on ward. Nov 22 Visited by sister. Since coming here patient has continued mildly melancholy & silly & with some dementia. Will at times answer much more sensibly than at others; ~~is boisterous~~; at times very unreliable in behavior. Dec 1 Has been visited once or twice by sister. General health seems to be fairly good. Dec 10 Visited by sister & friend: Has to be fed with tube a good deal of the time. Dec 22 Went home on trial. Very little if any improvement shown.

Discharged.

Died at home in April. 1899

Personal and Medical History of

Personal and Medical History of Adeline Gatzlaff.

Whole No. 5180

Residence, Winona. Minn.

Date Admission, November 19. 1898.

Admitted by Dr. A. F. Kilbourne hour, 10 am.

How Sent, H.L. Buck J. of P. Winona Co.

Sex, Female Age, 60

Civil Condition, married

Children, Four

Age Youngest Child, 18 years.

Occupation, Housewife (Husband a farmer.)

Degree Education, Can read & write German.

Profession, Religion, Lutheran.

Habits, Not intemperate.

Nationality, Germany (Parents also born there)

Physicians Committing, Edw. D Keyes & H. Lichtenstein.

Correspondents, Carl Gatzlaff (husband)
Lewiston, Minn.
(Telephone to H. Ness & Co. Lewiston Minn.)

No. of Years, 73

Insane Relatives, None

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form, Senile Dem. (with depression)

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, One year ago.

Duration, one year.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 59 yrs.

Time of Leaving, May 4. 1899

Time in Hospital, 5 mo 15 d.

Result, Discharged Nov. 1. 1899
Improved

EXAMINATION ON ADMISSION BY DR. R. M. Phelps & Rd. Best *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, quiet

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive, dull

REASONING POWER, Ordinary Subjects, dull

Special Subjects, failed

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, depressed

DELUSIONS, Systematized, Transitory, Special Subjects, history

No

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives, None known

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft PRESENT WEIGHT, 90 lbs. USUAL WEIGHT, NUTRITION, Quite poor.

WOUNDS, Abnormalities and condition of Skin, None. Skin pallid.

TONGUE, Coatings or Promptness of Movement, Will not show it.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Size normal.

SIGHT, ?

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Probably normal

COORDINATION, Arms, Normal. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Lack voluntary of hands

PATELLAR REFLEX, Normal Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Not very well studied - Seems Normal.

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

1/21/98 EXAMINATION URINE, Quantity, ℥ XXV 11/15 Sp. g. 1023 Reaction, acid Color and Appearance, Reddish Yellow. Brick Heavy deposit

Albumen, none Sugar, ~~sugar~~ none -

Casts and Crystals, Amor. urates & uric acid crystals & oxalate of lime - a few pus corp.

2/7/99 GYNECOLOGICAL EXAMINATION, Large amount eczema about external genitals - marked hyperaemia of vaginal orifice & labia minora & cervix - latter bleeds on touch - slight laceration of perineum & cervix - uterus retroflexed & adherent to left.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Dull - depressed & sluggish in every way. Somewhat pallid. Health seems impaired - Constipated & does not pass urine has to be catheterized.

Personal and Medical History of Adeline Gatzlaff.

1898

This patient was brought here by Sheriff Aug. Fuhrmann, attended by husband, in poor physical condition, with the following history:- No information concerning consanguinity, no heredity nor intemperance in patients nor parents. First symptoms of insanity manifested one year ago by hallucinations: Disease is stationary: Is variable with irregular rational intervals: Derangement now manifested by fears; imagines evils of various kinds on account of her sins: Also denies to run away. Not disposed to injure anyone: No filthy nor destructive habits: No previous peculiarities noted: No severe diseases except a stomach disorder- No injuries to head. Has been confined at home. Has been given only general treatment.

Nov. 19 On personal examination has a dull, demented countenance On admission put upon Infirmary. (Gen Rpt Complexion dark: hair gray: eyes gray: Skin in normal condition: No marks, scars nor bruises: Is clean: Behavior maniacal: Does not speak English)

Summary Notes by Dr. Phelps. Patient received on ward Nov 19 Very excitable, melancholy, restless. Dec 21 Seems to be in pain: Troubled with detention of urine: Is pale & seems weak- Nov 25 Patient seems to have vague physical trouble, although the retention of urine is the most prominent symptom. Dec 2 Still rather restless & excited at times, but, on the whole, however, quite quiet.

Dec 18 Kept in bed a good deal of the time of late: Is at times restless & anxious to get up. Jan 10 '99 Patient has been in bed a good deal, is, however, up today & seems to have improved considerably. Feb 28 Patient was put to bed on the 10th & has been there ever since. She seems to be suffering at times but no special symptoms can be detected. Is very dull & quiet says almost nothing. March 1- May 4 '99 By Dr Bebb. Physical condition impaired: Appetite poor. Bowels constipated requiring frequent enemata. Urine very offensive: Massage given: March 27 Visited by son & friends.

May 4. Must have our trial.

Discharged.

Personal and Medical History of

Personal and Medical History of Augusta (Louisa) Teske

Whole No. 5181

Residence, Faribault, Minn.

Date Admission, November 19th 1898

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

How Sent, R. A. Watt & J. & P. Rice Co.

Sex, Female Age, 38 yrs.

Civil Condition, married

Children, five

Age Youngest Child, 3 yrs.

Occupation, Housewife (Husband a mason)

Degree Education, Common school.

Profession, Religion, Lutheran

Habits, Not intemperate.

Nationality, Germany (Parents also born there.)

Physicians Committing, J. S. Seeley & D. McLeod.

Correspondents, Aug. Teske (Husband)
Faribault, Minn.

No. of Years, 7th

Insane Relatives, None

Cause Exciting, Unknown

Cause Predisposing,

Form, Chr. Melancholia

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, 6 yrs. ago

Duration, 6 yrs.

No. of Attack, 1st.

No. of Admission, 1st

Age First Attack, 30 yrs. (about)

Time of Leaving, Feb. 24. 1899

Time in Hospital, 3 m. 5 d.

Result, Discharged Aug. 9. 1899.

EXAMINATION ON ADMISSION BY DR. R. M. Phelps Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Seems rather dull. Quite clear & coherent this a little suspicious.

MEMORY, Past Events,

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

DELUSIONS, Systematized, Transitory, Special Subjects,
"Neighbors talk about her" only delusion discovered.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 6 yrs +

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Says no insanity
Father, living

Paternal Relatives,

Mother, living -- has had headaches.

Maternal Relatives,

3 Brothers and 5 Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says had no sickness.

HABITS, Drinking and Smoking, home made wine.

HEADACHES, COUGH, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, housework.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3 PRESENT WEIGHT, 123 lbs. USUAL WEIGHT, NUTRITION, Fair.

WOUNDS, Abnormalities and condition of Skin,

TONGUE, Coatings or Promptness of Movement, Some whitish coating

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Size normal - Response to light & accom.

SIGHT,

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING,

COORDINATION, Arms, Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

12/7/98 EXAMINATION URINE, Quantity, ℥ xl Sp. g. 1041 Reaction, alkaline Color and Appearance Yellow. heavy white flaky deposit

Albumen, Sugar,

Casts and Crystals, Amor. urates & uric acid cryptals. & oxalate of lime - a few epis. corp.

Dec/7 GYNECOLOGICAL EXAMINATION, External genitals normal except laceration of perineum - Crescentic laceration of os. Cervix hard, fibrous & corrugated - deep erosion around os which bleeds on touch. ectropion of lips - local tenderness - uterus retroposed & adherent to left.
MENSTRUATION, always regular except during one year - when 18 yrs. of age - suffers pain except when she works hard & then has dismenorrhoea & vomits. Continues for 8 days. Subject to headache.
OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Usually very good - Not very well here.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Seems paranoiac or half chronic. Is quiet, composed & normal in emotions. Firmly believes however that neighbors are against her. Is mildly dull & quiet.

Personal and Medical History of Augusta (Lewis) Ireke.

1898

This patient was brought here by Sheriffs deputy JB. Thompson, attended by husband August Ireke. in fair physical condition, with the following history: No history of consanguinity, heredity, nor intemperance in parents nor self. First symptoms manifested eight years ago - Present attack manifested about six years ago by thinking that the devil was pursuing & persecuting her Disease appears increasing: So variable with irregular, rational intervals: Derangement now manifested upon the subject of Demons. So disposed to injure others: No filthy nor destructive habits: Has always been light-tempered: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued: On personal examination shows in appearance & conversation that her mind is unbalanced.

Nov 19 On admission put upon Infirmary (Ex. N. Rpt. Complexion dark: eyes gray: hair brown. Skin in normal condition: No marks, scars nor bruises noted: So dirty: Behavior quiet: Has delusions.)

Summary Notes by Dr. Phelps. Nov 19 Put on ward: So quiet, dull, slept well.

Nov 25 Patient has done some little work; drifts along in a quiet, dull, melancholy way. In appearance her condition is a chronic one. Dec 2 Answers most questions readily: No special change. Feb 24 Went home with her husband. She had delusions that the neighbors talked about her but otherwise was quite rational & free from delusive ideas. Condition rather paranoiac.

Discharged

Personal and Medical History of

Personal and Medical History of Kate Byrnes.

Whole No. 5195

Residence, St. Paul, Minn.

Date Admission, November 16 1898.

Admitted by R. M. Phelps hour, 6.45 P.M.

How Sent, Gilfillrick & Ops. Ramsey Co.

Sex, female Age, 40 yrs.

Civil Condition, married.

Children, Two.

Age Youngest Child, Three years.

Occupation, Housewife - (Husband an Engineer)

Degree Education, Common school.

Profession, Religion, Catholic

Habits, Not intemperate.

Nationality, U.S. (Parent born in Ireland)

Physicians Committing, F. Leavitt - of Otsego.

Correspondents, Miss Celia Hunt, Magnolia, Iowa.

No. of Years, 78

Insane Relatives, Unknown. (Sister)

Cause Exciting, Domestic troubles

Cause Predisposing, —

Form, Melancholia (with delusions + mental confusion)

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, 3 yrs. ago.

Duration, 3 yrs.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 37 yrs.

Time of Leaving, July 6. 1900

Time in Hospital, 1 yr. 7 m. 19 d.

Result, Died. Abscess of Lung and Pneumonia

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 11/28/98

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Seems good.

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, Poor

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed but quiet.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, ?

ONSET, Gradual or Sudden, ?

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Dead - Kicked by horse.

Paternal Relatives,

Mother, Dead ?

Maternal Relatives,

Brothers and Sisters, 1 sister in Independence for 17 yrs. 2 children

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Lung fever as a child.

HABITS, Drinking and Smoking, No.

HEADACHES, VERTIGO, OR CONVULSIONS, Some

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,
Good.

Personal and Medical History

5195

M Kate Byrnes

Copy of Order for Hearing Petition of A W Gutridge for appointment of as guardian for Kate Byrnes insane; served and service admitted February 8 1900

(Papers filed with commitment papers.)

ACTERISTICS.

UAL WEIGHT, NUTRITION, Fair.

l. Reje normal. Response normal.

COORDINATION, Arms, normal. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Fairly steady.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Fairly normal.

ARTERIES,
Slightly harder than normal.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Normal.



CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

10/3/98 EXAMINATION URINE, Quantity, ℥XXXV ℈ Sp. g. 1020 Reaction, Neutral Color and Appearance, Yellow. clear - slight flaky deposit

Albumen, None Sugar, None.

Casts and Crystals, Amor urates - a few pus epith. cells. large amount oxalate of lime.

GYNECOLOGICAL EXAMINATION, Laceration of perineum, external genitals otherwise normal. Lateral laceration of cervix. Uterus retroflexed.

MENSTRUATION, + would menstr. again within a week. Says menstr. ceased at onset of present illness. always regular until birth of last child. since then has been very irregular. sometimes flowing profusely

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient seems rather paranoine in behavior. Hints at dimly mysterious beliefs. Also thought she was visited by an man who gave her certain instructions (after coming here). Health seems good. Always refers to her children as "the little boy + girl they call Cork + Lizzie Byrne."

Personal and Medical History of Kate Byrnes.

Whole No. 5195

Residence, St. Paul, Minn.

Date Admission, November 16 1898.

Admitted by R. M. Phelps hour, 6.45 P.M.

How Sent, Gilfillan & Ramsey Les.

Sex, female Age, 40 yrs.

Civil Condition, married.

Children, Two.

Age Youngest Child, Three years.

Occupation, Housewife - (Husband an Engineer)

Degree Education, Common school.

Profession, Religion, Catholic

Habits, Not intemperate.

Nationality, U.S. (Parent born in Ireland)

Physicians Committing, F. Leavitt & Okage.

Correspondents, Miss Celia Funk, Magnolia, Dak.

No. of Years, 78

Insane Relatives, Unknown, (S

Cause Exciting, Domestic trouble

Cause Predisposing, —

Form, Melancholia (with delusions + mental confusion)

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, 3 yrs. ago.

Duration, 3 yrs.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 37 yrs.

Time of Leaving, July 6. 1900

Time in Hospital, 1 yr. 7 m. 19 d.

Result, Died. Abscess of lung and hypaemia

EXAMINATION ON ADMISSION BY DR. R. M. Phelps Date of 11/28/98

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Seems good.

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, Poor

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed but quiet.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, ?

ONSET, Gradual or Sudden, ?

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Dead - Kicked by horse.

Paternal Relatives,

Mother, Dead ?

Maternal Relatives,

Brothers and Sisters, 1 sister in Independence for 17 yrs. 2 children

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Lung fever as a child.

HABITS, Drinking and Smoking, No.

HEADACHES, Some VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,
Good.

al and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7in. PRESENT WEIGHT, 120 lbs. USUAL WEIGHT, NUTRITION, Fair.

WOUNDS, Abnormalities and condition of Skin,

TONGUE, Coatings or Promptness of Movement, Normal.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Rep normal. Response normal.

SIGHT, Normal

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Somewhat deaf.

COORDINATION, Arms, normal. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Fairly steady.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Fairly normal.

ARTERIES,
Slightly harder than normal

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Normal.



CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

12/7/98 EXAMINATION URINE, Quantity, ℥XXXV Sp. g. 1020 Reaction, Neutral Color and Appearance, Yellow. clear - slight fleaky deposit

Albumen, None Sugar, None.

Casts and Crystals, Amor urates - a few pus epith cells. large amount oxalate of lime.

GYNECOLOGICAL EXAMINATION, Laceration of perineum, external genitals otherwise normal. Lateral laceration of cervix. Uterus retroflexed.

MENSTRUATION, + would menstr. again within a week. Says menstr. Ceased at onset of present illness. always regular until birth of last child - since then has been very irregular - sometimes flowing frequently

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient seems rather paranoiac in behavior hints at sundry mysterious beliefs. Also thought she was visited by an man who gave her certain instructions (after coming here). Health seems good. Always refers to her children as "the little boy + girl they call Cork + Lizzie Byrne."

Personal and Medical History of Kate Byrnes.

1898

This patient was brought here by Sheriffs deputy J.B. Arend, attended by J.H. Person, in fair physical condition, with the following history:- No history of consanguinity nor hereditary known: First symptoms of insanity manifested three years ago by hallucinations: Disease appears increasing: Is variable with rare rational intervals: Derangement now manifested in regard to religion, dresses & passes for a Sister of Charity: Not disposed to injure anyone: No filthy nor destructive habits: No information concerning previous peculiarities No severe diseases nor injuries to head: Has never been confined nor restrained: Has received no treatment.

Nov 26 On personal examination is irresponsible & has delusions: On admission put upon Infirmary Clin. Rpt. Complexion dark: hair black. eyes gray: Skin in normal condition: Is rather dirty: Behavior quiet. talks intelligently.

Summary Notes by Dr. Phelps. Nov. 26 Received on ward: Has quiet & slept well

27 Dec 9 worries considerably about being sent here: thinks she is not insane Still quiet & well behaved. Works on the ward. Is rather rambling in speech. Occasionally speaks of some delusion or hallucination. Nov. 27 Helps some with the work, & works well upon the ward. Is anxious to do what is right but is much confused generally as to what to do.

Mar. Sent by Dr. R.A. Bibb. Is very neat in habits & appearance: assists with work: appetite quite good: bowels regular: Apr. 27 Remained in bed: says she was "only worrying": became provoked if interfered with: May 1 Since last note T. 101 to 104½ P. 118 to 144: R. 32 to 42: On Apr. 28 face very much flushed:

Apr. Temp. 103. P. 140. R. 36. Sponge bath given: complained of pain in side after bath: became very restless: moaned at times: Apr. 30 Cotton jacket applied:

May 1-5 Temp. keeps high: first two days gradually reduced: May 4 T. 101 P. 108. R. 30: On liquid diet: receives medicine every two hours: complains of difficulty in breathing: moans, coughs & expectorates a great deal: Expectoration at first white & frothy: later rust colored: Seems to be in stupor: May 5-12: Temp. slightly reduced: pulse not to rapid: R. 24-30: Sleeps more soundly: Still coughs & expectorates: May 12 Commenced to sit up a few minutes each day: May 19 Cotton jacket removed: replaced by flannel jacket: May 26 Sat up for some time, but seemed quite exhausted:

May 27 to June 2. Alcohol baths daily: Temp. slightly higher: pulse more rapid: Sat up a little each day: was dressed for a short time: June 30 No special change: seems quite weak: still expectorates a great deal: bowels loose: remained up greater part of day: During first few weeks of her illness improved considerably mentally: gradually ceased to express her delusions: became more coherent & much more reasonable: From this

Personal and Medical History of Kate Byrnes.

time on her mental condition has been fairly good altho' she is extremely irritable & exacting at times: Is very lonely: has begged for weeks to see her children: July 99 Appetite very good: takes tonic after meals: Still complains of pain in left side: especially when she coughs: walks with aid of crutches:

Aug. Temp. a little lower: resp. more rapid: Sept. & Oct. Not strong enough to be up: Remains in bed: very weak: temp. higher afternoons: Nov 20 99 Little change physically: Has become interested in work: reads and mends: Appetite now is good: bowels regular: sleeps well: Still has moderate fever: converses readily: Is often irritable & fault finding & afterward sorry for having complained: Is very anxious and worries a great deal, over both important and unimportant matters: talks quite sensibly. During summer begged to go back to see children & seemed to be failing so rapidly that they were sent for. After their visit, in spite of her statements to the contrary, it seemed to be a comfort to her to have seen them: Frequently spoke of them & expressed satisfaction at knowing them to be well cared for: Is very sensitive & much of the time very depressed & melancholy, altho she makes an effort to occupy herself & to keep her mind from dwelling on her troubles.

Dec 1- Jan 5 1900 Jan 5 Wt. 96½ lbs. Feb 8. Quiet & rather depressed, at times irritable & fault finding: Sleeps fairly well: March - July 6 June 15 Bed constantly: very weak: talks sensibly: appetite good: bowels regular: Sleeps well: Failing gradually. July 6. Died at 10:40 P.M.

Post-mortem held.

Died.

Personal and Medical History of Rachel Stewart.

Whole No. 5197

Residence, Freeborn Co. Minn.

Date Admission, December 7th 1898

Admitted by Dr R. M. Phelps. hour. 6th P.M.

How Sent, A. Blackmer Dep. Sh. Freeborn Co.

Sex, Female Age, 54

Civil Condition, married

Children, None.

Age Youngest Child, —

Occupation, Housewife (father a farmer)

Degree Education, High school.

Profession, Religion, Not a church member.

Habits, Temperate (Father intemperate)

Nationality, Newyork, (Parents also born there.

Physicians Committing, M.E. Dodd + Hemi L. Nissany.

Correspondents, Benj Stewart Albert Lea, Minn.

Telephone. Clover Valley Creamery.

No. of Years, 85

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing,

Form, Melancholia agitans.

Accompanying Bodily Disorder, Double Hernia.

Suicidal or not, Yes. attempted with knife.

Date of this Attack, May 1898.

Duration, 7 months.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 54 yrs.

Time of Leaving, July 31. 1899

Time in Hospital, 7 mo. 24 d.

Result, Discharged Oct. 31, 1899
Recovered

EXAMINATION ON ADMISSION BY DR. R. M Phelps Date of 12/9/98.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Seems very sluggish - or is afraid to talk.

MEMORY, Past Events, Seemingly good
Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Seems dull.

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Quite extreme depression.

DELUSIONS, Systematized, Transitory, Special Subjects,
Mentioned none - would talk very little.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, ?

ONSET, Gradual or Sudden, ?

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Can't get her to say much.
Father, Dead

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

Brothers and Sisters,
No children.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had Typhoid fever "a long time ago." Left breast removed for cancer. time unknown.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Has headaches.

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,
Sleep very poor recently.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, Fairly good.

WOUNDS, Abnormalities and condition of Skin, Hernia - quite large. Skin mottled - Normal for age.

TONGUE, Coatings or Promptness of Movement, Somewhat dry + slight whitish coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Rize Normal.

SIGHT, Says she can read without glasses.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Seems fairly normal.

COORDINATION, Arms, Did not test - no Legs, signs of incoordination ~~Grasp~~, noticeable

TREMORS, Hands, Tongue, Facial Muscles, General, Normal.

PATELLAR REFLEX, Normal. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal

ARTERIES,
No impairment.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Fairly Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

12/9/98 EXAMINATION URINE, Quantity, 3j XL Sp. g. 1028 Reaction, acid Color and Appearance Yellow. Cloudy. Quite copious deposit.
Albumen, None Sugar, None.
Casts and Crystals, Amor. urates, a few uric acid crystals, fat globules, + all kinds of epith cells

12/22/99 GYNECOLOGICAL EXAMINATION, External genitals normal. Uterus adherent to left.

MENSTRUATION, Says menstruation was always regular but at times painful. Menopause past abt 7 yrs. ago

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient has been held for four days because of constant restlessness. Has been quiet since admission, however - Is simply very melancholy + depressed at present. Seems an effort for her to answer questions - Speaks of no definite delusions + gives little definite information.

Personal and Medical History of Rachel Stewart.

1898

This patient was brought here by Sheriff's deputy E.H. Ellickson + his husband, in fair physical condition, with the following history:- No history of consanguinity, heredity, nor intemperance in patient - father was intemperate. First symptoms manifested in May 1898, by peculiar ideas + fears: Disease appears increasing: Not variable: Derangement now manifested by fears of harm, loss etc. Not disposed to injure anyone: Has attempted suicide "by cutting": propensity active: No filthy nor destructive habits: Previous peculiarities are violent temper + unnecessary fear: Has tumor of breast + double hernia: Has never been confined nor restrained: Has received no treatment.

No further particulars noted on personal examination.

Dec 7 On admission put upon Infirmary (G.W.M. Supt. Complexion dark: eyes blue: hair brown part gray: Scar on left breast. (Breast removed on account of cancer) Several small bruises on legs + arms: has a hernia: Is very dirty. Behavior maniacal: Talks incoherently.)

Summary Notes by D. Phelps. Dec 7 Received on ward: Is at times restless + rather agitated: Seems a case of agitated melancholia. Dec 13 Complains of feeling sick, pain in chest: She is rather restless + troublesome altho at times becomes fairly quiet. Dec 27 Visited by husband + son. Got already to go home + had promised to go when she became excited + would not go. She does not seem to know what she wants to do. Feb 8 Visited by husband + taken home. March 1 - June. General health very good: Appetite good: Bowels regular: Neat in habits: Very much excited at times.

May 5 Visited by husband. + when he left became very greatly disturbed fought nurses. Sent by Dr R.A. Bebb. June to Aug. 99 Untidy + careless: Expresses many delusions: appetite good: sleeps well: bowels regular: Very noisy + restless at times: June 27 Visited by husband:

June 30 Drains to A: July 7 Has taken cold: complains of aching all over + coughs: Temp. 100° Pulse 100: Is very persistent in her requests to go home + continually follows physicians about ward, as is extremely troublesome, also annoys other patients by talking to them and holding them: frequently makes them angry: Is extremely hysterical in her manner + even if spoken to very kindly about her actions becomes very much excited: cries + wails + wrings her hands + claims that she is treated very unjustly:

July 31 Visited by husband + taken home on trial.

Discharged

Personal and Medical History of

Personal and Medical History of Sarah O'Neill

Whole No. 5194
Residence, Faribault, Rice Co, Minn.
Date Admission, December 12th 1898.
Admitted by Dr. P.M. Phelps hour, 6th PM.
How Sent, P.A. Nott. Supt. Rice Co, Minn.
Sex, Female Age, 25+
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Housekeeper (father a farmer)
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
Nativity, Nationality, Minn. (Parents Ireland.
Born in Rice Co.
Physicians Committing, P.M. Jackson + D.M. Cool.
Correspondents,

No. of Years, 87
Insane Relatives, None.
Cause Exciting, Uncongenial home life.
Cause Predisposing, —
Form, Adolescent (Mild mel. with maniacal outbursts)
Accompanying Bodily Disorder, Menstrual irregularity.
Suicidal or not, Not.
Date of this Attack, A year or more ago.
Duration, About a year
No. of Attack, 1st
No. of Admission, 1st here (At St. Joseph's St Paul)
Age First Attack, About 24 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. P.M. Phelps. *Date of*

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,
Special Subjects,
Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Dull. Quiet. mysterious. Wont talk freely.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden, Probably gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8. PRESENT WEIGHT, 132½ lbs. USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, None. Pale - anemic -
TONGUE, Coatings or Promptness of Movement, Very slight coating
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal size - Responds to light + accom.
SIGHT, Normal.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, has had granulated lids.
HEARING,
COORDINATION, Arms, Normal. Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None.
PATELLAR REFLEX, Normal Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal.
ARTERIES,

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

1/7/1/98 EXAMINATION URINE, Quantity, ℥ vvss ℈ Sp. g. 1006 Reaction, alkaline Color and Appearance, pale yellow - cloudy.
Albumen, Trace by Tsuretts Sugar, none
Casts and Crystals, amor. urates, a few epith. cells + a few uric acid crystals.

GYNECOLOGICAL EXAMINATION, External genitals normal; uterus adherent to left. tenderness over abdomen
MENSTRUATION, irregular at times. about 2 yrs. ago cessation ~~irregular~~ for several months. has had several treatments for pain in left ovarian region.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient quiet but peculiar - dull - unsatisfactory to talk with in every way. Health only fair - slightly anaemic.

Personal and Medical History of Sarah O'Neill.

1898

This patient was brought here by Sheriff's deputy H.B. Thompson attended by Timothy O'Neill, in fair physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor in parents. First symptoms of insanity manifested a year or more ago, became irritable & nervous with violent outbreaks of temper: Disease appears increasing: So variable with rational intervals: Derangement manifested by vulgar, profane & abusive language to parents. Thinks she would be better off if they were dead. Is disposed to injure others: So filthy & destructive in habits: No previous peculiarities manifested: No severe disease nor injuries to head: Was at St Joseph's hospital one month - received treatment from Dr Riggs - no benefit. On personal examination is pale, anaemic, pulse quick & has general appearance of poor health: Has some menstrual irregularity.

1/12/99 On admission put upon Infirmary Ward (1st N. Pat. Complexion dark: hair light brown: eyes gray: Skin in normal condition: No marks, scars nor bruises noted: So clean: Behavior quiet: Talks intelligently.

Summary Notes by Dr. Phelps. Dec 12 Received on ward. Patient has slept well: & has seemed in normal physical condition since coming: is, however rather discontented, sullen & suspicious: will not talk much Dec 13 Is grooming rather restless; has fought once or twice recently. Feb 1899 Trans. to C.

Now very obstinate & troublesome Feb. 27 Condition is continually irritable, restless, & full of delusions up to date

Mch 1 To Nov. 30 '99. By Dr. Bebb. Physical condition somewhat impaired: Appetite poor: Frequently refuses meals Bowels inclined to be constipated: Put upon tonic but dislikes to take medicine & sometimes refuses it. Receives massage: Is very irritable also inclined to be violent & at times refuses to go to bed. Struck nurse A. Sheehan bruising eye badly: & cutting it slightly. Apr 10 Complained of pain in stomach: Appetite continues poor: Sleeps quite well. Trans. to C. Cries a good deal: Reads greater part of time. July 20 Struck nurses on head. Sept 1 Is becoming better in habits & appetite is improving. Bowels regular: Sleeps well: Menstr: regular. Takes out door exercise: Talks more sensibly. Mental condition gradually improving. Sept 1 - Feb 28 1900 Patient quiet & agreeable tho somewhat depressed: works some: appetite good: sleeps well: occasionally disturbed & somewhat violent: Menstruates regularly. Mch 1 - Nov 30 1900 Neat: Converses readely: Works on ward: Sometimes depressed & very irritable: Appetite fair: bowels regular: Complains of headache: Quite sick at menstrual periods & remains in bed. July 20 Vaccinated successfully. Aug 7 Attacked one of Laundresses: Takes out door exercise usually does not speak unless spoken to. Sept 17 Disturbed &

Personal and Medical History of Sarah O'Neill

violent: Trans. to C. Sept 20. Very much improved: quiet. Again transferred to C. Oct 11. Trans. to A. Nov 16 Wt. 128 3/4. Dec 1 - Feb 28 1901 General health fair: failing somewhat in weight. 130 Feb 28 Mar. to June 1901. Mar 25 visited by sister and father, neat in habits and appearance, is unoccupied as a rule sits quietly about the ward, at times is very nervous and irritable and becomes violent and will then attack nurses. menstruates regularly when she has to go to bed for two or three days has considerable pain and headache. Mar. 30 Wt. 115#. June to Sept. No change in mental or physical condition, Aug. 30 Wt. 111#. Sept. to Dec. sleeps rather poorly at times General condition remains unchanged. Nov. 30 Wt. 119#.

Dec. to Feb 1903 No change. Wt about 124#

Personal and Medical History of Jane O Moen.

Whole No. 5700
Residence, Houston, Houston Co, Minn.
Date Admission, December 15th 1898
Admitted by Dr. R.A. Bebb. hour, 3 PM.
How Sent, J. Ryan D of P. Houston Co.
Sex, Female Age, 45
Civil Condition, married
Children, six.
Age Youngest Child, 17 yrs.
Occupation, Farmer's Wife
Degree Education, No. education.
Profession, Religion, Lutheran
Habits, Not intemperate.
Nationality, Norway (Parents also born there)
Physicians Committing, Dr Ferguson & H. W. Freeman.
Correspondents, Sigurd O. Moen, Houston, Minn.

No. of Years, 9?
Insane Relatives, Feebleminded son.
Cause Exciting, Unknown.
Cause Predisposing, —
Form, Recurrent mania (Sec. Dem.)
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, 4 yrs. ago.
Duration, about 4 yrs.
No. of Attack, 3rd
No. of Admission, 3rd
Age First Attack, 32 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 12/21/98

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - sluggish.
MEMORY, Past Events, Can't tell - Dull - confused
Recent Events, do Special Subjects, do.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull.
REASONING POWER, Ordinary Subjects, Poor.
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Dull & indifferent
DELUSIONS, Systematized, Transitory, Special Subjects,
Not known - will not talk much
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Long. (Unknown)
ONSET, Gradual or Sudden, Probably very gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
can learn nothing from her.
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Cannot learn.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2 in. PRESENT WEIGHT, 128 lbs. USUAL WEIGHT, NUTRITION, Fair.
WOUNDS, Abnormalities and condition of Skin, Superficial sores on arms & legs (chiefly) & scars from former ones.
TONGUE, Coatings or Promptness of Movement, Dry & somewhat irritated.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Size Normal.
SIGHT, Probably good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Probably good.
COORDINATION, Arms, Normal. Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None noted.
PATELLAR REFLEX, Normal. Other Reflexes, —
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Normal - Examination rather superficial - Will not do as we want her to.
Apex Beat, Regularity,
ARTERIES,
sclerotic.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

12/21/98 EXAMINATION URINE, Quantity, ℥ LV ℈ Sp. g. 1016 Reaction, acid Color and Appearance, Reddish yellow clear.
Albumen, none Sugar, none.
Casts and Crystals, Amor. urates & of all kinds of epith cells

12/27/98 GYNECOLOGICAL EXAMINATION, External genitals normal - except laceration of perineum, laceration of cervix. Vaginal orifice eroded - ulceration of os probably specific. Erosion of os.
MENSTRUATION, Irregular
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Seemingly thoroughly chronic. Previous histories indicate her to have been steadily insane for 5 yrs. or more. Possibly was not previously very bright. No history of its beginning or progress.

Personal and Medical History of Jane O Morn.

1898.

This patient was brought here by Sheriffs deputy N. N. Forsyth attended by Emma Forsyth, in fair physical condition, with the following history:- No history of consanguinity: no heredity. but has a feeble-minded son; First attack of insanity occurred thirteen years ago + lasted three months: second attack 9 years ago and lasted eight months, this is patients third admission here. (Was here from Mch. 1188 to July 30 '88 Vol. 10 Fol. 42 No. 1662. + from Oct 1' 89 to Apr. '90 Vol-13 Fol. 21 No. 2181) The first symptoms of present attack were manifested four years ago; has been "bad" ever since then. Disease appears stationary: Not variable: Patient not disposed to injure anyone: Not filthy nor destructive in habits: No previous peculiarities manifested: No severe disease nor injury to head: No confinement nor restraint employed since leaving hospital. No treatment pursued for her relief. On personal examination patient found to have hands + arms badly burned, from lying around stove. Has not been in bed for four years.

17/5/98 On admission put upon Infirmary (Gtn. Kpt. Complexion dark: Hair brown: eyes blue: Skin in normal condition: Scars from burns on hands, arms + legs: Ulcers on hands + arms. A few small bruises on legs: Is very dirty: Behavior quiet. Will not answer freely)

Summary Notes by Dr. Phelps. Dec. 15 Quiet on ward: General health fairly good: Condition apparently one of chronic dementia, She has been here before. Dec 18 Does not change any from day to day. Feb 8 '99 Condition in every way about as at time of coming. Mch 1 - Aug 31 '99. General physical condition fair: Appetite quite good: Is neat in habits but careless in appearance: Assists with work on sleeping flat: Talks incoherently but does not converse: Menstr. regular. Is very excitable + noisy at times. Aug 18 Wt. 121 #

Sept 1 - Feb 28 1900 Neat: Very noisy + violent. Works on sleeping flat. Menstruates regularly. Jan 1st Wt 121 #. Mch 1 - Nov 30 1900 Has delusions: Talks incoherently Is at times excited, noisy + violent: General health is fair: Eats + sleeps well. Takes outdoor exercise: menstruates regularly: Assists with ward work: July 3 Vaccinated Aug 30. Sick in bed with severe diarrhoea. Sept 1. Well - up on ward: Nov 28 Wt. 115 #. Assists on ward. Violent + noisy at times: Appetite good: Goes riding + walking.

Dec 1 - Feb 28 1901 - Appetite good: bowels regular: sleeps well: Takes outdoor exercise: Feb 1. Has a slight cold. Medicine given every 2 hrs. Mch 4 Wt 130 #

Mar. 1 - June 1 - 1901 Assists with work on ward. no change in mental or physical condition. May 31 Wt. 128 #

June to Sept. July 25 visited by gentlemen friends, assists with ward work, takes out door exercise, no change mentally or physically Sept. 1 Wt. 123 #.

Sept. to Dec. Nov. 30 Wt. 129 #.

Personal and Medical History of

Sept. to Feb. 1903 Patient is at times quite noisy, sometimes violent but is usually quiet. Never converses or answers questions. During night is usually restless and noisy out of bed a great deal. She assists with the work: takes out door exercise: General health is fairly good. Appetite good: bowels regular. Rather untidy and careless. Dec. 1 st Wt 142 1/2 #.

Personal and Medical History of Kate Miller

Whole No. 5201

Residence, St. Paul, Minn.

Date Admission, December 19' 1898.

Admitted by Dr. A.M. Phelps. hour, 6.45 P.M.

How Sent, G. Willich & Co's Ramsey Co.

Sex, Female Age, 49 yrs.

Civil Condition, widowed.

Children, none

Age Youngest Child, -

Occupation, Housewife.

Degree Education, Can read & write.

Profession, Religion, Catholic.

Habits, Not intemperate.

Nationality, Luxemburg, Germany. (Parents also born there)

Physicians Committing, H.P. Wainwright. Paul Ritchie

Correspondents,

No. of Years, 9+

Insane Relatives, None.

Cause Exciting, Spiritualism.

Cause Predisposing, Unknown.

Form, Mania with delusions?

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, Dec. 16'98.

Duration, 3 days.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 49 yrs.

Time of Leaving, June 29 - 1901

Time in Hospital, 2 Yr 6 mo 10 ds

Result, Died: Chronic nephritis, complicated with valvular heart disease

See newspaper clipping Page 81.

EXAMINATION ON ADMISSION BY DR. T.M. Phelps. Date of 12/21/98

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick but confused.

MEMORY, Past Events,
Recent Events, ? Special Subjects,

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

REASONING POWER, Ordinary Subjects, Poor.

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Incoherent in talk.
Depressed & dull.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Probably gradual.

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Can't learn very much from her. Seems afraid to talk freely.
Father, Living.

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

? Brothers and ~~Sisters~~,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
?

HABITS, Drinking and Smoking, ?

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Living at home with brother.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, good.

ory of

PHYSICAL CHARACTERISTICS.

IGHT, not taken USUAL WEIGHT, NUTRITION, Seems good.

n, None noted Skin in normal condition.

t, Some whitish coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - rather large.

SIGHT, uses spectacles for reading.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal.

HEARING, Normal.

COORDINATION, Arms, Normal Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Normal - Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Pulse irritable - did not test.

ARTERIES,
do

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
do.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

12/21/98 EXAMINATION URINE, Quantity, ℥ XL Sp. g. 1020 Reaction, Acid Color and Appearance, Yellow - clear Slight ropy deposit

Albumen, Trace by Esbach + HNO3 Sugar, None.

Casts and Crystals, Amor. urates, a few pus corpuscles, all kinds of epith. cells

12/27/98 GYNECOLOGICAL EXAMINATION, External genitals normal: Uterus adherent to left side: Small amount of whitish leucorrheal discharge.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient quietly in bed now but full of threats. She says she cannot be made to stay here. Is incoherent & full of delusive ideas - No history of value obtainable from her & no relatives have been seen. She hints of insanity reaching back for years.

Personal and Medical History of Kate Miller.

Whole No. 5201

Residence, St. Paul, Minn.

Date Admission, December 19th 1898.

Admitted by Dr. P.M. Phelps. hour, 6:45 P.M.

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

Sex, Female Age, 49 yrs.

Civil Condition, widowed.

Children, none

Age Youngest Child, -

Occupation, Housewife.

Degree Education, Can read & write.

Profession, Religion, Catholic.

Habits, Not intemperate.

Nationality, Luxemburg, Germany. (Parents also born there)

Physicians Committing, P.M. Wainwright. Paul Ritchie

Correspondents,

No. of Years, 9+

Insane Relatives, None.

Cause Exciting, Spiritualism.

Cause Predisposing, Unknown.

Form, Mania with delusions.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, Dec. 16'98.

Duration, 3 days.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 49 yrs.

Time of Leaving, June 29 - 1901

Time in Hospital, 2 Yr 6 mos 10 days

Result, Died: Chronic nephritis, complicated with valvular heart disease

EXAMINATION ON ADMISSION BY DR. P.M. Phelps. *Date of* 12/21/98

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick but confused.

MEMORY, Past Events, ?

Recent Events, ? Special Subjects,

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

REASONING POWER, Ordinary Subjects, Poor.

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Incoherent in talk.
depressed & dull.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Probably gradual.

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Can learn very much from her. Seems afraid to talk freely.
Father, Living.

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

? Brothers and ~~Sisters~~,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
?

HABITS, Drinking and Smoking, ?

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Living at home with brother.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Good.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, Seems good.

WOUNDS, Abnormalities and condition of Skin, None noted Skin in normal condition.

TONGUE, Coatings or Promptness of Movement, Some whitish coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - rather large.

SIGHT, uses spectacles for reading

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal.

HEARING, Normal.

COORDINATION, Arms, Normal Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Normal - Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Pulse irritable - did not test.

ARTERIES,
do

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
do.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

12/21/98 EXAMINATION URINE, Quantity, ℥ XL Sp. g. 1020 Reaction, Acid Color and Appearance, Yellow - clear Slight ropy deposit.

Albumen, Trace by Tsuretz + HNO_3 Sugar, None.

Casts and Crystals, Amor. urates, a few pus corpuscles, all kinds of epith. cells

12/27/99 GYNECOLOGICAL EXAMINATION, External genitals normal: Uterus adherent to left side: Small amount of whitish leucorrheal discharge.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient quietly in bed now but full of threats. She says she cannot be made to stay here. Is incoherent & full of delusions ideas - No history of value obtainable from her & no relatives have been seen. She hints of insanity reaching back for years.

Personal and Medical History of Kate Driller.

1898

This patient was brought here by Sheriffs deputy J.B. Arnd attended by J. James & Mrs. Hart. in fair physical condition, with the following history:- No history of Consanguinity, heredity nor intemperance in patient nor in parents: First symptoms of insanity manifested Dec. 16. 98 by acute mania with delusions: Disease appears increasing: Is not variable: Derangement now manifested by delusions that his brother is dead & money lost or stolen & that she will die soon: Not disposed to injure anyone. No filthy nor destructive habits: Patient a spiritualist & has had occasional delusions for years: No severe diseases nor injuries to head: Was confined in jail for three days. On personal examination is incoherent and violent in talk & actions are threatening

12/19/98 On admission Put upon Infirmary Mat (G.H.M. Rpt. Complexion dark: eyes brown: hair brown part gray: Condition of skin normal: Is very dirty: Behavior fairly good Has delusions.)

Summary Notes by Dr. Phelps. Received on ward Dec 19 Is rather obstinate, resistive & attempts to fight. Dec 26 Rather uncertain in behavior but most of time keeps quiet. Refuses being fed & refuses medicine or other treatment.

Jan 10 Has been rather obstinate, altho has been somewhat more quiet. Feb 25 Much quieter than at time of coming. Still however has the same ideas, manner & behavior. Mch. 1 - Aug 31 Physical condition good: Appetite good: Bowels regular: Is very violent at times: Has many delusions May 9 Attempted to elope when door was open. May 11 Fought nurses while being transferred to B2. May 25 Attempted to take nurses keys - fought. Is exceedingly disagreeable much of time & quarrels with other patients Refuses to bathe or take outdoor exercise. Is stupid at times: Has many delusions: Physical condition gradually improves: Appetite good but does not sleep well: Neat in habits & appearance: Is occasionally in seclusion. July 29 Wt. 174# Sept 1 - Feb 28 1900 Quite noisy: Scolds a great deal occasionally violent: Strikes other patients & nurses: resists being bathed: Expresses delusions: Appetite good: Sleeps well: Takes outdoor exercise: Menstruates regularly: Feb 27 Wt. 122#. Mch 1 - Nov 30 1900. Neat: Very stubborn & resistive. Has delusions: Sometimes aggressive & strikes patients Appetite variable: Menstruation regular: July 25. Fought nurses. Has delusions regarding food: Fed with tube Aug 8-9-10-13-20. On 20 seemed quite sick: transferred to Infirmary: Examination showed Kidney trouble: albumen found in urine & casts - put to bed & put upon milk diet: given diuretics Remained on Infirmary until Oct 18 1900. Sept 30 In bed: Violent at times Expresses many delusions: Thinks food poisoned: Fed mechanically Oct 18. 1900 Trans to B2. Nov 14. Fed by tube Nov 20 Wt 127#. Dec 1 - Feb 28 1900. Dec 7-11 Fed with tube: expresses many delusions: Thinks food

Personal and Medical History of

is poisoned Feb 21 - 24. Remains in bed: fed twice daily with tube. occasionally violent & resistive. Jan 9 - Feb 27 Fed with tube. Feb 27. Wt 107#. General health rather poor due to refusing food: Expresses delusions of poisoning. Mar. to June 1901 Mar. 15 patient mentally disturbed expresses numerous delusions especially of persecution and poisoning, is very noisy and violent, refuses nourishment, is fed by a tube. No change in either mental or physical condition, May 27 Wt. 100#. June to Sept 1901

June 24 patient still refuses to eat, has become very weak, transferred to Infirmary West. June 29 patient continues to fail physically, fed by tube regularly, became stuporous and died at 9:15

Died

Personal and Medical History of Ella Paul

Whole No. 5203

Residence, 716 Robinson St. St. Paul, Minn.

Date Admission, December 19th 1898

Admitted by Dr Ran. Phelps hour, 6 P.M.

How Sent, G. Willrich & of P. County Co.

Sex, Female Age, 39 yrs.

Civil Condition, widow.

Children, one.

Age Youngest Child, 5 years.

Occupation, —

Degree Education, Elementary.

Profession, Religion, Not a church member.

Habits, Not intemperate.

~~Nationality~~ Nativity, Missouri (Parents born in Kentucky)

Physicians Committing, O.N.O. Lundahl & E.A. Barchardt.

Correspondents,

No. of Years, 96

Insane Relatives, Unknown

Cause Exciting, Desertion & want.

Cause Predisposing,

Form, Melancholia ag. chr.

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Not

Date of this Attack, 18 mos. ago.

Duration, 18 Mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 38 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. ..... *Date of* .....

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, ?

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Agitated & depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

—

HALLUCINATIONS, —

ILLUSIONS, —

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Dull history not obtainable from her.

Father, Dead.

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, None

OCCUPATION, Healthy or not, All kinds - Washing Canvassing Etc.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

TRIES TO STAB WITH A HAT PIN

Dec 20 '98

TWO VIOLENT INSANE WOMEN ON A TRAIN.

Deputy Sheriffs Have an Exciting Trip to Rochester With Two Patients—One of Them Tries to Stab an Attendant With a Hat Pin, and the Other Attempts to Jump From a Window—Deputy Calms One by Talking to Her—Little Johnnie Paul's Plight.

It was a peculiar party that went to Rochester from St. Paul Monday afternoon. It consisted of Mrs. Ella Paul and Mrs. Kate Miller, both insane, John B. Arend and J. H. Jensen, deputy sheriffs, Mrs. Hart and another female attendant and little Johnnie Paul, the five-year-old son of Mrs. Paul.

Soon after the train left St. Paul Mrs. Miller became violent. She was sure that the deputies were taking her out somewhere to murder her. She started by hitting Deputy Jensen a blow in the face which, being entirely unexpected, nearly floored him. Then she struck the other deputy in the face, and seizing a long hat pin from her hat, made a murderous assault on Mrs. Hart. Deputy Arend recovered from his surprise in time to take the pin from her and force her back into her seat. After some persuasion she became quiet. Then she wanted a drink of water, and insisted on drawing it herself, so that it could not be poisoned.

On her way back to her seat she started to tear the shawl from Mrs. Paul's shoulders, saying it was hers. The deputies overpowered her again, and then Mrs. Paul became excited. She thought that Mrs. Miller and the deputies wanted to rob her.

One of Them Soothed.

As soon as Mrs. Paul was quiet Mrs. Miller again became violent. Sheriff Wagener was on the train taking a boy to the reformatory at Red Wing and he told Arend to try talking to Mrs. Miller in her own language. Both are Luxemburgers, and when Mrs. Miller discovered that Arend was born in a town only two miles from her own native town, there was no more trouble with her during the trip.

Soon after passing Red Wing, where it was necessary to change cars, Mrs. Paul became violent and it required considerable force to prevent her jumping out of the window. Both women were finally landed in the hospital at Rochester.

A pathetic incident of the trip was the presence of little Johnnie Paul. The probate judge directed that he be taken with his mother because she refused to accompany the deputies unless the boy went along. The boy is a bright, clever little fellow and became fast friends with the deputies. They bought him fruit and candy on the train and he was absolutely happy.

At the hospital Dr. Phillips took charge of the little fellow. Dr. Killbourne, the superintendent gave him clothes and shoes belonging to his own little son. Yesterday morning the deputies returned to St. Paul, bringing the boy with them. He is now at the jail and will be turned over to the Children's Home society. Frank Kennedy of Rochester, who saw the little fellow while he was at the hospital wants to adopt him.

dical History of

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 125 lbs, USUAL WEIGHT, NUTRITION, Somewhat poor.

nd condition of Skin, None. Skin very dirty.

mptness of Movement, White coating.

esponse to Light, and Accommodation, Equal - Rxs Normal.

good.

Arcus Senilis, or other troubles, Normal.

good.

Normal. Legs, Grasp,

ie, Facial Muscles, General, None.

Normal Other Reflexes,

d, Hesitating, Slow, Normal.

Paretic, Sad, Etc.,

gth, Sounds, Size,

rity,

ng.

y, Expansion,

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

E, Quantity, ℥ XXVV 41/4 Sp. g. 1012 Reaction, acid Color and Appearance, yellow. Slight fatty deposit

now Sugar, none.

rystals, Amor. urates - a few uric acid crystals - a few bladder cells.

12/27/98 GYNECOLOGICAL EXAMINATION, External genitals normal, except laceration of perineum, laceration of cervix. Many adhesions about uterus binding it firmly to left & posterior. Leucorrhoea - considerably whitish discharge.

MENSTRUATION, Could secure no history.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient quiet except for crying & rocking over loss of child. Cannot seem to get mind off of it to talk of anything else. Speaks of no delusions but seems to look around at times as if child were in room.

Personal and Medical History

Whole No.

Residence,

Date Admissi

Admitted by

How Sent,

Sex, Fema

Civil Condition,

Children, one.

Age Youngest Child, 5 years.

Occupation, —

Degree Education, Elementary.

Profession, Religion, Not a church member.

Habits, Not intemperate.

~~Nationality~~ Nativity, Missouri (Parents born in Kentucky)

Physicians Committing, Dr. O. Lindahl + E.A. Barchardt.

Correspondents,

Form, Melancholia ag. chr

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Not

Date of this Attack, 18 mos. ago.

Duration, 18 mo.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 38 yrs.

Time of Leaving,

Time in Hospital,

Result,

There
prompt
if you want a set of Th
if you act
delivered to you on or be
is now holding many sets
warns its readers that the
promptly unless orders are
The
remarka
success
which has attended our Centu
the start is a source of much gr
the Pioneer Press. It is a rema
to be able to procure so excellent
great a reduction and on such
fortunate that all good things must
However, all good things must
There is yet time to avail yourse
Persons living in St. Paul w
Exhibition rooms, Suite
the examiner, if we will se
may be examined at our office
now, ample binding outside of
and gaining living is now to the
Persons living in the country
below, as the grandest combi
Pioneer Press Monthly as a premium
Three-Quarter Months
especially suitable as a present
APPLICATION BLANK
To The Pioneer Press Co.
I accept the offer made by The Pioneer Press to
of the Pioneer Press Monthly, for the term of
the regular subscription price of
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Address
As a Result of the Recommendatio
LOGGING WILL
BE RESUMED
COMMISSIONER HERMAN DECIDES
REGARDING THE CHIPEWAS.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in. PRESENT WEIGHT, 125 lbs. USUAL WEIGHT, NUTRITION, Somewhat poor.

WOUNDS, Abnormalities and condition of Skin, None. Skin very dirty.

TONGUE, Coatings or Promptness of Movement, White coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Rxs Normal.

SIGHT, Probably good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal.

HEARING, Seems good.

COORDINATION, Arms, Normal. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Normal Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Rapid - quite strong.

ARTERIES,

Normal.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

10/xx/98 EXAMINATION URINE, Quantity, ℥ XXXV 11/14 Sp. g. 1012 Reaction, acid Color and Appearance, yellow- slight flaky deposit

Albumen, none Sugar, none.

Casts and Crystals, Amor. urates - a few uric acid crystals - a few bladder cells.

10/xx/98 GYNECOLOGICAL EXAMINATION, External genitals normal, except laceration of perineum, laceration of cervix. Many adhesions about uterus binding it firmly to left + posterior. Leucorrhoea - Considerable whitish discharge.

MENSTRUATION, Could secure no history.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient quiet except for crying + worrying over loss of child. Cannot seem to get mind off of it to talk of anything else. Speaks of no delusions but seems to look around at times as if child were in room.

EXAMINATION ON ADMISSION BY DR. ..... Date of .....

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, ?

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Agitated + depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

—

HALLUCINATIONS, —

ILLUSIONS, —

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Dull history not obtainable from her.

Father, Dead.

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

None.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, None

OCCUPATION, Healthy or not, All kinds - washing carrassing etc.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of Ella Paul.

1898

Patient brought here by Sheriffs deputy Nick Sergis, attended by Mr. Louran in fair physical condition, with the following history:- No information concerning consanguinity, heredity nor intemperance in patient nor in parents: First symptoms of attack manifested 18 months ago, in distress but refuses help: declares herself sick: Disease is variable: Derangement manifested by going to neighbors and demanding that they pay rent or leave her property: Not disposed to injure anyone: So careless & filthy in in habits: No information concerning history previous to attack.

12/19/98 On personal examination is nervous, & stubborn & claims imaginary riches. On admission put upon Infirmary Ward. (G. H.U. Rpt. Complexion dark: hair brown part gray: eyes brownish gray: Skin in normal condition: No marks, scars nor bruises. So very dirty: Behavior maniacal: Talks intelligently.

Summary Notes by Dr. Phelps. Dec 19 Received on ward. So restless, agitated, melancholy, crying. Dec 25 Thinks her little boy is here: cries & is still melancholy about it. Dec 31 Is restless, at times has been more stupid: Walks about ward & is becoming more demented. Jan 24 99 Trans. to 6[2]. Feb 27 General health good. Has sore eye. So still restless & troublesome.

Mch 1- Aug 31 99. Physical condition fair. Appetite fairly good: Bowels constipated: Habits untidy: Is occasionally noisy during night: usually resists when dressed & undressed & bathed, requiring four nurses to care for her. During day sits stupidly unoccupied as a rule but is occasionally very active & noisy: Usually sleeps well.

Aug 7 Trans. to Annex & remained there four days was very much disturbed there & noisy most of time & was kept in seclusion. Trans. to C[2] on Aug. 11th. Aug 30 Appetite improved: Takes outdoor exercise: At times noisy especially at night. Sept 1- Feb 28 1900 Had head cut during night & neck scratched: Cause unknown: Nov 29. Quiet: appetite good: Sleeps well: Habits dirty: Bowels constipated: Noisy at times: Jan 17 Wt. 113½#.

Mch 1- Nov 30 1900. Appetite fair: Sleeps well: Dirty in habits: Takes outdoor exercise: Nov 20. Wt. 108#. Dec 1- Feb 24 1901 General health good. Feb 15 Wt. 116#. Mar. to June General health good, inclined to be violent at times, untidy in habits at night, is unoccupied, attends no amusements, demented, says little to those about her, is delusional, May 29 Wt. 119#.

June to Sept. Still very obstinate, Sept. 8 patient received wounds during the night. cause of trouble unascertainable, trans. to Inf. West, right eye badly swollen, laceration aseptically treated and five sutures taken. Sept. 21 wound healed perfectly, trans. to 6. 2 West. Aug 31 Wt. 115#.

Sept. to Dec. No change in mental or physical condition Nov. 25 Wt. 95#.

Personal and Medical History of

Dec to Feb 1903 Patient is noisy & quite troublesome most of the time. Disturbed & sometimes violent. Quite restless. Walks to and fro in the Bay where she is kept most of the time. Talks incoherently and has no lucid intervals. At times is put in mittens. Is untidy and careless in appearance. Takes exercise: does no work: is at times secluded. Appetite good: bowels regular: sleeps well. General health good.

Personal and Medical History of Candace A. Ballard.

Whole No. 5206
Residence, St. Paul. Minn.
Date Admission, December 27 1898.
Admitted by Dr. R.M. Phelps hour, 6.45 P.M.
How Sent, G. Willrich & Asst. Ramsey Co.
Sex, Female Age, 58
Civil Condition, Married.
Children, four.
Age Youngest Child, 25 yrs.
Occupation, Housewife.
Degree Education, Common School.
Profession, Religion, Presbyterian.
Habits, Not intemperate.
~~Nationality~~ Maternity, Ohio (Father born Ohio, Mother Penna)
Physicians Committing, H.C. Johnson & R.M. Phelps.
Correspondents,

No. of Years, 99
Insane Relatives, None.
Cause Exciting, Mental shock caused by her house burning
Cause Predisposing, Unknown.
Form, Acute Melancholia (mild agitation)
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, 2 Wks. ago.
Duration, 2 Wks.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 58 yrs
Time of Leaving, Jan 3. 1899
Time in Hospital, 8 da.
Result, Died - Exhaustion in acute melancholia.

EXAMINATION ON ADMISSION BY DRS. A.A. Bebb & R.M. Phelps Date of 12/28/98

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Fairly quick.
MEMORY, Past Events, } Probably fair.
Recent Events, } Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,

REASONING POWER, Ordinary Subjects, Not accurate yet can
Special Subjects, answer fairly well.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed

DELUSIONS, Systematized, Transitory, Special Subjects,
Fear of death & poisoning

HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Duration 20 yrs.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, insane at about 50 - Kind of rambling - Died from injury on Ry at 58
Paternal Relatives, 1 aunt & 1 uncle insane.
Mother, Died - pneumonia at 70.
Maternal Relatives,
3 Brothers and 3 Sisters, - Healthy.
4 Children.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking, Drinks a little beer,
HEADACHES, VERTIGO, OR CONVULSIONS, has headaches but not quite so many of late years.
OCCUPATION, Healthy or not, At home.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,
Sleep poor. bowels about normal. Appetite poor.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, — PRESENT WEIGHT, — USUAL WEIGHT, NUTRITION, Fair - thinks poor.
WOUNDS, Abnormalities and condition of Skin, Skin in normal condition.
TONGUE, Coatings or Promptness of Movement, Slightly dry.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Response to light & accom. normal.
SIGHT, Fair with glasses.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal.
HEARING, Fairly normal.
COORDINATION, Arms, Normal Legs, do, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Some of facial muscles - not especially notable.
PATELLAR REFLEX, Normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Fairly normal.
ARTERIES,
Slight atheroma.

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

1/3/99 EXAMINATION URINE, Quantity, Sp. g. 1035 Reaction, Acid Color and Appearance, Brownish red. Cloudy, heavy pink deposit.
Albumen, # all tests Sugar, None.
Casts and Crystals, Amor. urates & pus corp. & epith. cells. Several granular casts.

GYNECOLOGICAL EXAMINATION,

MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient is a mildly agitated melancholia. So intelligent enough to answer many questions but is afraid of death as coming - of being killed, of being poisoned etc. Her health seems good & general intelligence still fair. Husband states that she has been more or less insane for 20 yrs. Her father committed suicide while being taken to Asylum,

Personal and Medical History of Landau R. Ballard.

1898

This patient was brought here by W Jenson as Sheriffs deputy attended by A Gallick & her husband, in fair physical condition, with the following history.
No history of intemperance: heredity nor consanguinity noted:
First symptoms of insanity manifested two weeks ago by delusions:
Disease appears increasing: Is variable: Derangement now manifested by hallucinations of persecution: Not disposed to injure anyone:
No filthy nor destructive habits: Thinks she is possessed by the devil.
No severe diseases nor injuries to head. No confinement nor restraint employed: No treatment pursued for relief of patient.
On personal examination Claims that she is possessed by the devil and persecuted by a mob to hang her.

12/27/98 On admission put upon Infirmary Mat (Gitt Rpt. Complexion fair: hair gray: eyes gray: Bruises on both legs: Behavior very excited. Large bruise on forehead.. Summary Notes by Dr. Phelps. Dec 27 98 Received on ward. Bruises on both legs & hips: also on forehead: would not stay in bed during first night. Dec 28 Visited by husband. Patient is very excited & troublesome: appetite very poor: General condition poor. Dec 30 Temp 99° still very active & troublesome: Visited by husband. Fed with tube eats nothing. Patient everything done for her. In restraint last night to keep her in bed. Thinks she is going to be hung. Dec 31 Temp. up to 101°. Jan 1 99 Temp. up to 100. Is very restless & in poor condition. Visited by husband today Jan 2 Temp. 102. Very restless: seems to be getting weaker. Jan 3 Temp. 100°. Is in a comatose condition seems to be failing steadily. Jan 4 Died at 8.30 P.M.

Died.

Personal and Medical History of

Personal and Medical History of Mari Hannul.

Whole No. 5207
Residence, Rice Co. Minn.
Date Admission, December 30th 1898
Admitted by Dr. R.M. Phelps hour, 6:45 P.M.
How Sent, R.A. Mott J. of P. Rice Co.
Sex, Female Age, 30 yrs.
Civil Condition, Single.
Children, –
Age Youngest Child, –
Occupation, Housekeeper.
Degree Education, Common school.
Profession, Religion, Lutheran
Habits, Not intemperate.
~~Nativity~~ Nationality, Germany (Parents also born there)
Physicians Committing, R.M. Jackson & D.M. Cool.
Correspondents,

No. of Years, 100
Insane Relatives, None.
Cause Exciting, Masturbation.
Cause Predisposing, Previous attacks,
Form, Adolescent (mel. with some dem.)
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Not.
Date of this Attack, July, 1898.
Duration, 5 months.
No. of Attack, 2nd
No. of Admission, 1st
Age First Attack, 26 yrs.
Time of Leaving, Apr. 29. 1899
Time in Hospital, 9 mo. 29 d.
Result, Discharged Nov. 1. 1899 Improved

EXAMINATION ON ADMISSION BY DR. R.M. Phelps *Date of* 12/31/98

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, Can't tell. Seems to remember.
Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Very dull & inactive

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

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Dull - depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, ?
ONSET, Gradual or Sudden, Probably gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Living
Paternal Relatives,
Mother, Living
Maternal Relatives,
Brothers and Sisters, ?
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
?
HABITS, Drinking and Smoking,
HEADACHES, now VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, fair Appetite, Not very good. and Bowels, usually constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, — PRESENT WEIGHT, — USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, Normal.
TONGUE, Coatings or Promptness of Movement, Very White.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal
SIGHT, Normal
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal.
HEARING, Good
COORDINATION, Arms, normal Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None.
PATELLAR REFLEX, normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal,
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal
ARTERIES,
Normal

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

1/11/99 EXAMINATION URINE, Quantity, Sp. g. 1020 Reaction, Acid. Color and Appearance, Yellow. Clear.
Albumen, Trace by Tannets Sugar, None.
Casts and Crystals, Amor. urates + a few epith. cells.

1/30/99 GYNECOLOGICAL EXAMINATION, External genitals normal. hymen intact. Uterus adherent to left. Leucorrhea large amount whitish discharge.
MENSTRUATION, – History of menstruation not obtainable.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient young. Pubescent case. Seems very dull. Health fair. Is morose & unsatisfactory in Conversation.

Personal and Medical History of Mary Harmel.

1898

This patient was brought here by Sheriff's deputy JB Thompson attended by Charles Harmel (bro.) in fair physical condition, with the following history:- No knowledge of consanguinity, heredity, nor intemperance in patient nor her parents. First symptoms of insanity manifested July '98 by masturbation & foolish & vulgar talk. Disease appears increasing. Is variable, with irregular rational intervals. Not inclined to injure anyone. No filthy nor destructive habits. No previous peculiarities manifested. Nor injuries nor severe diseases sustained. Has not been confined nor restrained & has received no treatment. Hypo-ago Bromidia, Gelsem & Viburnum. On personal examination is restless morose & stupid.

On admission sat upon dispensary rest (Gen. N. Rpt. brown, slightly streaked with gray; eyes blue; small mark on right arm. Cried & resisted a good deal.)

Summary Notes by Dr. Phelps. Dec 30 '98 Pted on ward. Has small mark on right arm. Resisted considerably when brought in. Dec 5 Cries a good deal. Is very untidy. Seems rather demented. Is very foolish in behavior. Jan 2 '99 General health has not changed much. Is untidy & obstinate. Has been contented to lie in bed a good deal of the time. Feb 12 Patients condition has changed very little. Was visited by her father on the first & is at times rather excited. Mch 1 - Apr 30 '99 Physical condition good. Appetite fair. Refuses to take outdoor exercise. Usually sleeps well. Usually very resistive, cross & cries a good deal. Frequently uses profane language. Refuses to go to dining room unless compelled to do so. Is rather violent at times. Apr 28 Visited by father Apr 29 Taken home on trial. Very much excited & very resistive.

Discharged.

Personal and Medical History of

Personal and Medical History of Monica Von Lubomiecka.

Whole No. 5209

Residence, Winona Co. Minnesota.

Date Admission, January 3rd 1899.

Admitted by Dr. R. A. Bebb hour, 4 P.M.

How Sent, H. L. Buck & off. P. Winona Co.

Sex, Female Age, 30 yrs.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Dressmaking.

Degree Education, Can read & write.

Profession, Religion, Unknown.

Habits, not intemperate.

Nationality, Germany (Parents also born there.)

Physicians Committing R. Lichtenstein & H. L. Roberge.

Correspondents,

No. of Years, 10 yr.

Insane Relatives, None.

Cause Exciting, Wrongful accusation against moral character.

Cause Predisposing, Unknown.

Form, Acute Melancholia (?)

Accompanying Bodily Disorder, None mentioned. Temp. 101

Suicidal or not, Not.

Date of this Attack, 1½ yrs. ago.

Duration, 1½ yrs.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 28 yrs.

Time of Leaving, May 7. 1900

Time in Hospital, 1 year 4 m. 4 d.

Result, Discharged Aug. 8. 1900
Died since leaving.

EXAMINATION ON ADMISSION BY DR. R. W. Phelps *Date of* 1/4

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,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Quiet

DELUSIONS, Systematized, Transitory, Special Subjects,
None noted.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 7 yrs.

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Denies any. Died of asthma.

Paternal Relatives,

Mother, living in old Country.

Maternal Relatives,

Brothers and Sisters, ?

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
?

HABITS, Drinking and Smoking, ?

HEADACHES, VERTIGO, OR CONVULSIONS, no.

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, poorly, Appetite, and Bowels, Normal.

Personal and Medical History of Monica Von Lubomiecka.

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, Fair wt. very anaemic

WOUNDS, Abnormalities and condition of Skin, pallid.

TONGUE, Coatings or Promptness of Movement, White coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Size normal.

SIGHT, Normal ?

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, normal ?

COORDINATION, Arms, Cannot try Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Heart laboring excessively while peripheral circulation is very poor.

ARTERIES,
L

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Lungs show all sorts of rales & dullness on Rt. side.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

4/9/99 EXAMINATION URINE, Quantity, Sp. g. 1024 Reaction, Acid Color and Appearance, dark yellow. cloudy - pearly deposit

Albumen, Trace by all tests Sugar, None.

Casts and Crystals, acinous. uratic, a few pus corp. & epith cells.

GYNECOLOGICAL EXAMINATION, External Genitals normal. hymen intact. leucorrhea-slight.

MENSTRUATION, Always regular. until admission here. has not menstruated since - usually 3 days pain except headache

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient seems quite helpless. Was sitting in chair having hair combed & seemed to sit . Put to bed however as very weak. Had to be carried down. Left side seems quite helpless but moved leg on pricking with pin. Says father had asthma & she has had it.

Personal and Medical History of Monica Von Lubomiecka.

1899

This patient was brought here by Sheriff Aug. Fuhrmann attended by Mr. Fuhrmann, in poor physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in parents nor in patient. First symptoms of insanity manifested about a year & a half ago: Lost ambition & commenced wandering around town at night; Coyed not; slept. Disease appears stationary or increasing & is variable with irregular, rational intervals: Derangement now manifested by a complete change in habits; in personal uncleanliness, does not change underclothing nor bathe for months: sleeps in clothes & exposes herself to cold: Threatens injury to herself & to others: No filthy nor destructive habits: No previous peculiarities manifested: Patients lungs are affected at present: No injury to head ever sustained: Has never been confined nor restrained in any way: Has received general treatment.

On personal examination Temp. 101, Pulse 100, respiration 44. Talks rationally but under nervous excitement admits truth of charge in habits.

1/3/99 On admission put upon Infirmary (Gitted Rpt. Complexion dark: Hair brown: eyes gray: Skin hot & dry: No marks, scars nor bruises noted: Is very dirty:- behavior quiet: has delusions.)

Summary Notes by Dr. Phelps. Jan 3 99 Patient received on ward: Seems very weak. Temp 102+ Resp. 36. Fell out of bed. Slept about three hours during night.

Jan 4 Is unable to use her left arm of late. Complains of pain in back. Left arm was noted yesterday as being helpless but she was helpless & lax in every way & the distinct paralysis was not noted. Temp. today 102 2/5 in the afternoon. Coughs considerably. Speaks of having had asthma. Seems to have cardiac weakness. There was no history obtained of the time when the paralysis came on, but it seems to have been sometime between the afternoon she was arrested & the time of reaching the hospital. She seemed to have some pneumonia & jacket was applied. Jan 7 Temp. still remains 101-102: coughs a good deal. Is restless at times.

Jan 8 Temp. 107 4/5. Jan 11 Temp. today as high as 103 1/5. The cough & lung trouble seem, however, rather vague altho the respiration is as high as 38 to 40.

Jan 14 Temp. has gone down a little. Today. 100 3/5. Is more quiet. Jan 17 Temp. today 100. Resp. 36. Jan 24 Temp. quite variable but now down to about normal. Seems to be growing stronger & feels well. Jan 31 Temp. normal. Resp. 24. Talks some & seems much clearer mentally. Feb 28 Upon ward. Seems to be growing much stronger. Cannot use left side of body. Her general condition has not changed much.

March 1 to Nov 30 1899. General health fair: Appetite good: bowels regular: Given massage daily: In November became neater in habits & usually occupied with reading & fancy work. Nov 30. Feb 28 1900 Jan 5. Wt. 100 lbs. Feb 28. usually cheerful: at times irritable. Converses readily: always busy

Personal and Medical History of

with some work or reading: usually neat in habits: Appetite fair: Sleeps well: Bowels somewhat constipated. Walks with cane & is able to use left hand. March - May 7 1900. Usually quiet & agreeable converses readily: Bowels regular with aid of laxatives. Sleeps well. Apr. 30. Has been in bed for past two weeks: Complains of back ache - limbs swollen: Sleeps poorly: Somewhat irritable & fault finding & rather untidy in habits. Given electrical treatment & massage. May 7. Taken home by sister.

Discharged -

Died a few days after reaching home.

Personal and Medical History of Annie M. Subbening

Whole No. 5213

Residence, Pedwing, Minn.

Date Admission, January 9th 1899.

Admitted by A. M. Phelps M.D. hour, 6th P.M.

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

Sex, female Age, 49 yrs.

Civil Condition, married.

Children, 9

Age Youngest Child, 5 yrs.

Occupation, Housewife (husband a machinist)

Degree Education, Common school.

Profession, Religion, Grman Methodist Church.

Habits, Not intemperate.

~~Nationality~~ Nativity, Germany (Parents also born there) Became resident of State, Co. in 1870.

Physicians Committing, H. Jackwig & Edlen Allen. M.D.

Correspondents, Jno. Subbening. 533 W. 7th St. Pedwing, Minn.

No. of Years, 106

Insane Relatives, None.

Cause Exciting, Followed attack of Pneumonia.

Cause Predisposing, —

Form, Acute Delirium

Accompanying Bodily Disorder, Pneumonia.

Suicidal or not, Not suicidal.

Date of this Attack, January 2' 1899.

Duration, one week.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 49 yrs.

Time of Leaving, Jan. 16 th. 1899

Time in Hospital, 8 da.

Result, Died. Ext. in Acute Delirium.

EXAMINATION ON ADMISSION BY DR. ..... *Date of* .....

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Much confused with comparatively lucid intervals

MEMORY, Past Events, Imp.

Recent Events, " Special Subjects, do.

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

REASONING POWER, Ordinary Subjects, Imp.

Special Subjects, "

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Excited - maniacal.

DELUSIONS, Systematized, Transitory, Special Subjects,
Imagines she has died & come to life again

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, One week.

ONSET, Gradual or Sudden, Rather sudden

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Cannot obtain history

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

?

HABITS, Drinking and Smoking, no.

HEADACHES, VERTIGO, OR CONVULSIONS, ?

OCCUPATION, Healthy or not, Housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,

First attack

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken PRESENT WEIGHT, Not taken USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Scar on left leg - right side of forehead & chest - Eruption over body. Bruises on legs. Skin dry & feverish.

TONGUE, Coatings or Promptness of Movement,

PUPILS, Equality, Size, Response to Light, and Accommodation,

SIGHT,

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING,

COORDINATION, Arms, Unable to make test Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

1/11/99 EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, acid Color and Appearance, Yellow Cloudy.

Albumen, Trace by heat. # by HNO_3. # by Tannets Sugar, none.

Casts and Crystals, amor. & ammon. urates. uric acid crystals. a few pus & blood corp. & all kinds of epith.

GYNECOLOGICAL EXAMINATION,

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Previous Mental grade probably about average. Present Condition that of acute del. mania probably caused by recent attack of Pneumonia. Urinalysis shows excess of albumen, pus & blood corpuscles. Part of time excited, maniacal & incoherent, expresses delusions, at times has lucid intervals when quiet & rational.

Personal and Medical History of Annie Dr. Subbersing

Personal and Medical History of

1899

This patient was brought here by Sheriff Lundquist attended by Drs. Kress and her son Jno. Subbersing, in a weak physical state, with the following history: No history of consanguinity known. No heredity nor intemperance in patient nor in her parents: First symptoms of insanity manifested Jany 2'99 by unnatural hilarity. Disease appears increasing: Is not variable: Derangement manifested on no special subject. No previous peculiarities manifested. No severe disease, (preceding this attack of pneumonia.) nor injury to head. Manual restraint employed at short intervals: Insanity was preceed by an attack of pneumonia about Christmastime. Has been given chloral, morphine & chloroform, only partially successful. On personal examination pulse & temperature normal. Insomnia, violent mania: No rational intervals.

1/9/99 On admission put upon Infirmary Mat (Gen. Rpt. Complexion dark: eyes gray: hair brown: skin hot & dry: Scars on left leg, right side of forehead & chest: Eruptions over body: Bruises on legs: Is clean: Behavior maniacal: speech incoherent.)

Summary Notes by Dr. Phelps. Jan 9 Put on ward: Temp. 101. Resp. 36. Is rather restless & excited: would not stay in bed. Noisy during night. Jan 10 Temp 104. Fed with tube: Visited by post. Put in restraint with cold applications to head. Jan 11 Temp. 105⅖. Struggles considerably: Imagines she has died & come to life again 12 Temp. 103⅘. Resp. 40. Patient very excited & restless. Jan 16 Patient died at 11.30 AM. Temp. went down during last few hours & she sunk into a comatose condition.

Died.

Personal and Medical History of Mary Haggerty. #1

Whole No. 5217
Residence, St. Paul, Minn.
Date Admission, January 12' 1899.
Admitted by Dr. R. M. Phelps hour, 6.45 P.M.
How Sent, E.W. Bazille J. of P. Ramsey Co.
Sex, female Age, 76 yrs.
Civil Condition, married.
Children, Nine.
Age Youngest Child, 37 yrs.
Occupation, housewife (Husband a farmer)
Degree Education, none.
Profession, Religion, R. Roman catholic.
Habits, not intemperate.
~~Nationality~~ Nativity Ireland (Parents also born there)
Physicians Committing, E.J. Abbott & O'Marhl.
Correspondents, Son-in-law J.E. Haggerty, 58 Dousman St. St. Paul, Minn.

No. of Years, 110
Insane Relatives, None known.
Cause Exciting, Senility.
Cause Predisposing, —
Form, Senile Dem.
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, 1898.
Duration, Less than one year.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 77 yrs.
Time of Leaving, Aug. 14' 1900
Time in Hospital, 1 yr. 7 mo. 2 da.
Result, Discha, unimproved Feb. 6' 1901.

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 1/13/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused.
MEMORY, Past Events, Poor
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,

REASONING POWER, Ordinary Subjects, Poor
Special Subjects, do
Own Mental State, do
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
indifferent

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Said to be 2 yrs.
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
? Can't tell.
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, None
OCCUPATION, Healthy or not, None now.
Detail Date, Duration, and Character of Previous Attack, if any,
None known
Sleep, Appetite, and Bowels,
Fair

Personal and Medical History of Mary Haggerty

PHYSICAL CHARACTERISTICS.

HEIGHT, PRESENT WEIGHT, USUAL WEIGHT, NUTRITION, Senile - fair flesh.
WOUNDS, Abnormalities and condition of Skin, Skin fair for age.
TONGUE, Coatings or Promptness of Movement, Prompt - Some white coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. (blind)
SIGHT, Sees scarcely at all.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Inflamed lids - Clouded corneas.
HEARING, fair - tho' somewhat impaired.
COORDINATION, ~~Arms,~~ Very feeble - Possibly ~~Legs,~~ incoordination but ~~Grasp,~~ with old age.
TREMORS, Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, ~~No~~ Murmurs, ~~Y~~ Strength, Sounds, Size, Sounds very faint & distant - Lung sounds over heart. Size probably normal. Apex beat normal - regular.
Apex Beat, Regularity,
ARTERIES,

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
No notable signs.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

1/19/99 EXAMINATION URINE, Quantity, ℥ XV ʒ Sp. g. 1028 Reaction, Acid Color and Appearance, Yellow - cloudy flaky deposit.
Albumen, Large amount - all tests Sugar, None.
Casts and Crystals, Amor. urates. a few epith cells + uric acid + oxalate of lime crystals - ✕ Epis. copp. hyaline + granular casts.
2/7/99 GYNECOLOGICAL EXAMINATION, External genitals normal except laceration: large rectocele: many adhesions across upper right side of vagina: Struggled so that examination with speculum impossible.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Senile in type + quite typical. So very feeble - History not obtained - No notable signs of importance - No specially impaired organ noted.

Personal and Medical History of Mary Haggerty.

1899

This patient was brought here by Sheriffs deputy J.B. Arend attended by Mr. Haggerty + daughter, in an aged, feeble condition. with the following history: No information concerning consanguinity & heredity. No intemperance in patient nor her parents. First symptoms manifested during past year, by hallucinations: Disease appears increasing: Is variable: Derangement now manifested by delusions of persecution, - thinks people are taking property, bedding, etc. Not disposed to injure anyone. No filthy nor destructive habits. No previous peculiarities manifested. No severe diseases nor injuries to head. No confinement nor restraint employed. No treatment pursued. On personal examination is almost blind, had delusions as above stated. On admission put upon Infirmary Ward West / Gen. Rpt. Complexion hair gray. eyes.

Summary Notes by Dr. Phelps Jan 23 '99 Put on ward. Fairly quiet. Slept most of night.

Jan 18 Patient up on ward. Rather rambling in talk: behavior rather Senile Feebleminded. At times resists. Jan 25 More active + resistive. Feb 3d General health good. Complains considerably + resists what is done for her.

Jan 25 More active + resistive. Feb 3d General health good. Complains considerably + resists what is done for her. Mch 1 - Aug 31 '99 Is advanced in years + feeble. Appetite good. Sleeps well: bowels regular. Untidy in habits. Very trouble-some on ward especially when dressed + undressed. Scolds + fights at times + is resistive + violent. Complains of eyes paining her. Sight very poor. July 20 Visited by friend.

Sept 1 - Feb 28 1900 Patient almost blind + very feeble. Is resistive: appetite fair: bowels regular: Goes around + touches other patients + is liable to injury. Kept in bay. Jan 18 Wt 117 lbs. Feb 28 Has many delusions: Thinks her people are dying: occasionally cries: Wanders about ward feeling of furniture. Mch 1 - Aug 14 1900. Untidy: Has delusions + kept in bay + fed on tray: Does not take outdoor exercise because she will not go up + down stairs: Appetite good: Bowels usually constipated. Usually sleeps well but occasionally disturbed + noisy. July 16 Vaccinated: Aug 14. Taken home.

Discharged

Letter received from daughter Jan 17 1901 - Says patient is about same condition as at time of leaving Hospital - realizes that she is at home but that is about all - Quite well physically.

Personal and Medical History of

Personal and Medical History of Frances Dio.

Whole No. 5220
Residence, St. Paul, Minn.
Date Admission, January 16' 1899.
Admitted by Dr. R. M. Phelps hour, 6th P.M.
How Sent, E.W. Bazille J. of P. Ramsey Co.
Sex, female Age, 22 yrs.
Civil Condition, Single
Children, none
Age Youngest Child, -
Occupation, Housemaid.
Degree Education, —
Profession, Religion, —
Habits, Unknown.
~~Nativity~~ Nationality, Unknown.
Physicians Committing, Dr. Chas Wirtl & C.E. Riggs.
Correspondents,

No. of Years, 1/3
Insane Relatives, Unknown.
Cause Exciting, Unknown.
Cause Predisposing, Previous attack.
Form, Stuporous melancholia
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, Unknown.
Duration, "
No. of Attack, "
No. of Admission, Three 1 St. Peter.
Age First Attack, Unknown.
Time of Leaving, Oct 1. 99
Time in Hospital, 9 m. 15 d.
Result, Disc. Apr. 17. 1900 Rec.

EXAMINATION ON ADMISSION BY DR. ..... *Date of* .....

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - sluggish.
MEMORY, Past Events, Imp.
Recent Events, " Special Subjects, do.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull - probably illusive
REASONING POWER, Ordinary Subjects, Imp.
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed & stupid.
DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none.
attention impaired - is slow, dull & shows loss of will power.
HALLUCINATIONS, None apparent.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
History not obtainable.
Father, Living
Paternal Relatives,
Mother, Dead.
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
?
HABITS, Drinking and Smoking, No.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Cannot secure definite information in regard to previous attack. Was born at St. Peter.
Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in PRESENT WEIGHT, 135 USUAL WEIGHT, NUTRITION, fairly good.
WOUNDS, Abnormalities and condition of Skin, none noted. skin normal.
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation,
SIGHT, Quite good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Quite good
COORDINATION, Arms, unable to make tests Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None.
PATELLAR REFLEX, delayed. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, does not talk.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, diminished
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
ARTERIES,
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

1/19/99 EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, acid Color and Appearance, yellow- clear light flaky deposit
Albumen, Trace by Heat + HNO3 # Sanita Sugar, none.
Casts and Crystals, Amor. urates. a few epith cells + uric acid crystals + pus corpuscles.

2/7/99 GYNECOLOGICAL EXAMINATION, External genitals normal- Uterus normal position- local tenderness with slight hyperaemia.
MENSTRUATION, History of menstruation cannot be obtained.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Previous mental grade probably below average. Lies most of time perfectly quiet & helpless - never talks & is apparently quite indifferent to surroundings. General health somewhat impaired. Urinalysis reveals presence of albumen

Personal and Medical History of Frances Dio.

1899

This patient was brought here by Sheriffs deputy J. Hanson attended by Mrs. Byrnes, in fair physical condition, with the following history: Nothing known concerning consanguinity, heredity nor intemperance in parents nor self. Was at one time at St. Peter hospital, but no information obtained concerning previous attacks of insanity, nor duration of present attack: Disease appears increasing: on Jan 4th 99 had a lucid interval for 15 minutes: No disposition shown to injure anyone: filthy in habits: No information concerning previous peculiarities. Severe diseases nor injuries to head. Nor concerning confinement, restraint nor treatment pursued.

On personal examination - Patient has been under observation in the City + County hospital since Jany 4th 99. has been in a stupor since admission with one exception when she was lucid for 15 minutes.

Jan 16 On admission put upon Infirmary (Gyn Rpt. Complexion dark. Hair brown: eyes blue: Skin normal condition: No marks, scars nor bruises. Is dirty: Behavior quiet: Refuses to talk.

Summary Notes by Dr. Phelps. Jan 16 99 Patient received on ward: Was seemingly in a condition of stuporous melancholia Jan 22 No change in any essential respect. Temp. normal but general condition not very good. Very silly + stupid in behavior Feb 7 Is brightening up some + is up on ward Feb 28 Has improved very much + can answer questions quite accurately at present March - Aug 31 99 By Dr. Betts. Appetite good: bowels regular: untidy in appearance: Very quiet in behavior. Menses regular: May 7 Remained in bed: Quite stupid. May 8 up + dressed but still very stupid (continued so for some days.) May 15 Fought nurses; refused to go to bed.

May 16-19. Very noisy + destructive. May 19. Trans. to C. Has many delusions + talks incoherently. Remains inactive. Takes outdoor exercise. Trans. to C3. Aug 31 Improving very much.

Oct. 1 99. Patient has practically recovered mentally - In very good physical condition. Allowed to go out on trial today.

Discharged

Personal and Medical History of

Personal and Medical History of Ida Kettle

Whole No. 5221

Residence, St. Paul, Minn.

Date Admission, January 16th 1899.

Admitted by Dr B.M. Philips hour, 6th PM

How Sent, Ex. Bazille Jos P. Ramoyles.

Sex, Female Age, 19.

Civil Condition, Single

Children, None

Age Youngest Child, –

Occupation, Housemaid.

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate

~~Nativity~~ Nationality, Switzerland (Parents also born there)

Became resident of State Co. 6 yrs. ago.

Physicians Committing, C.E. Riggs + W.J. Hawkins.

Correspondents,

No. of Years, 11 6

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing,

Form, Adolescent (Insanity of manner) Hysterical element prom.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, One month ago

Duration, One month.

No. of Attack, 2nd

No. of Admission, 2nd

Age First Attack, 18 yrs.

Time of Leaving, Nov. 7. 1900

Time in Hospital, 1 yr. 9 m. 22 d.

Result, Died Septic Endocarditis

EXAMINATION ON ADMISSION BY DR. ..... *Date of* .....

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quite clear - quick.

MEMORY, Past Events, Good

Recent Events, " Special Subjects, fair

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Alert fairly correct.

REASONING POWER, Ordinary Subjects, fair

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Very excitable. often Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,

None apparent now.

HALLUCINATIONS, probably none.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, living

Paternal Relatives,

Mother, died diphtheria

Maternal Relatives,

Brothers (died) and 2 Sisters, / stepsister

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

No.

HABITS, Drinking and Smoking,

HEADACHES, ~~VERTIGO~~ sometimes, OR CONVULSIONS, hysterical probably

OCCUPATION, Healthy or not, attended school

Detail Date, Duration, and Character of Previous Attack, if any,

see previous history.

Sleep, Appetite, and Bowels, Poor, Constipated. Has nightmare often screams from

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ PRESENT WEIGHT, 134 USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, None.

TONGUE, Coatings or Promptness of Movement, slight coating prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal.

SIGHT, good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good

COORDINATION, Arms, fair Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, slight of hands (twitch) + of tongue. frequent twitching of muscles in general. Head, tongue, arms, legs. slight choreic in form - partly voluntary.

PATELLAR REFLEX, diminished Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, normal

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, hyperaesthetic.

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity, regular

ARTERIES, Pulse weak.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical
Expansion fair
B. sounds normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact but lax. Mild leucorrhoeal discharge. uterus antiflexed.

MENSTRUATION, Says has never been regular - periods often 6 wks. apart. has dysmenorrhoea. pain during first two days of menses. own body of uterus, also in back flows about five days.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Rather disturbed

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

See next page for note

Personal and Medical History of Ida Kittle

1899

This patient was brought here by Sheriffs deputy J.B. Arend attended by Fresie Ketchum, in fair physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor in parents. First attack occurred Aug. 13. 1897 + patient was in this hospital from Aug 13 '97 to July 5 '98 (Ins Vol. 34 Fol. 333 No. 4844) First symptoms of present attack manifested one month ago - became violent: disease appears increasing: is variable: Derangement now manifested by spells of violence + refusal to Feed: Is disposed to do injury to others: No filthy nor destructive habits: No previous peculiarities known: No severe diseases nor injuries to Head: Was confined in this hospital eleven months, as stated above, + was in City hospital, St. Paul, ten days. - Constructive treatment pursued- On personal examination is intolerant of control, subject to

Jan 6 spells of violence. On admission put upon. G.S.W. (Epileptic) Complexion light hair light, eyes blue.

Summary Notes by Dr. Phelps Rec'd on ward Jan 16 Jan 20 Patient up + about ward is however somewhat noisy at times. Jan 22 Seems to be growing more noisy.

Jan 29 Has been growing more noisy every day Feb 20 Is quite hard to care for. Struggles against being dressed + against almost everything which it is necessary to do for her.

Note- history as given by patient. Said had fainting spells until 12 yrs. old. father + sister had them also. Lasted about 15 minutes - unconscious - usually occurred in church. Says she always learned easily + led her class. Says father + sister get angry easily. Had chorea from 14 yrs. for several yrs. Always very nervous + hysterical. Hands + arms + legs twitch + jerk nervously, probably largely voluntary. Goes without eating for days at a time also often screams + sings loudly during night. During these paroxysms she is destructive obstinate, resistive + at times very violent, requiring 6-7 nurses to hold her. Cannot be reasoned with altho apparently quite sensible: Between these spells she is friendly, rather elated + very talkative, always silly, affected + childish in manner. She has not expressed any delusions + appears quite rational - When returned to hospital was rather stupid + dazed for a few days + acted like a spoiled child.

Mch 1 to Sept 1 '99. Patient exceedingly disagreeable: struggles + fights + blocks door with bed. July 13 Hypodermics given when noisy at bedtime Lavage given + patient put in restraint July 24 - 27 Refused to eat very disagreeable: Fed with tube. did not retain food. Trans. to Annex July 28. + put in restraint: Refused nourishment, fed mechanically One tooth on plate in upper set broken, while feeding her (replaced) July 30 Trans. to B3 Aug 14 Fed by tube Stubborn + fought + again transferred to D.W. Aug 19. Back to B3.

Aug 30 '99 Complained of indigestion: medicine given. Lavage continued. Trans. to Infirmary.

Personal and Medical History of

Sept 1. Feb 28 1900, Sept 3 very resistive, irritable + disagreeable: Complains of pain in stomach: retains very little nourishment: Stomach washed daily: Bowels very constipated: Noisy at times: Requires sleeping doses: In restraint until Sept 11th. Nov. 11 Very disagreeable: fights frequently + delights in annoying nurses. Menstruation regular. Dec 9. Very disagreeable: nervous + restless: Fed with tube. In restraint occasionally: noisy day + night. Requires hypodermics frequently. Feb 27. Takes outdoor exercise. Mr. 12 7th. Under Nov 30 1900 very disagreeable + contrary much of time: Does not express any delusions: Sleeps poorly + requires frequent hypodermics: Appetite fair: bowels usually regular: menstruates regularly but painful + patient confined to bed a few days: at such times is very hysterical: July 16. Vaccinated: Aug 6. Complained of pain in stomach Stomach washed out + cathartics given: Takes exercise: attends amusements + chapel: Cares for room + assists in dining room.

Sept 1 Complained of sore throat: sent into Quarentine at Brick House. Suspected diphtheria: smears taken + bacilli found: cultures made + sent to State Board. Diagnosis doubtful. 2000 units antitoxin administered. + throat sprayed with peroxide: Stimulants given: Second culture sent + negative diagnosis returned: Given antiseptic bath + returned to ward Oct 3rd.

Oct 7th. Sick complained of pain in chest + side: Temp. 103°, Pulse 98. Resp. 20. Pain over cardiac area increased: breathing became panted + labored: Nov 3. patient became stuporous: refused medicine + nourishment: seemed quite weak: Trans to Infirmary: Fed with tube: pulse rapid + fluttering: given stimulants every two hours: Patient grew weaker: was comatose until death which occurred Nov 7 at 8:25 Father + sister were here Nov 6 + 7th. Temp gradually ran up from 103 - 105°. Pulse 148, Resp 48. During time frequent tub baths: to reduce temp. A diagnosis of septic pericarditis with endocarditis was made.

Died.

Personal and Medical History of Catherine Adams

Whole No. 5275

Residence, St. Paul, Minn.

Date Admission, January 23rd 1899.

Admitted by Dr. R.A. Bibb. hour, 6:45 P.M.

How Sent, Ed. Bazille Dep't Ramsey Co.

Sex, female Age, 50 yrs.

Civil Condition, married

Children, none

Age Youngest Child, -

Occupation, Housewife.

Degree Education, Common school.

Profession, Religion, Roman catholic

Habits, Unknown.

~~Nationality~~ Nativity, Ireland. (Parents born in Ireland)

Physicians Committing, Dr. Bacon - P.A. Quinn.

Correspondents,

No. of Years, 118

Insane Relatives, Unknown.

Cause Exciting, Unknown.

Cause Predisposing,

Form, Probably Organic Dimen. (Apoplexy)

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, Jany 12th 1899.

Duration, 11 da.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 50 yrs.

Time of Leaving, Apr. 20. 1900

Time in Hospital, 1 yr. 2 m. 27 da

Result, Dism Nov. 7. 1900 Improved

EXAMINATION ON ADMISSION BY DR. R. M. Phelps. *Date of* 1/20/99.

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,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Dull, quiet - simple childishness.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, ?

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, None known.

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Says none.

OCCUPATION, Healthy or not, Housework.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 4ft 10 PRESENT WEIGHT, 102½ lbs USUAL WEIGHT, NUTRITION, Fair flesh pallid.

WOUNDS, Abnormalities and condition of Skin, has sores - Skin pallid.

TONGUE, Coatings or Promptness of Movement, Clean now - slightly sore - tumor

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Liz normal.

SIGHT, No special trouble

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Seems fair -

COORDINATION, ~~Arms,~~ Slight uncoordination Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Slight - to now weak from staying in bed.

PATELLAR REFLEX, Exaggerated. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Fair with slight stumbling.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, no Murmurs, Strength, Sounds, fair Size,

Apex Beat, Regularity, irregular.

ARTERIES,

Slightly hard + full.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal.



Jan. 1900

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

1/26/99 EXAMINATION URINE, Quantity, ℥ XXXV Sp. g. 1020 Reaction, acid Color and Appearance, yellow. clear + white flaky deposit

Albumen, + by heat ++ by HNO_3 - Faucets Sugar, none.

Casts and Crystals, amor. urates - large amt of pus, uric acid crystals - Oxalate of lime - a few epith cells. - Hyaline casts (?)

2/7/99 GYNECOLOGICAL EXAMINATION, External genitals normal except laceration: inflamed especially around vaginal + urethral orrifice. extreme local tenderness: uterus + cervix atrophied.

MENSTRUATION, Regular. + quite free from pain.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Married at about 20. Thinks had this disease at 23. Is uncertain about dates - Was treated - Seems to have thought herself fairly well until last year or two. Says had sore throat for some years. but not so bad as last years. Sores have been growing about a year - Are very large. Are scattered over limbs, chest back + face. Mostly covered by a large scab. Nose sore - throat sore. First man died + she married again a few years ago. 2nd man was all right she thinks - Had no children - One miscarriage at age of 23.

Personal and Medical History of Katherine Adams.

1899.

This patient was brought here by Sheriffs deputy Peter Wagner, attended by Mrs Julia Adams, in fair physical condition, with the following history.- No information concerning heredity, consanguinity nor intemperance. First symptoms of insanity manifested Jany 17'99 by rambling talk: Disease stationary: not variable. Derangement now manifested by hallucinations as to her surroundings + people + objects that do not exist. No disposition to injure anyone, nor to filthy nor destructive habits. No previous peculiarities manifested: No severe diseases nor injuries to head: Has never been confined nor restrained. No treatment pursued: On personal examination, conversation uncertain + incoherent - articulation indistinct -

Jan 28 On admission put upon Infirmary (Fifth Rpt. Complexion dark: eyes brown, hair brown part gray. Skin normal condition: Ulcers on neck arms + limbs: Is dirty: Behavior quiet: Talks intelligently.

Summary Notes by Dr. Phelps. Jan 28 Put on ward. Large ulcers some open + some with scabs on neck, chest, arms + limbs. 2g doses on arm and daily dressing. Mental state is one of profound dementia of a very quiet + symmetrical character, however, without prominent delusions. She hardly knows where she is or what she was sent away from home for. Feb 2 Patient's ulcers are greatly improved. She was given mercury to start with + was salivated. She has improved very slightly in mental condition.

Mch 1 - Aug 31'99. By Dr Bell. General health + appetite good: Bowels usually constipated. Takes tonic: Neat in habits + appearance. Sore on left limb dressed daily. July 7 Trans. to B3. July 26 Assists with ward work: Inclined to be irritable: Is always asking to go home: Is on parole: Went to town returned by Miss Morris + transferred to A. Aug 21 More pleasant + agreeable: Asks repeatedly to go home: Talks quite sensibly.

Sept 1 - Feb 28'1900. (Dr Heyndale) Neat in habits: Does some work in dining room: Goes out for exercise: Is troublesome at times: frequently asks to be sent home: Appetite good: Bowels somewhat constipated Jan 18 Wt 129#.

Mch 1 - Mch 19'1900. (Dr H.) Neat: Eats + sleeps well: somewhat constipated: Takes out door exercise: Assists in dining room: Mch 13 Transferred to Infirmary: Mch 13. Had a condition of hypertrophy of great toe. Remained in bed two days. Then returned to A. Mch 19 - Sent home

Discharged

Personal and Medical History of

Personal and Medical History of Mary Clement

Whole No. 5276
Residence, Wascca Minn.
Date Admission, January 26th 1899.
Admitted by Dr. A. F. Kilbourne hour, –
How Sent, Gro. A Wilson D. of P. Wascca Co.
Sex, Female Age, 3
Civil Condition, Single
Children, None.
Age Youngest Child, –
Occupation, Housekeping –
Degree Education, Common school.
Profession, Religion, Congregational.
Habits, Not intemperate.
~~Nativity~~ Nationality, Wascca Co Minn (Father N.H. Mother Ky.)
Physicians Committing, Gd Swartwoudt + Wm Chamberlin
Correspondents, Father H.S. Clement Wascca, Minn

No. of Years, 119
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, Previous attacks
Form, Adolescent (mild melan.)
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, 1896.
Duration, 2-3 yrs.
No. of Attack, 2nd
No. of Admission, 2nd
Age First Attack,
Time of Leaving, July 6. 1899
Time in Hospital, 6 m. 11 d.
Result, Discharged Feb. 7. 1900 Improved

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 3/1/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Dull + confused.
MEMORY, Past Events, Seems good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull.
REASONING POWER, Ordinary Subjects, Poor.
Special Subjects, Poor.
Own Mental State, Knows how she is.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Dull + depressed.
DELUSIONS, Systematized, Transitory, Special Subjects,
Not known - Don't speaks of any.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Not definitely known - Probably had some trouble from time to time - when at home.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. PRESENT WEIGHT, 129 lbs. USUAL WEIGHT, NUTRITION, Fair.
WOUNDS, Abnormalities and condition of Skin, Fair
TONGUE, Coatings or Promptness of Movement, Normal
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Size normal.
SIGHT, Normal.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Normal.
COORDINATION, Arms, Normal. Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Normal.
PATELLAR REFLEX, Normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal
ARTERIES,
Normal
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

2/4/99 EXAMINATION URINE, Quantity, ℥ XXXV ⅿ 19 Sp. g. 1020 Reaction, Acid Color and Appearance, Yellow. Clear - White flaky deposit.
Albumen, None Sugar, None
Casts and Crystals, Amor. urates - a few pus. corpuscles Epith. cells. all kinds - ~~uric acid crystals + ass. abate of~~
GYNECOLOGICAL EXAMINATION, External genitals normal - extreme tenderness in posterior part of Vagina. Uterus retroflexed.
MENSTRUATION, Estab. at 14. Probably regular. formerly painful. Pain in lower part of back + back of head
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient young + a quite typically pubescent case - The recurrences are irregular but quite likely the tendencies to recur are more regular - A recurrence seems quite likely to occur at time of menstruation. Her behavior at each succeeding attack is the same as in all preceding.

Personal and Medical History of Mary Clement.

1899

This patient was brought here by Sheriffs Deputy Frank Collins, attended by Wm. Clement, brother, in good physical condition, with the following history. No history of consanguinity, heredity nor intemperance in patient nor in her parents. This is second attack of insanity & third admission here. was here from Sept 26'91 to Oct. 28'91 (Vol. 17 Fol. 357 No 2827) & from Aug 27'96 to Feb 18'97. Vol. 30 Fol. 297 No. 4506). Patient has not been well mentally since return from hospital & has been growing worse for two months past. Disease appears increasing is variable but with no rational intervals. Derangement now manifested on no particular subject. Not disposed to injure anyone. Destroys clothing & furniture. No previous peculiarities manifested. No severe diseases nor injuries to head. Has received hospital care & treatment, as above stated.
On personal examination is morose, melancholy & indisposed to notice anything. On admission put upon Infirmary (G.H.N. Dpt.
Complexion dark: eyes brown: hair brown: skin hot & dry: is dirty: behavior quiet: is reticent but answers questions intelligently.)
Jan 24 (Summary Notes by Dr. Phelps) Tried on ward. Is restless & excitable: rather confused in manner. Jan 30 Temp about normal altho it has been as high as 100. In general patient is fairly well behaved, altho confused in manner. Feb 28 Is receiving gynaecological treatments. Is rather stubborn at time & once or twice has been slightly violent. (Summary continued by Dr. A. F. Strickler.) June 1'99 Neat in habits and appearance. Is in good general health, altho she is somewhat anxious about her home. Converses rationally & shows no signs of mental derangement.
Went Home July 6-99.

Letter received from father dated Oct. 21st '99. States that patient is "some better. does not get over that dreamy, listless mood. When for any reason she does arouse thy an extra effort. She seems quite natural for a time. Is very uneasy & discontented with her surroundings. Works about the house, but needs to be managed for she has some strange notions & does not seem to be able to keep the run of her work: wants to sleep a good deal: general health the same as when she left the Hospital."

Discharged

Personal and Medical History of

Personal and Medical History of Emma Wagner.

Whole No. 5229
Residence, Ramsey Co. Minn.
Date Admission, February 2nd 1899.
Admitted by Dr. R. M. Phelps hour, 6th P.M.
How Sent, E.W. Bazille J. of P. Ramsey Co.
Sex, Female Age, 28 yrs.
Civil Condition, single
Children, none
Age Youngest Child, -
Occupation, Domestic.
Degree Education, Common school.
Profession, Religion, Lutheran.
Habits, Not intemperate.
~~Nationality~~ Nativity, Germany (Parents also born there.)
Has been resident of Ramsey Co 6 yrs.
Physicians Committing, J.F. Beaudette & J.G. McNamara
Correspondents,

No. of Years, 1 yr
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing,
Form, Acute Mania -
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, Feb. 1st 1899
Duration, 1 day.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 28 yrs.
Time of Leaving, Feb 14. 1899
Time in Hospital, 12 d
Result, Discharged Aug. 9. 1899

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 2/3/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Fairly clear -
MEMORY, Past Events, Good as far as known.
Recent Events, Special Subjects, Cannot remember accurately the ways she behaved at attack yesterday
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Slightly dull today.
REASONING POWER, Ordinary Subjects,
Special Subjects, Sluggish & uncertain.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Slightly depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Describes a maniacal attack yesterday - can give no details
No delusions found today.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 1 day (she says)
ONSET, Gradual or Sudden, Sudden.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Denies any insanity in family.
Father, Dead
Paternal Relatives,
Mother, Dead.
Maternal Relatives,
3 Brothers and 2 Sisters, Healthy as far as she knows.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, has had headaches all her life - since childhood.
OCCUPATION, Healthy or not, Domestic
Detail Date, Duration, and Character of Previous Attack, if any,
Denies any
Sleep, Appetite, and Bowels,
Says usually good.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1 in PRESENT WEIGHT, 92 lbs. USUAL WEIGHT, NUTRITION, Slightly emaciated.
WOUNDS, Abnormalities and condition of Skin,
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Size normal.
SIGHT, Good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, Good Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None of note.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal
ARTERIES,
Normal
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

2/7/99 EXAMINATION URINE, Quantity, ℥ XXXV III/IV Sp. g. 1034 Reaction, acid Color and Appearance, Yellow. clear White flaky deposit
Albumen, Trace by heat + Sulphosals Sugar, none.
Casts and Crystals, Amor. + ammon. urates, a few blood corpuscles, large ant. pus. all kinds of epith. cells.
2/7/99 GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact - hyperaemia of vagina + external local tenderness - uterus normal position - leucorrhoea - abundant yellowish + offensive discharge.
MENSTRUATION, Thinks always regular - considerable pain. Subject to sick headaches.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient seems fairly intelligent - describes having been taken by patrol wagon yesterday from house where she was working. Thinks she was out of her mind but don't know exactly what she did. Says the woman had her on lounge + went for help. Denies any previous trouble except headaches - Hesitates some in her account + is sluggish but answers with fair clearness.

Personal and Medical History of Emma Wagner.

1899

This patient was brought here by Sheriff's deputy J.B. Arnd, attended by Mrs Hallingshead in fair physical condition, with the following history: No consanguinity, heredity nor intemperance in patient nor in her parents. First Symptoms of insanity manifested Yesterday (Feb. 13th) by an acute maniacal attack: Disease appears increasing: So variable: Derangement now manifested on no particular subject. Patient has shown no disposition to injure anyone, nor to filthy nor destructive habits: No previous peculiarities noted. No severe diseases nor injuries to head: Has never been in confinement nor restraint: Has received no treatment. On personal examination is dull, refused to talk. information mostly derived from her sisters.

On admission put upon Infirmary (Gen. N. Rpt. Complexion dark: eyes gray: hair brown: Skin in normal condition: No marks, scars nor bruises noted: Is clean: behavior quiet: Talks intelligently)

Feb 14 (Summary Notes by Dr. Phelps.) Received on ward. Feb 3 Answers questions quite accurately: Was somewhat noisy in the afternoon. Feb 8 Receiving Gynaecological treatments: Answers questions quite accurately: seems somewhat more quiet. Feb 14 Visited by brother & sister in law. & taken home.

Discharged.

Personal and Medical History of

Personal and Medical History of Ellen Melby.

Whole No. 5231

Residence, Bridgewater, Minn.

Date Admission, February 3rd 1899.

Admitted by Dr. R.M. Phelps hour, 6th PM.

How Sent, James Hunter J. of P. Rice Co.

Sex, Female Age, 50

Civil Condition, widowed

Children, one

Age Youngest Child, 20 years.

Occupation, Housekeeper. (Husband was a farmer)

Degree Education, ordinary.

Profession, Religion, Not a church member.

Habits, not intemperate.

~~Nationality~~ Nativity, Norway. (Parents also born there)

Physicians Committing, J.R. Phillips + Wd. Hunt.

Correspondents, Ed Melby (Son) Northfield, Minn.

No. of Years, 124

Insane Relatives, None known.

Cause Exciting, Mental anxiety.

Cause Predisposing, —

Form, Melancholia (father senile)

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Threatens

Date of this Attack, October 1898.

Duration, About 4 mos.

No. of Attack, first.

No. of Admission, first.

Age First Attack, 50 yrs

Time of Leaving, Apr. 24 1900

Time in Hospital, 1 yr. 2 mo. 21 d..

Result, Disc. Nov. 6. 1900 Recovered.

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 2/22/99.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Wont talk much.

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, Poor.

Special Subjects, "

Own Mental State, "

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks she ought not to eat etc.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of Ellen Melby

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ PRESENT WEIGHT, 121lbs USUAL WEIGHT, NUTRITION, Poor.

WOUNDS, Abnormalities and condition of Skin, Feet swell some - oedema. Skin fair condition.

TONGUE, Coatings or Promptness of Movement, White - heavy coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal.

SIGHT, Good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good.

COORDINATION, Arms, Normal. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None very marked.

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Fair - Stacks very little

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, ~~Size,~~
No Clicking 2nd sound
Apex Beat, Regularity,
Apex beat normal Pulse quite weak.

ARTERIES,
No atheroma noticed.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Fairly normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

2/3/99 EXAMINATION URINE, Quantity, Sp. g. 1034 Reaction, Acid Color and Appearance, Yellow clear - White pasty deposit.

Albumen, Trace by Tests Sugar, None.

Casts and Crystals, Amor. urates - Mucin bands - a few epith. cells + pus corpuscles. Hyaline Casts

2/7/99 GYNECOLOGICAL EXAMINATION, External genitals normal except laceration. marked hyperaemia around os. mucus polyp from cervix. Local tenderness. Uterus normal position. Slight leucorrhoea.

MENSTRUATION, Always regular - Sometimes pain in back - formerly subject to headache. Menopausal last summer - Not Much since
" irregular for several years.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Patient half senile in appearance. Says only 50. Dull + melancholy. Stands about - feet swell if she stands.

Personal and Medical History of Ellen Melby.

1899

This patient was brought here by sheriffs deputy W.E. Hibbard, attended by Elise Carlson, in fair physical condition, with the following history:- No history of consanguinity, no heredity known, No intemperance in patient nor her parents: First symptoms of insanity manifested in October, 1898. Disease appears increasing: Is variable: Derangement now manifested by homicidal & suicidal delusions: Not disposed to injure anyone: No filthy nor destructive habits: Has always showed disposition to melancholy: Menopause past: Has been kept under watch for week, by son & neighbors: Has been given tonic treatment, rest & as much nourishment as could be afforded her. On personal examination has genral appearance of mental derangement and periods of excitement.

Feb 3 On admission put upon Infirmary (4th Ward Rpt. Complexion dark: hair gray: eyes blue: Condition of skin normal: No marks, scars nor bruises noted: Is rather dirty. head & vermin: Behavior quiet: Has delusions.)

Summary Notes by Dr Phelps. Feb 5 Proved on ward. Feb 6 Patient out of bed most of the day: is excited: Imagines she is to be killed: Is quite restless. Feb 8 Necessary to feed her mechanically. Feb 9 Very hard to get her to take nourishment.

Feb 16 No restraint today. Feb 28 Seems quieter but stands around ward a good deal of the time. Is melancholy & depressed. Cont. by Dr. R.A. Bebb) Mar.) Receives gyn. treatments and douches. takes medicine: Fed by nurse: During March and April limbs & feet became very badly swollen and inflamed Stands most of time & cannot be persuaded to sit down: During April gradually became neater in habits & appearance: breath very offensive: mouth washed frequently. Apr 4 Put to bed on account of limbs. First 10 days had slight fever: Still fed by nurse. Aug. 99 Is decidedly improving mentally: converses more readily: Is quiet & depressed: Oct. 6 Dec. Assists with work: Still much depressed, altho' less so than formerly: visited some with other patients & works some: talks more readily:

Oct. 30 Slipped & fell in diningroom, causing intercapular fracture of left hip: In bed six weeks: extention applied to limb: Nov. 30: Now talks quite readily: Is fairly cheerful, altho' still depressed: There is some ground, however, for her depression as her only son & support has gone to war since she came here & she is unable to get any trace of him: generally talks intelligently and is quite reasonable: appetite is now good: bowels constipated: Is now neat & tidy.

Sept 1- Feb 28 1900 (Dr. Hayrdale) Dec 30 Still in bed: Quiet & somewhat depressed. Converses readily: Appetite fair: Bowels constipated: Sleeps well: Given electrical treatments & massage Three times a week.

Mch 1- Apr 24. 1900. Quiet & usually cheerful. Converses readily: occasionally becomes melancholy: Does some work on ward.

Personal and Medical History of

heads & sews: Sleeps well: Bowels require laxatives. Apr 24 Sent home.

a letter written by her to Dr Heyrdale Oct 11- States that she is doing nicely.

Discharged

Personal and Medical History of Delia Griffin.

Whole No. 5 v 34

Residence, Redwing, Minn.

Date Admission, February 6th 1899.

Admitted by P. M. Phelps hour, 6th P.M.

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

Sex, female Age, 27 yrs.

Civil Condition, married

Children, one.

Age Youngest Child, –

Occupation, Housekeeper (Husband Section foreman)

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate.

~~Nationality,~~ Nativity, Wisconsin - Parents born in Ireland
Became a resident of Dept Co in 1893

Physicians Committing, J. Anderson + B Jacking

Correspondents,

No. of Years, 127

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, Previous attack

Form, Manica (mixed - followed by a period of depression)

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, December 27th 1898.

Duration, about six weeks.

No. of Attack, 2nd

No. of Admission, 1st

Age First Attack, 26 yrs.

Time of Leaving, Aug. 4. 1899

Time in Hospital, 5 m. 29 d.

Result, Discharged Feb. 7 1900
Improved

EXAMINATION ON ADMISSION BY DR. P. M. Phelps Date of 2/22/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Confused not sluggish.

MEMORY, Past Events, Uncertain

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Dull.

REASONING POWER, Ordinary Subjects, Poor

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Mildly exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,

Many - transitory. Is incoherent.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, ?

ONSET, Gradual or Sudden, ?

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Thos Mullen - 2nd cousin.

Father, Died in 1880 of cancer.

Paternal Relatives,

Mother, living family well.

Maternal Relatives,

4 Brothers and 3 Sisters, all healthy except one sister

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Always has had headache

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, ——— PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, Good

TONGUE, Coatings or Promptness of Movement, Prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Size normal

SIGHT, Good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good -

COORDINATION, Arms, Normal Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None

PATELLAR REFLEX, Normal. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

No special abnormalities noted

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, Acid Color and Appearance, Greenish pink reddish yellow

3/6/10/99
3/1/99

Albumen, Trace by Esbachs Sugar, ———

Casts and Crystals, Amor. urates, a few pus corp. a few Epith. cells

GYNECOLOGICAL EXAMINATION, External genitals normal except slight laceration of perineum. Implants of cuticles beneath umbilicus. Laceration of cervix. Uterus retroverted - slight leucorrhoeal discharge.

MENSTRUATION, Says always irregular - Estab at 13 yrs when she flowed for about 2 wks. then did not menstruate again for 2 yrs. – usually quite free from pain.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient somewhat anaemic. Lies quietly in bed but is subject to periods of unreasoning violence. Is vague + incoherent in talk, even while appearing quite intelligent. Does nothing - sits idly about.

Personal and Medical History of Delia Griffin.

1899

This patient was brought here by Sheriffs deputy. in fair physical condition with the following history:- No history of consanguinity, heredity nor intemperance in patient nor her parents. First attack of insanity occured in latter part of December 1897 & lasted about five months: First symptoms of present attack manifested December 27th 1898 by acting & talking strangely: Disease appears increasing, is variable - no rational intervals. Derangement now manifested by jealousy & on subject of religion: Patient not disposed to injure anyone: No disposition shown to filthy nor destructive habits: No previous peculiarities manifested. Had an abscess on head when two years old: Was restrained for a short time by manual restraint. Has been given tonics & sedatives. On personal examination is excited - labors under religious delusions, is jealous of her husband.

Feb 6 On admission put upon Infirmary. (Ad'n Rpt. Complexion dark: hair black: eyes gray: Skin in normal condition: Both legs & arms bruised: Is clean: Behavior maniacal: Has delusions.

Summary Notes by Dr. Phelps Feb 6 Placed on ward: Legs & arms bruised: Struggled considerably on admission Feb 13 In restraint: Was put to bed as her left leg was swollen from the hip down. & showed a mild tendency toward a milk leg. Feb 28 Visited by mother & sister on the 23. Has for the last four days been upon 6s. Is mildly maniacal at times & behavior is rather uncertain Mch 1 to May 31 99 By Dr Bett. Physical health fair. Appetite quite good: Sleeps well: Habits untidy: At times destructive & violent In restraint a couple of nights. Bowels constipated: refuses medicine. Is dull & stupid most of time Has many delusions. Visited by sister & husband in March. Remained in bed part of time during March & complained of headache & pain in right side: pulse weak. June 99 Appetite good: usually sleeps well: untidy part of time: rather dull: seldom takes any exercise unless compelled to: careless in appearance: bowels constipated July 1 Trans. to Inf. on account of poor appetite & general debility: complained frequently of pain in cardiac region: Is very anaemic: very listless, usually quite indifferent altho' at times brightens up & appears quite animated: Is especially interested in the dances & always attends them: usually answers questions quite sensibly & face brightens up when Spoken to. Spends most of her time unoccupied & frequently lying down on account of pain in her side. Aug 4. Taken Home by Sister.

Discharged

Personal and Medical History of

Personal and Medical History of Juliana Kregar.

Whole No. 5242

Residence, Inver Grove, Dakota Co. Minn.

Date Admission, February 2d 1899

Admitted by Dr. A. Kilbourne hour, 6th

How Sent, Thos. P. Moran Dep. Dakota Co.

Sex, Female. Age, 57 yrs.

Civil Condition, married

Children, 11

Age Youngest Child, 4 yrs.

Occupation, Housekeeper (Husband a farmer)

Degree Education, Can read & write.

Profession, Religion, German Lutheran.

Habits, not intemperate.

~~Nationality~~ Nativity, Germany (Parents also born there)

Physicians Committing, H. Fitch & H. Van Beek.

Correspondents,

No. of Years, 13?.

Insane Relatives, a sister & brother had epilepsy following a fall — a step-sister from — trouble because Shamocal

Cause Exciting, Unknown.

Cause Predisposing,

Form, Melancholia - Rather senile in character)

Accompanying Bodily Disorder, Epilepsy + headaches.

Suicidal or not, Not

Date of this Attack, About one year ago.

Duration, 1 year.

No. of Attack, 1st

No. of Admission, 1st time - (Mt. City Hospital, St. Paul.)

Age First Attack, 56 yrs.

Time of Leaving, May 2. 1899

Time in Hospital, 2 mos. 8 d.

Result, Discharged Nov. 1. 1899. Improved

EXAMINATION ON ADMISSION BY DR. A.M. Phelps *Date of* 2/25/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Dull - repeats phrases.

MEMORY, Past Events, } Dull & uncertain.
Recent Events, }
Special Subjects,

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

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

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Mildly depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Says 1 yr.

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Information apparently not very reliable.
Father, Living in St. Peter.

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

8 Brothers and ~~Sisters~~,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Typhoid fever(?)

HABITS, Drinking and Smoking, Drinks some

HEADACHES, VERTIGO, OR CONVULSIONS,
Lots, sometimes.

OCCUPATION, Healthy or not, Housework.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Takes medicine for bowels.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 PRESENT WEIGHT, 127 USUAL WEIGHT, NUTRITION, Poor.

WOUNDS, Abnormalities and condition of Skin, Small bruise on back of ~~hand~~. Skin in fairly good condition

TONGUE, Coatings or Promptness of Movement, Slight coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Response fair.

SIGHT, Says is poor.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, All right

COORDINATION, Arms, Did not test. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Fairly steady.

PATELLAR REFLEX, Somewhat sluggish 3-4 Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Fairly normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, ~~Size~~,
Slight click to Aort. 2nd sd.
Apex Beat, Regularity,

ARTERIES,
No noticable hardening

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

2/24/99 EXAMINATION URINE, Quantity, Sp. g. 3 XLV 11/4 Reaction, 1020 Color and Appearance, Yellow. clear White flaky deposit

Albumen, none Sugar, None

Casts and Crystals, Amor. urates - a few blood corp. & epith cells.

2/25/99 GYNECOLOGICAL EXAMINATION, Laceration of perineum & cervix. cystocele & rectocele - leucorrhoea abundant yellowish discharge - adhesions to left of uterus.

MENSTRUATION, always regular, but painful - subject to headache - laceration of perineum & cervix

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient generally working her mouth at times - does not much attention. Is quiet & not very restless about staying in bed. Cries some at times. Seems very dull. Does not talk about home or her own condition much. Seems too dull.

Personal and Medical History of Juliana Kregar.

1899

This patient was brought here by Sheriffs deputy attended by Mr. Deschler, in fair physical condition, with the following history: No history of consanguinity; half-sister maniacal, half brother epileptic. No intemperance in patient nor her parents. First symptoms of insanity manifested about one year ago by loss of memory, melancholia, & almost incessant crying. Patient was sent to City Hospital, St. Paul, last April, no result. Disease appears increasing; is variable but no entirely rational intervals. Derangement now manifested by depression, cries upon slight provocation, leaves her home. So disposed to injure others: No disposition to filthy or destructive habits; no previous peculiarities manifested: No severe diseases nor injuries to head. No confinement nor restraint employed: No information concerning specific treatment. Ov personal examination Hystero Epilepsy for six months - severe frontal
Feb 24 & —— headaches, melancholia, loss of memory, crying spells.
Ov admission put upon Infirmary - (Fifth Pt. Complexion dark: hair brown part gray: eyes blue: Skin in normal condition: Small bruise on right leg: Is clean: Behavior quiet: Talks intelligently but says she has a "bothered" feeling in her head.)

Summary 1st day Record by Dr. Bibb. Feb 24 to Mch. 9 Temp. 98°-99°. Pulse 72-96. Resp. 16-20. Appetite good: Bowels regular: Sleeps well. Feb 26 Complains of mouth being sore: Appears rather unsteady in walking: Quiet in behavior: Feb 28 up on ward: Talks quite sensibly: Mch 1st & 6th Complained of head ache & backache & remained in bed. Mch 8. up on ward. Summary cont'd Mch 23 Trans to A3, Apr. 3-17-28 Complained of pain in back & head & remained in bed. also complained of nausea, nausea.
Apr 24 Face swollen: Apr 30. Visited by husband: Mayy Taken Home on trial
Appetite has continued good: bowels regular: usually rather untidy in appearance.

Discharged.

Personal and Medical History of

Personal and Medical History of Mrs. Emma Arndt.

Whole No. 5243.
Residence, Pine Island, Minn.
Date Admission, February 24th 1899.
Admitted by Dr. R.M. Phelps hour, 6 45 PM.
How Sent, H. Blackmer Sheriff Goodhue Co.
Sex, Female Age, 40 yrs.
Civil Condition, married.
Children, Six
Age Youngest Child, About 15 months.
Occupation, Housekeeper - (Husband Saloonkeeper)
Degree Education, Common School.
Profession, Religion, Not a church member.
Habits, Not intemperate.
~~Nationality~~ Patients Nativity, Missouri (Parents born in Germany
Because resident of State 3/8/78 + of County Sep 1880
Physicians Committing, T.L. McKinstry + H. Wellner M.D.
Correspondents, Charles Arndt. Pine Island. Minn.

No. of Years, 136
Insane Relatives, None.
Cause Exciting, Uterine trouble.
Cause Predisposing, Unknown
Form, Melancholia (mild - With delusions)
Accompanying Bodily Disorder, Uterine trouble.
Suicidal or not, Not.
Date of this Attack, March 1898.
Duration, 11 months.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 39 yrs.
Time of Leaving, ~~Sept. 24~~ October 19 1900.
Time in Hospital, 1 yr, 7 mo, 25 Ds.
Result, Discharged. Improved May 1 1901

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 2/25/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick
MEMORY, Past Events, Fair.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
REASONING POWER, Ordinary Subjects, Fair
Special Subjects, Poor
Own Mental State, Poor.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Slightly depressed.
DELUSIONS, Systematized, Transitory, Special Subjects,
see "General remarks."
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 1 yr. or so.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
No insanity except Sister so far as he knows.
Father, Died in army.
Paternal Relatives,
Mother, Died heart disease
Maternal Relatives,
2 Brothers and 1 Sisters, Sister kind of foolish - born that way
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Sick some from in Dec. 97 + in March was bothered some.
HABITS, Drinks and Smoking, Drinks but not much.
HEADACHES, Some Pain in Head - VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Takes something at times

W. L. CRADDOCK, M. D.

Pine Island, Minn., Feby. 9th 1900 ~~99~~

Dr. A. J. Kilbourne
Rochester Minn

My dear Doctor:

Owing to late developments in the case of Mrs Emma Arndt I think that she would be very much better off under your care that at her home here. — She has very lately tried to poison her husband & as the attempt was clumsy & she made the hired girl quite sick — who took the dose — it was cloves & powder. — Her family relations are not such as tend to calm her. There is a constant jangling between the members of the family — & under these circumstances she has been getting worse for some time past

Respectfully
Dr. Abraham L. Craddock

PHYSICAL CHARACTERISTICS.

...IGHT, NUTRITION, Normal.

...newhat dilated. Response sluggish

Grasp,

...lexes,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

...n, Acid Color and Appearance, Reddish yellow-cloudy, Trace deposit.

...4.
...few epith cells & fine corp. a few fat globules & uric acid crystals.

GYNECOLOGICAL EXAMINATION, Laceration of perineum external genitals & uterus normal. Lateral laceration of cervix. Cervix inflamed. Uterus hypertrophied & retroflexed. endometritis with yellowish discharge. Eruption over external genitals.

MENSTRUATION, Regular during last 2 yrs. + free from pain - formerly irregular & painful - menstruated every three weeks upon birth of last child. Had one miscarriage at about 3 mos. Says she has suffered from womb trouble for about six years caused by lifting a stone. Had gyn. treatments for some time.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient quite stupid - Has a systematized delusion that Christ appeared to her & the Devil came before she could address him (Christ?) So that now she is condemned to die & suffer torture - Pictures out the actual Devil & the furnace which she sees.

Personal and Medical History of

Whole No. 5243.

Residence, Pine Island, Minn.

Date Admission, February 24th 1899.

Admitted by Dr R.M. Phelps hour, 6th PM.

How Sent, H Blackmer Dep't Goodhue Co.

Sex, Female Age, 40 yrs.

Civil Condition, married.

Children, Six

Age Youngest Child, About 15 months.

Occupation, Housekeeper - (Husband Saloonkeeper)

Degree Education, Common School.

Profession, Religion, Not a church member.

Habits, Not intemperate.

~~Nationality~~ Nativity, Wisconsin (Parents born in Germany - Became resident of State prior 1878 - of County prior 1880

Physicians Committing, T.L. McKinstry & F.G. Wellner M.D.

Correspondents, Charles Arndt. Pine Island. Minn.

No. of Years, 136

Insane Relatives, None.

Cause Exciting, Uterine trouble.

Cause Predisposing, Unknown

Form, Melancholia (mild - with delusions)

Accompanying Bodily Disorder, Uterine trouble.

Suicidal or not, Not.

Date of this Attack, March 1898.

Duration, 11 months.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 39 yrs.

Time of Leaving, ~~Sept, 24~~ October 19 1900.

Time in Hospital, 1 yr. 7 mo. 25 Ds.

Result, Discharged. Improved May 11 1901

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 2/25/99

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Fair.

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

REASONING POWER, Ordinary Subjects, Fair

Special Subjects, Poor

Own Mental State, Poor.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Slightly depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
see "General remarks."

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 1 yr. or so.

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
No insanity except Sister so far as he knows.
Father, Died in army.

Paternal Relatives,

Mother, Died heart disease

Maternal Relatives,

Brothers and Sisters, Sister kind of foolish - born that way

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Child was born in Dec. 97 & in March was bothered some.

HABITS, Drinking and Smoking, Drinks but not much.

HEADACHES, VERTIGO, OR CONVULSIONS,
Some pain in head -

OCCUPATION, Healthy or not, housework.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Takes something at times

and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1 PRESENT WEIGHT, 141 USUAL WEIGHT, NUTRITION, Normal.

WOUNDS, Abnormalities and condition of Skin,

TONGUE, Coatings or Promptness of Movement, Whitish. Slight coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Somewhat dilated. Response sluggish

SIGHT, Good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good

COORDINATION, Arms, Normal. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Normal.

PATELLAR REFLEX, Normal Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, No Murmurs, Strength, Sounds, Size, Intermittent

Apex Beat, Regularity,

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

2/28/99 EXAMINATION URINE, Quantity, 3 XI Sp. g. 1028 Reaction, Acid Color and Appearance, Reddish yellow - cloudy, dark deposit.

Albumen, None Sugar, None.

Casts and Crystals, Amorph & ammon. urate a few epith. cells & pus corp., a few fat globules & uric acid crystals.

GYNECOLOGICAL EXAMINATION, Laceration of perineum external genitals otherwise normal. Lateral laceration of cervix. Cervix inflamed. Uterus hypertrophied & retroflexed. Endometritis with yellowish discharge. Eruption over external genitals.

MENSTRUATION, regular since last 2 yrs. & free from pain - formerly irregular & painful - menstruated every three weeks upon birth of last child. Had one miscarriage at about 3 mos. Says she has suffered from womb trouble for about six years caused by lifting a stone. Had gyn. treatments for some time.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient quite stupid. Has a systematized delusion that Christ appeared to her & the Devil came before she could address him (Christ) So that now she is condemned to die & suffer torture. Pictures out the actual Devil & the furnace which she sees.

Personal and Medical History of Mrs. Emma Arndt.

1899

This patient was brought here by Sheriff's deputy P.J. Lundquist attended by her husband. in fair physical condition, with the following history:-
No history of heredity, consanguinity nor intemperance in parents nor in patient: First symptoms of insanity manifested in March 1898 by irrational talks & restlessness: Disease appears increasing: Is variable - patient being worse about the menstrual period: Derangement now manifested on subject of religion - believes that her soul is lost by neglect. Not disposed to injure anyone: No filthy habits, but has destroyed clothing: No previous peculiarities noted. No severe diseases nor injuries to head. No confinement nor restraint employed. No information concerning treatment pursued.
On personal examination talks too much, is irrational, has delusions has recvnd treatment from Drs. Mayo & Stinchfield -
7/24/99 On admission put upon Infirmary (Gth Apt. Complexion dark: hair black: eyes brown: Skin in normal condition: Eczema on head: a few small bruises on legs: Is dirty. Right breast very large & caked. Behavior quiet Has delusions.
7/24 to 8/1/99 Summary 14 da record by Dr Bell. Temp. 98°-99°. Pulse 74-100. Resp. 19-24. Appetite good. bowels usually regular: Very restless & sleeps little: Is very noisy at times and has many delusions;- thinks devil is after her. Talks constantly & fairly sensibly at times: Is often out of bed at night pounding on door. Appears quite weak. Liniment applied to breasts. Feb. 28 up on ward: very restless & noisy talking incoherently. Mch 1 Visited by husband: After Mch 3rd she was quieter & rested better: untidy in appearance: noisy during day. Has a bad habit of picking her head until it becomes quite sore.
Summary continued Mch. 14 Visited by husband & brother. Mch 20 Trans. to B3. Apr. 21 Visited by husband Apr. 25 by husband, sister & children. May 7 by friend - June 28 by husband & Aug 17 by two sons: May 8 Trans to C3. May 10 Threatened to kill herself. Trans. to B2. During June restless and very nervous. Picks at her body causing sores: Complains of feeling ill: Seldom takes outdoor exercise: Is quite melancholy & cries at various times: Aug 28 Wt. 164#. Continues talkative: Is rather disagreeable: Often uses profane language & is at times destructive.
Sept 1- Feb 28 1900. (Dr Heyerdale) Expresses many delusions & hallucinations Cries & is very nervous. Has headaches mornings. Appetite good. Sleeps fairly well. Menstruates regularly: Takes outdoor exercise:
Mch 1- Nov 30 1900 Clean. Appetite good: Bowels regular: Never goes out: Is quarrelsome at times & disagreeable: occasionally profane. Attends chapel: July 16 Vaccinated: Aug 1. Visited by friends Oct 19. Went home with husband.

Jan 21 1901. Letter received from husband. Patient's behavior variable - part of time allright & part of time mind wanders.

Discharged.

Personal and Medical History of

Personal and Medical History of Tillie Burgess.

Whole No. 5244.
Residence, St. Paul, Minn.
Date Admission, February 24th 1899
Admitted by Dr R.M. Phelps hour, 6th P.M.
How Sent, C.M. Bazille & aft. Ramsey Co.
Sex, female Age, 43 yrs.
Civil Condition, married
Children, None
Age Youngest Child, -
Occupation, Domestic.
Degree Education, Common school.
Profession, Religion, Not a church member.
Habits, Not intemperate.
~~Nationality~~ Nativity, Germany - (Parents also born there)
Physicians Committing, R.M. Merrill & C.J. Woolley
Correspondents,

No. of Years, 13
Insane Relatives, Paternal Grandmother.
Cause Exciting, Syphilis.
Cause Predisposing, Heredity
Form, General Paresis (Dem. Dem.)
Accompanying Bodily Disorder, Syphilis.
Suicidal or not, Not.
Date of this Attack, September 1898.
Duration, about 5 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 43 yrs.
Time of Leaving, Aug. 17. 1899
Time in Hospital, 5 m. 24 d.
Result, Died. Convulsions in General Paresis.

EXAMINATION ON ADMISSION BY DR. R.M. Phelps *Date of* 2/25/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
(Obliterated seemingly.)
MEMORY, Past Events,
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Very dull.
REASONING POWER, Ordinary Subjects, Special Subjects, Own Mental State, } dull.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Dull - indifferent.
DELUSIONS, Systematized, Transitory, Special Subjects,
None known.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Not known. Suggestions that it is only part of a year.
ONSET, Gradual or Sudden, Gradual -
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Will not talk - or is too demented to talk & no history is obtainable from her.
Sleep, Appetite, and Bowels,

Dr
John H. Stewart
533 Robert St
St Paul
Tillie Burgess

AL CHARACTERISTICS.

06 lbs. USUAL WEIGHT, NUTRITION, Somewhat impaired.
of old ulcer near base of spine on back. Skin slightly anaemic.
not show it.
dation, Equal. Response slight.

SIGHT,
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Dont seem to hear.
COORDINATION, ~~Arms~~, There is a kind of stammering & weakness in walking that I judge to be incoordination but does not sway much ~~Legs~~, nor standing still. Rodenmel ~~Grasp~~,
TREMORS, Hands, Tongue, Facial Muscles, General, Hesitation & sluggishness of motion but no marked tremor.
PATELLAR REFLEX, Exaggerated. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Will say only a single phrase in a blurred way, the always the same.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal.
ARTERIES,
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

7/27/99 EXAMINATION URINE, Quantity, Sp. g. 1020 Reaction, Acid Color and Appearance, Yellow clear.
Albumen, Trace by Tannic Sugar, None.
Casts and Crystals, Amor. urates. a few epith. cells

GYNECOLOGICAL EXAMINATION, External genitals normal. uterus normal position. leucorrhoea, yellowish streaked with blood on 2nd exam. later leucorrhoea absent.
MENSTRUATION, Can obtain no information.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient Profoundly demented - So much so as to be "Vacant" in mind - Does not seem to know one is talking. Attention can rarely be held or even caught - So fairly quiet, ths restlessly picking at clothing & is up & about.

HOT AND COLD BATHS.
RATES $1, $1.25, $1.50, ACCORDING TO ROOMS.
Two Blocks from Grand Opera and Three blocks from Metropolitan Opera.
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A. CHARBONNEAU, PROPRIETOR
Corner Seventh and Wabasha Streets.
SPECIAL RATES TO THE PROFESSION.
TELEPHONE 1512
ST. PAUL, MINN.
ACCOMMODATIONS IN PROPORTION TO THE MONEY.

Personal and Medical History of Lillie Burgess.

Whole No. 5244.

Residence, St. Paul, Minn.

Date Admission, February 24th 1899

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

How Sent, Ell Bazille & off. Ramsey Co.

Sex, female Age, 43 yrs.

Civil Condition, married

Children, None

Age Youngest Child, -

Occupation, Domestic.

Degree Education, Common school.

Profession, Religion, Not a church member.

Habits, Not intemperate.

~~Nationality~~ Nativity, Germany. (Parents also born there)

Physicians Committing, H.R. Merrick & C.J. Woolway.

Correspondents,

No. of Years, 13

Insane Relatives, Paternal Grandmother

Cause Exciting, Syphilis.

Cause Predisposing, Heredity

Form, General Paresis (Sec. Dem)

Accompanying Bodily Disorder, Syphilis

Suicidal or not, Not.

Date of this Attack, September 1898.

Duration, about 5 mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 43 yrs.

Time of Leaving, Aug. 17. 1899

Time in Hospital, 5 m. 24 d.

Result, Died. Convulsions in General Paresis.

EXAMINATION ON ADMISSION BY DR. R. M. Phelps. Date of 2/25/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

(Obliterated seemingly.)

MEMORY, Past Events,

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Very dull.

REASONING POWER, Ordinary Subjects,

Special Subjects, } dull.

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Dull. indifferent.

DELUSIONS, Systematized, Transitory, Special Subjects,

None known.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Not known. Suggestions that it is only part of a year.

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any, Will not talk - or is too demented to talk of it. History is obtainable from her.

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. PRESENT WEIGHT, 106 lbs. USUAL WEIGHT, NUTRITION, Somewhat impaired.

WOUNDS, Abnormalities and condition of Skin, Scar of old ulcer over base of spine on back. Skin flabby, anemic.

TONGUE, Coatings or Promptness of Movement, Will not show it.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Response slight.

SIGHT, ?

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Don't seem to hear.

COORDINATION, ~~Arms~~, there is a kind of stammering & weakness in walking that I judge to be incoordination but does not stray much ~~Legs~~, on standing still. Sociodental ~~Grasp~~,

TREMORS, Hands, Tongue, Facial Muscles, General, Hesitation & sluggishness of motion but no marked tremor.

PATELLAR REFLEX, Exaggerated. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Will say only a single phrase in a blurred way, tho always the same.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Normal.

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

7/7/99 EXAMINATION URINE, Quantity, Sp. g. 1020 Reaction, Acid Color and Appearance, Yellow clear.

Albumen, Trace by Tanrets Sugar, None.

Casts and Crystals, Amor. urates. a few epith. cells

GYNECOLOGICAL EXAMINATION, External genitals normal. uterus normal position. leucorrhoea, yellowish streaked with blood on 3rd exam. later leucorrhoea absent.

MENSTRUATION, Can obtain no information.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient profoundly demented. So much so as to be "vacant" in mind. Does not seem to know one is talking. Attention can rarely be held or even caught. So fairly quiet, ths restlessly picking at clothing & is up & about.

Personal and Medical History of Tillie Burgess.

1899

11 This patient was brought here by Sheriffs deputy Du Kynum, attended by Dro. in fair physical condition, with the following history:- No history of consanguinity: Father's mother insane: Patient & her father both addicted to use of malt liquors. First symptoms of insanity manifested last September - by Illusions Disease appears increasing: Is not variable: Derangement now manifested by illusions & hallucinations: Not disposed to injure any one: Filthy & destructive in habits: Previous peculiarity - irritability of temper: No severe diseases nor injuries to head: No confinement nor restraint employed. Antisyphilitic treatment pursued.
On personal examination imagines she sees people & things not present.

3/24/99 On admission put upon Infirmary (G.W.N.Pat) Complexion fair: Hair light brown: eyes blue: Skin in normal condition: Scar on lower part of back from ulcer. Eruption on chest & back: Ulcers on lower part of back: Is rather deity: Very excited when being bathed: Talk incoherent.

3/24/99 to 3/9/99 Summary 14 da record by Dr Bro. Temp. 99 - 99⁴ Pulse 78-84 Resp. about normal: Appetite good: Bowels irregular: untidy in habits: Talks very incoherently: Out of bed most of time: usually sleeps quite well but restless at times: Receives Gyn- treatments & vaginal douches: resists considerably. Mch

Summary contd. Mch 11 Had a chill - Temp. 99⁴: Hot sand bags applied remained in bed. Apr 16 Trans. to B'. Frequently talks incoherently to herself. June 8 Sick this morning: extremities cold: pulse quite weak: put to bed. Hot sand bags applied & hypodermic given: Remained about same until June 12th when able to be up on ward: Continues active, restless, resistive & noisy. most of time: Taken out for exercise. Aug 10 Had convulsion Aug 11 Fell. during convulsion bruising left eye. Aug 16 - 17 Had series of convulsions quickly following one another, some lasting as long as 1½ hour. Temp. 108⁸ Pulse weak: Hypodermics given also medicated enemata but gradually became weaker until death Aug 17 99.

Died.

Personal and Medical History of

Personal and Medical History of Mary Larsen 2nd

Whole No. 5745
Residence, Alden, Minn.
Date Admission, February 24th 1899.
Admitted by Dr. P. M. Phelps hour, 6th P.M.
How Sent, H. Blackmer J. of P. Freeborn Co.
Sex, Female Age, 41 yrs.
Civil Condition, married.
Children, 4.
Age Youngest Child, 5½ yrs.
Occupation, Housekeeper (husband a farmer)
Degree Education, Common school.
Profession, Religion, Dru. Baptist.
Habits, Not intemperate.
~~Nationality~~ Native, Denmark - Parents also born there
Physicians Committing, John Watson & J. Fron Berg.
Correspondents, James Larsen, Alden, Minn (husband)

No. of Years, 138.
Insane Relatives, None.
Cause Exciting, May be from uterine disease
Cause Predisposing, Unknown
Form, Melancholia chr
Accompanying Bodily Disorder, Uterine disease.
Suicidal or not, Not.
Date of this Attack, 3 yrs. ago
Duration, 3 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 38 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. P. M. Phelps *Date of* 2/25/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Somewhat confused.
MEMORY, Past Events, Can't recollect accurately.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull.
REASONING POWER, Ordinary Subjects, } Impaired
Special Subjects, }
Own Mental State, }
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed.
DELUSIONS, Systematized, Transitory, Special Subjects,
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden, Probably gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Denies heredity does not give any clear account.
Father, D.
Paternal Relatives,
Mother, L.
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Operation 5½ yrs. ago. Ear trouble since operation
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Poor Appetite, and Bowels,

Personal and Medical History of Mary Larsen 2nd

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4 PRESENT WEIGHT, 128 USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, Slight bruise on hand.
TONGUE, Coatings or Promptness of Movement, Slight coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal.
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Quite deaf.
COORDINATION, Arms, Quite steady Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None
PATELLAR REFLEX, Normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, 1st and 2nd Strength, Sounds, Size,
Apex Beat, normal ~~Regularity~~,
Sounds fair. 2nd accentuated some
ARTERIES,
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Quite resonant & full.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

3/1/99 EXAMINATION URINE, Quantity, Sp. g. 1032 Reaction, Acid Color and Appearance, Yellow. cloudy. flaky deposit.
Albumen, None. Sugar, None
Casts and Crystals, Amor. urates. a few pus corp & epith cells.

2/25/99 GYNECOLOGICAL EXAMINATION, External genitals hyperaemic. Laceration of perineum. Extensive laceration of cervix. Prolapse of uterus. Much local tenderness
MENSTRUATION, Every Three Weeks until recently. Some pain in back during menses.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). So depressed & somewhat dull in manner cannot hear well. but seems somewhat dull aside from that. Lies quietly in bed.

Personal and Medical History of Mary Larson.

1899

This patient was brought here by Sheriffs deputy W.B. Mitchell attended by her husband, in fair physical condition, with the following history:- First symptoms of insanity manifested three years ago, became irritable peevish at times - melancholic & abusive toward husband: Disease appears increasing in variable but no rational intervals (has conducted housework all the time, but at no time rational) Derangement now manifested by delusions that husband poisons food. Has shown desire to injure husband. No filthy nor destructive habits: No previous peculiarities manifested: No severe diseases nor injuries to head. No confinement nor restraint employed. Has been given tonics, sedatives, injections & medicated tampoons. On personal examination is anaemic, suspicious, dejected.

On admission put upon Infirmary (Gyn'l Ct. Complexion dark: Hair brown: eyes brown: Skin in normal condition: Red mark on left shoulder: Right arm badly bruised says it was done by her husband: Is clean: Rather deaf in left ear: Behavior quiet: Talks intelligently.)

2/24/99 to 3/9/99. Summary 1st da record by Dr Bob. Temp. 102 - 99⅖ Pulse 104-72 Resp. 30-17. Appetite poor first few days. later improved some. Bowels very constipated: Sleep much disturbed sometimes awake greater part of night often crying. On admission hands & arms bruised. Is very hard of hearing. Usually quiet: Talks quite rationly: Is very melancholy, crying at times during day. Complains of having pain before & after micturition. Feb 2-8 Appeared quite emaciated, Emuls twice. Mch 2 Emuls. Medicine given. Mch 5 up on ward: complains of feeling weak. Mch 6 Assists some with work. Summary continued - Mch 20 Trans. to B3 Apr. 22 Menstruating: Remained in bed: Complains of pain in head & back. Refuses gynecological treatments: Refuses medicine after meals: Bladder irrigated daily with Boracic acid solution: Is neat in habits & appearance: Appetite fair bowels regular: Menstruation regular: assists with work: May 9 Irrigation of bladder discontinued. Visited by husband: Aug 30 Expresses delusions: Is often depressed during menstruation; is quite hysterical: very silly: refuses to have her hair combed & runs about ward: (Sept.) Trans. to Inf: very melancholy: T. P. R. about normal: appetite poor: fed by nurse: bowels constipated: receives medicine & lavations: rather restless & contrary: part of time refuses food: Sept. 16 Up and dressed: Oct. 15 No special change since last note: Trans. to B3: Nov. 30 Does some dining room work: Is about the same both mentally & physically: Imagines that there is a butterfly in her head & ear. Dec 1 - Feb 28 1900. Dr. Heyrdale) Is quiet & quite agreeable: Neat in habits: Assists some with work: Appetite fair: menstruates regularly: Jan 15 Wt. 178 #. Feb 28 Becoming very irritable: Scolds & seems very angry at times.

Personal and Medical History of Mary Larson #2.

Expresses many delusions. Nch 1 - Nov 30 1900 Apr 9. Visited by friend: Has many delusions & expresses them freely: Says she has a butterfly in her head: & that she hears voices talking to her: Menstruates regularly: Occasionally somewhat destructive of clothing Apr 3. Attacked nurses: held for a time: June 14 Attacked nurses: Neat: appetite good: July 21 Vaccinated. Nov 21 Wt. 122 #. Dec 1 - Feb 28 1901. General health good: Occasionally somewhat disturbed Wt. 112 #.

Mar. to June 1901. Mar. 4 visited by husband, no change in mental or physical condition, May 31 Wt. 116½ #. June to Sept. June 13 visited by husband, general condition remains unchanged, Aug. 31 Wt. 112 #.

Sept. to Dec. Patient is quite deaf, expresses many delusions and hallucinations of hearing, thinks she is being more or less persecuted, does not read or converse, appetite fair, general health fair, bowels regular, takes out door exercise, occasionally attacks other patients, and is violent with nurses. July 22 trans. to C. 3 West. occasionally is destructive and tears up table covers Sofa pillows and plants.

Dec to Feb 1903 No change. Wt about 110 #. Dec. 3, '01 visited by a friend. Apr. 2-02 - and 23rd visited by friends. Jan. 22nd patient fought nurses. Jan. 23rd visited by friends.

Personal and Medical History of Betsy Nelson.

Whole No. 5257

Residence, Albert Lea. Minn.

Date Admission, March. 14' 1899.

Admitted by Dr. P.M. Phelps. hour, 5th P.M.

How Sent, St. P. Packet & St. P. & Freeborn Co.

Sex, Female Age, 26 yrs.

Civil Condition, married.

Children, 2.

Age Youngest Child, -

Occupation, Housewife

Degree Education, Has been a school-teacher.

Profession, Religion, Lutheran.

Habits, Not intemperate.

~~Nationality~~ Nativity U.S. (Parents born in Norway)

Physicians Committing, G.G. Bard & Henrik Kivesy.

Correspondents,

No. of Years, 150

Insane Relatives, Mother had an attack years ago.

Cause Exciting, Overwork, + measles + abscess of ear -

Cause Predisposing, Heredity.

Form, Melancholia with Delusions

Accompanying Bodily Disorder, Had measles

Suicidal or not, Not.

Date of this Attack, Several months ago.

Duration, Several months -

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 26 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. P.M. Phelps *Date of* 3/2/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Dull - Will not talk.

MEMORY, Past Events,

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, No history obtained

Paternal Relatives,

Mother, Will not talk

Maternal Relatives, say.

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

In case Mrs. Betsy Nelsons husband wishes to take her home, notify her father, (his regent) before allowing her to go.

June 26 1899

(Fathers address)

Mr. Thorsten Morris

Manchester

Box 63. Minn

tory of Betsy Nelson.

PHYSICAL CHARACTERISTICS.

EIGHT, 112 lbs. USUAL WEIGHT, NUTRITION, Fair.

tin, Sore on neck. Some on arms + legs - not very deep but many - as if held.

ent, Fairly clear.

and Accommodation, Equal.

other troubles,

Legs, Grasp,

General, Normal.

Other Reflexes,

w,

Normal - Regular.

ARTERIES,

No notable atheroma. Pulse of considerable tension

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitalia normal except laceration of perineum. extensive laceration of cervix. Eversion of ant + lower lip of cervix everted. Whitish milky leucorrheal discharge

MENSTRUATION, History of menstruation can not be obtained.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Part of time lies in dull way as if asleep. Today will not talk at all. No sign of bodily ailment. On first coming - exam of urine made - Sp.g 1040 Sugar found - March 21 Sp.g. 1014 - some pus + albumen.

Personal and Medical History of Betsy Nelson

Whole No. 5257

Residence, Albert Lea. Minn.

Date Admission, March. 14' 1899.

Admitted by Dr. P.M. Phelps. hour, 5th P.M.

How Sent, H.B. Clackner Sh. P. Freeborn Co.

Sex, Female Age, 76 yrs.

Civil Condition, married.

Children, 2.

Age Youngest Child, -

Occupation, Housewife

Degree Education, Has been a school-teacher.

Profession, Religion, Lutheran.

Habits, Not intemperate.

~~Nationality~~ Nativity U.S. (Parents born in Norway)

Physicians Committing, G.B. Barck & Henrik Kinsey.

Correspondents,

No. for

In

A

Suicid

Date of th

Duration, Dep

No. of Attack,

No. of Admission,

Age First Attack, 76 yrs

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. P.M. Phelps Date of 3/17/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Dull- Will not talk.

MEMORY, Past Events,

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, No history obtained. Will not talk.

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of Betsy Nelson

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5 PRESENT WEIGHT, 112 lbs. USUAL WEIGHT, NUTRITION, Fair.

WOUNDS, Abnormalities and condition of Skin, Sore on Neck. Some on arms & legs - not very deep but many - as if held.

TONGUE, Coatings or Promptness of Movement, Fairly clear.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal.

SIGHT, Good (Supposedly)

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Normal.

COORDINATION, Arms, Normal. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Normal.

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Normal - regular.

ARTERIES,

No notable atheroma. Pulse of considerable tension

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal except laceration of perineum. Extensive laceration of cervix. Erosion of os & lower lip of cervix everted. Whitish milky leucorrheal discharge

MENSTRUATION, History of menstruation can not be obtained.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Part of time lies in dull way as if asleep today will not talk at all. No sign of bodily ailment. On first coming - exam of urine made. Sp.g. 1040 Sugar found- Much vi. Sp.g. 1014 - some pus & albumen.

Personal and Medical History of Betsy Nelson.

1899

This patient was brought here by Sheriffs deputy W.C. Mitchell attended by James P. Nelson in fair physical condition, with the following history:- No information concerning consanginity, Mother had attack of insanity years ago: First symptoms appeared during past few months has at times exhibited fears of things not existing: Talks incoherently: Disease appears increasing: Is variable: Derangement now manifested by fears that someone will hurt her: Talks incoherently: has hallucinations & delusions: Not disposed to injure anyone: Nor to filthy nor destructive habits: No previous peculiarities noted, Two years ago had measles & abscess of the ear. was confined in house two weeks: Has been given narcotics with some quieting effect. On personal examination is morose - talks irrationally is quiet. On admission put upon Infirmary Mrst (Gth Dpt. Complexion dark: hair & eyes brown. Skin in normal condition: Ulcers on back of neck, under arm & on left hand. Large bruises on arms & legs: So clean: Behavior quiet: does not speak English.)

3/14/99

3/14 5/3/99 Summary 1st da record by Dr Bebb. Temp. 98-100 Pulse 66-100 Resp. about normal: Appetite usually quite good: Mch 16 Refused breakfast: Bowels inclined to be constipated During first week frequently necessary to catheterize her as she seemed unable to urinate: Eminent applied to Breast: Usually sleeps quite well: is occasionally noisy & out of bed: Quite noisy & talks incoherently: is excited & restless at times. After Mch 19 became more quiet, Leaving only occasional excited spells. Apr. 16 Trans to C1. June 26. Appetite has been good: sleeps well. Takes outdoor exercise: Very noisy & incoherent.

June Mental condition seems to have improved somewhat. Today transferred to Infirmary. Dec. 99 Patient quiet: usually fairly cheerful but at times quite depressed. Is neat about her person: Comprehends readily & helps daily with ward work: Physical condition is quite good: Mental condition has improved. Visited frequently by husband & sister & on June 26 by parents.

Sept 1- Feb 28 1900 (Dr Heyndale). Dec 3 & 17. Visited by sister Nov 10 & 11 by husband: 2 Feb 00 - Works some on ward: Expresses many delusions: Seems depressed & cries: Talks rather incoherently: Bowels constipated At times noisy & sleeps poorly: Feb 27. Operated upon by Dr Bebb. Permanent hernia - under direction of Dr Mayo. Recovery uneventful Began sitting up on March 21st. Up & dressed after the 29th.

May 3 Trans. to A3. Appetite fair: Bowels somewhat constipated: Sleeps well Irritable & noisy at times. Conversation incoherent. May 27 Visited by husband: June 21. Quite disturbed: Trans. to B2. July 21 Vaccinated: Aug 23 Visited by parents Aug 28-29-31 by husband. Assists in dining room: Is inclined to stay by herself. Nov 10. Wt. 147 1/2 # Dec 16 - Feb 28 1901 Visited by husband: General health good: Occasionally much disturbed & scolds violently

Feb 26 Wt. 148 1/2 #

Personal and Medical History of Betsy Nelson.

Mar. to June 1901 Mar. 28 and 29 visited by husband, general health remains unchanged. May 29 Wt. 140#. June to Sept: No change in mental or physical condition, July 30 Wt. 136 1/2 #. Sept. to Dec. Nov. 25 visited by two friends, patient in good physical condition, as a rule eats and sleeps well, takes regular out of door exercise, assists with ward work, menstruates regularly. At times she becomes disturbed mentally when she is noisy and scolds a great deal and threatens other patients, although she never harms them, expresses many delusions of persecution occasionally pounds herself with her shoe and uses vulgar language answers questions intelligently. Dec. 28 & 29 visited by husband. Dec. 30 taken home by husband. Nov. 25 Wt. 129 1/2 #.

Dec. to Feb. 1903 No change Wt about 133 # June 25-28, '02 patient went camping at Oronoco. Aug. 1st visited by sister.

Personal and Medical History of Hattie Stewart.

Whole No. 5759	No. of Years, 15 Y
Residence, St. Paul, Minn.	Insane Relatives, Unknown
Date Admission, March 16 1899.	Cause Exciting, Unknown
Admitted by R.A. Bess M.D. hour, 6 P.M.	Cause Predisposing, Unknown
How Sent, Ell. Bazille. Jof P. Ramsey Co.	Form, Melancholia Agitans, Acute
Sex, Female Age, 47 yrs.	Accompanying Bodily Disorder, None mentioned.
Civil Condition, married.	Suicidal or not, Propensity probably active.
Children, none.	Date of this Attack, 8 Months ago.
Age Youngest Child, —	Duration, 8 mos
Occupation, Housewife.	No. of Attack, 1st
Degree Education, Common school.	No. of Admission, 1st
Profession, Religion, Presbyterian.	Age First Attack, 47 yrs.
Habits, Not intemperate.	Time of Leaving, June 27. 1899
Nationality, Vermont. (Parents born in U.S.)	Time in Hospital, 3 m. 11 d.
Physicians Committing, Ad. Whitcomb — Arthur Storey.	Result, Discharged Dec. 27. 1899 Recovered.
Correspondents, F.J. Stewart (husband) 976 Ramsey St. St. Paul Minn.	

EXAMINATION ON ADMISSION BY DR. R. N. Phelps *Date of* 3/22/99

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, } Clouded by delusions.
Recent Events, } Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dulled

REASONING POWER, Ordinary Subjects, } Poor.
Special Subjects, }
Own Mental State, }

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed & somewhat agitated.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 1 year.

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Husband says no heredity.

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None given.

HABITS, Drinking and Smoking, Good

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,
Fair health before attack.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7. PRESENT WEIGHT, 129 lbs. USUAL WEIGHT, NUTRITION, Fair

WOUNDS, Abnormalities and condition of Skin, Very small scar on left arm. Small bruise on legs & arms. Otherwise normal

TONGUE, Coatings or Promptness of Movement, Some coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Reg. normal.

SIGHT, Normal.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Normal.

COORDINATION, Arms, Normal. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None noted.

PATELLAR REFLEX, Exaggerated 8-9. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Fairly normal.

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Normal -

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal except laceration of perineum. Uterus adherent to right. laceration of cervix - Thick yellowish leucorrhoeal discharge. Cyst in cervix.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient said she began by using Planchette Board over a year ago. Gradually came to believe implicitly in it, then to believe in Spiritualism & in last few weeks to have delusions. Is now exceedingly restless in every way & full of vague fear. Has appearing intelligent. Seems in fair health.

Personal and Medical History of Katie Stewart.

1899

This patient was brought here by Mr Stewart, as sheriff's deputy. attended by Mr & Mrs. Putnam, in fair physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor his parents: First symptoms of insanity manifested 8 wks ago - began to hear voices & to become excited & melancholy: Disease appears stationary: Not variable: Derangement now manifested by believing that people are killing others in her room. Sees men in closets & under beds, & hears voices. Is melancholy, taciturn & irrational: Not disposed to injure anyone: No filthy nor destructive habits, previous peculiarities nor severe diseases nor injuries to head: Was at St. Joseph's Hospital, St Paul, for five wks: Treatment pursued - restraint, nourishment & tonics. On personal examination is quiet & taciturn, moans, occasionally searches closets for strange men, & is generally depressed. On admission put upon Infirmary Diet (Std. Rft) Complexion dark: hair brown, part gray: Eyes gray: Skin in normal condition: Small ulcer on left elbow: A few small bruises on legs: Is clean: Very nervous, resisted being bathed: Refused to answer questions.)

3/16 to 3/29/99 Summary 14 day record by Dr. Bibb. Temp. about normal: Pulse 72-110 Resp. normal: Appetite very poor. Refused to eat for several days & was fed by tube: after Mch. 21 Appetite improved & she took a fair amount of nourishment: Bowels constipated, enemata & salts given as needed: Quite restless & out of bed frequently & tried to get out of room when door open: Sleep often disturbed: Some nights bring up out of bed for hours: Mch 19 Up on ward: walks about: seems very much excited and tries to get out of door: Insists everything done for her: Mch 20 Has bruise on right leg above knee: Is menstruating. Mch. 25 Noted as being more quiet during day, but still resistive.

Summary continued Apr. 1 Visited by husband: Was out with him part of day. Menstruation regular: Neat in habits & appearance: Has many delusions. Went home -

Discharged

Personal and Medical History of

Personal and Medical History of Mrs. Haga Hay.

Whole No. 5760

Residence, Freeman Pk. Lincoln P.O. Minn.

Date Admission, March 21 1899.

Admitted by Dr. R. M. Phelps. hour, 5th Bm.

How Sent, H. Blackmer & of B. Freeborn Co.

Sex, Female Age, 64

Civil Condition, Widow.

Children, Five.

Age Youngest Child, 23 yrs.

Occupation, Housewife - (Husband a farmer)

Degree Education, None.

Profession, Religion, Lutheran.

Habits, Not intemperate

Nativity, Nationality, Norway (Parents also born there)

Physicians Committing, G.G. Belcheim & Ab. Weiler.

Correspondents,

No. of Years, 153,

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, "

Form, Melancholia

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, 6 mos. Ago,

Duration, 6 mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 64 yrs.

Time of Leaving, Dec. 2 1900.

Time in Hospital, 1 yr. 8 mo. 29 da.

Result, Discharged. Improved. May 1 1901.

EXAMINATION ON ADMISSION BY DR. R. M. Phelps *Date of* 3/22/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Dull & confused.

MEMORY, Past Events,

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed & dull.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, History not obtained from her

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of Mrs. Haga Hay.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4" PRESENT WEIGHT, 153 USUAL WEIGHT, NUTRITION, Fair.

WOUNDS, Abnormalities and condition of Skin, both heels sound but frozen.

TONGUE, Coatings or Promptness of Movement, Fairly normal.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. normal.

SIGHT, Seems good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Normal.

COORDINATION, Arms, Normal Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Impulse, Apex Beat, Regularity, fairly regular

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Laceration of perineum, otherwise external genitals normal- Cystocele & rectocele present. Mucous polipi. Uterus adherent to right- irregular laceration of cervix. Vaginal orifice inflamed.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient is rather dull & depressed. Has heart lesion above noted, but no direct symptoms from it. Is depressed & uneasy.

Personal and Medical History of Mrs. Kaga Hay

1899.

This patient was brought here by Sheriff McMitchell attended by John T. Hay, in fair physical condition, with the following history: No history of consanguinity or heredity: and no intemperance known in patient nor her parents: First symptoms of insanity manifested in September 98. appeared out of her head & wanted to go away. Disease appears increasing, not variable. Manifested by general delusions & mania. Has a fear that for safety of her son in Dakota, whom she thinks has been murdered, also her other children. Talks irrationally: No disposition to injure anyone: Shows slight tendency toward filthy & destructive habits: No previous peculiarities manifested: No severe diseases nor injuries to head: Has required constant watching since last September to keep her from running away. No treatment pursued.

3/21/99 On personal examination appears stupid & melancholy, talks, but says nothing that is rational. On admission put upon Infirmary West (Gth Dpt. complexion dark: Hair brown, eyes blue. Skin in normal condition: Small scar on nose: Both heels sore, have been frozen: Is very dirty: Behavior maniacal: Speaks very little English.)

3/21/99 Summary 14 day records by Dr Bibb Temp 98°-100.4° Pulse 72-108 Resp. 18-30. Appetite
4/6th/99 good: Bowels usually regular. Usually sleeps well: Mch 22 Has sores on feet, caused by being frozen, which are dressed daily: Talks quite sensibly.
Apr 3 Out of bed most of day. Quite noisy.

4/24/99 Summary Continued. Apr 27 Visited by son. July 28 Do. Aug 27. by Robt. Is very rest-
to less & noisy at times: untidy in appearance: Appetite not so good:
Sept 1/99 May 10 Trans. to A'. At times refuses nourishment & is fed mechanically: Continues very restless June 10 Takes meals: June 15 Trans. to B'. Has many delusions which she expresses freely. Is given gyn. treatments: Is often noisy during night: Tries to escape when taken out of doors.

Sept 1 Feb 24 1900. (Dr. Heyndale) Nov 27. Visited by son. 29 Very active & restless & noisy at night. Bowels quite regular: Jan 18 Wt. 104# Feb 28 Talks Norwegian: Has many delusions: Thinks those about her are members of her family: Seldom sits down. Mch 1- Nov 30 1900. Quite feeble & often has to go to bed but when up walks up & down hall continually: has delusions: Appetite is poor: Bowels irregular: laxatives given: Has organic heart trouble & seems to be troubled frequently with pleuritic pains. Walks with left shoulder drawn down a great deal of time: Takes outdoor exercise. July 16 Vaccinated. Aug 3. Swelling noticed on wrist-wrist bandaged. Sept 10 Had a severe diarrhoea: Trans. to Infirmary: Given liquid diet. 17 Much improved: Trans. to B'. Oct. 21 Very feeble. Trans. to A'. Nov 16 Wt. 107# Dec 20 General health fairly good: Takes outdoor exercise. Behavior quiet. Dec 20 Taken home by son.

Personal and Medical History of

Personal and Medical History of Adolphine Schmidt.

Whole No. 5263

Residence, Jamesville, Minn.

Date Admission, March 22nd 1899.

Admitted by Dr. R. A. Rebbs. hour, 4 PM.

How Sent, Ge. A. Wilson Dep. Waseca Co.

Sex, Female Age, 28

Civil Condition, Married

Children, 3.

Age Youngest Child, 3 mos.

Occupation, Housewife (Husband a draygman)

Degree Education, Common school.

Profession, Religion, Lutheran.

Habits, Not intemperate.

~~Nationality~~ Nativity, Germany (Parents also born there.)

Physicians Committing, M. J. Taylor & F. A. Brantmadt.

Correspondents, Henry Schmidt Jamesville, Minn. (Husband.)

No. of Years, 156

Insane Relatives, None.

Cause Exciting, Probably indirectly result of childbirth.

Cause Predisposing, —

Form, Acute Melancholia

Accompanying Bodily Disorder, Operation on cervix & for prolapsus 3 mos. ago.

Suicidal or not, Not

Date of this Attack, Mch. 20th '99

Duration, 2 days.

No. of Attack, 1st.

No. of Admission, 1st.

Age First Attack, 28 yrs.

Time of Leaving, May 4th. 1899

Time in Hospital, 1 mo. 12 d.

Result, Discharged Oct. 31. 1899

Received

EXAMINATION ON ADMISSION BY DR. R. H. Phelps *Date of* 3/23/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Slightly confused

MEMORY, Past Events, Quite good -

Recent Events, " " Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Not dull - Incorrect.

REASONING POWER, Ordinary Subjects, Quite good.

Special Subjects, Impaired -

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed - occasionally very restless and threatens suicide -

DELUSIONS, Systematized, Transitory, Special Subjects,
Afraid of something, don't say what. Don't tell freely

HALLUCINATIONS, None apparent.

ILLUSIONS, " "

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Short

ONSET, Gradual or Sudden, Acute

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Heredity denied by Husband
Father, Living. Healthy -

Paternal Relatives,

Mother, Dead - always sickly

Maternal Relatives,

7 Brothers and 3 Sisters,
1 Unknown 3 Children living

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None noted except childbirth & Operation

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,
None or less since baby was born in January

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,
Said to be in good health

Personal and Medical History of Adolphine Schmidt.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 PRESENT WEIGHT, 120 USUAL WEIGHT, NUTRITION, Normal.

WOUNDS, Abnormalities and condition of Skin, Normal.

TONGUE, Coatings or Promptness of Movement, "

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal.

SIGHT, Good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good

COORDINATION, Arms, Normal- Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

4/7/99 GYNECOLOGICAL EXAMINATION, External genitals normal - uterus normal position leucorrhoea slight Dr. Mayo - operated 3 mo. previous to admission (Alexander's operation - repair of cervix & perineum)

MENSTRUATION, usually regular. but painful. Pain previous & menst. ceasing when flow begins Subject to headache.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient quite healthy in appearance. Said to have seemed quite well for past year but "nervous" since baby was born. Operation about one month ago. was thought to have recovered well. After coming home seemed afraid - Went away from home. Supposedly to father but wandered about in cold. Now appears slightly reserved. Seems apt to be afraid but can't say of what.

Personal and Medical History of Adolphine Schmidt.

1/6/99

This patient was brought here by Sheriffs deputy Michael Ryan, attended by Henry Schmidt (husband) in fair physical condition, with the following history: No history of consanguinity, heredity or intemperance in parents or self: First symptoms of insanity manifested Monday evening Mch 20th Ran away from home & was out in the cold 3 hours or more, must 3 or 4 miles into country. Disease appears increasing: So rambles with irregular rational intervals. Derangement manifested on no particular subject. Tries to run away from so constant watching is necessary. Not disposed to injure anyone. Not disposed to filthy nor destructive habits. No previous peculiarities noted. No severe diseases nor injuries to head - 3 Wks. ago was operated upon for lacerated cervix & prolapsus. Has been restrained at home since Monday, March 20th. On personal examination no further facts noted.

3/22/99 On admission put upon Infirmary (Gen Rpt Hair & eyes brown: Complexion dark: Skin normal condition: Small bluish mark on upper part of left leg. On each side of abdomen caused by an operation: Small bruise on nose. Is clean: Behavior quiet: Talks intelligently.)

3/23/99 to 4/5/99 Summary 14 days. Record by Dr Bebb. Temp. 98°-100. Pulse 74-130 Resp. 18-30. Appetite good: Bowels usually regular: Quiet in behavior: Talks quite sensibly: Threatens homicide & suicide. Mch 23 Tore sheet during night: Very nervous & excited: Threatens to hang herself & to kill others: Very melancholy: Face flushed & quite restless: Usually rest is broken & she sleeps poorly: Apr 1 Assists with ward work: Is more quiet: Apr 3 Goes walking. Apr 12 Visited by husband.

May 4 Summary continued. Neat in habits & appearance: Went home on trial today.

Discharged.

Personal and Medical History of

Personal and Medical History of Mrs. Mary Aden.

Whole No. 5768

Residence, Leon, Goodhue Co. Minn.

Date Admission, March 29th 1899.

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

How Sent, Asst. Hallen Dept. Goodhue Co.

Sex, Female Age, 36 yrs.

Civil Condition, Married.

Children, None.

Age Youngest Child, -

Occupation, Housewife.

Degree Education, Common school.

Profession, Religion, Lutheran.

Habits, Not intemperate.

~~Nationality~~ Ustinty, Norway (Parents also born thus.)

Physicians Committing, Became resident of State 1866 in 1866 J. Thoreson & M. Evans.

Correspondents, Husband - Leon, Goodhue Co. Minn.

No. of Years, 161

Insane Relatives, Two brothers & maternal uncle.

Cause Exciting, Religious excitement.

Cause Predisposing, Unknown

Form, Acute delirium.

Accompanying Bodily Disorder, Unknown.

Suicidal or not, Not.

Date of this Attack, 9 days ago.

Duration, 9 days.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 36 yrs.

Time of Leaving, Apr. 3rd. 1899

Time in Hospital, 10 da.

Result, Died. Acute Delirium.

EXAMINATION ON ADMISSION BY DR. ..... *Date of* .....

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Confused - quick.

MEMORY, Past Events, Impaired.

Recent Events, " Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Alert - illusive.

REASONING POWER, Ordinary Subjects, Imp.

Special Subjects, "

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Very restless & agitated

DELUSIONS, Systematized, Transitory, Special Subjects,

of persecution.

HALLUCINATIONS, None apparent.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Nine days.

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives, uncle insane

Brothers and Sisters, 2 brothers insane.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

?

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, ——— PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION, Much impaired

WOUNDS, Abnormalities and condition of Skin, Eruption on lower part of back - bruises on arms & legs - Small sore on nose

TONGUE, Coatings or Promptness of Movement, Skin dry -

PUPILS, Equality, Size, Response to Light, and Accommodation,

SIGHT,

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING,

COORDINATION, Arms, Unable to make tests Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION,

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Much disturbed

BOWELS, Present Condition, Not constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Maniacal on admission & talked incoherently. The first night extremely restless. T. 103°. Gradually becomes more & more delirious & muttered to herself. Struggled almost constantly when awake. Physical condition much impaired.

Personal and Medical History of Mrs. Mary Aden.

1899

This patient was brought here by Sheriffs deputy Cow. Drs. attended by O Falkenquist & Miss Lundquist in fair physical condition, with the following history:- No consanguinity in family: Mr brothers & maternal uncle insane: First symptoms of insanity manifested nine days ago by loss of memory & delusions of persecution: Disease appears increasing: not variable: Derangement now manifested on religious subjects - thinks she is eternally condemned: Not disposed to injure anyone: Habits filthy & destructive. Previous peculiarities predominant religious impressions. No severe diseases nor injuries to head. Manual restraint has been employed. No information concerning treatment. On personal examination is restless, emaciated, mutters to herself, answers no questions. On admission put upon Infirmary diet. (Typh. Pat. Complexion dark: hair brown: eyes blue: Skin in normal condition: Eruption on lower part of back: small sore on nose: Bruises on legs & arms: Is dirty: Behavior maniacal: Talks incoherently.)

3/22/99 Summary 1st day. Record by Dr. Bebb. Patient extremely noisy resisted being put in restraint on admission - Temp. 102-104°. Pulse 104-150 Resp. 30-40. Takes milk & broth quite well usually. Mch 28 necessary to feed her mechanically: Bowels more frequently. Struggles continually when awake: Quite noisy at times: Hot baths given as needed, with cold applications to head: Sleeps only a few hours at a time

3/22/99 to 4/5/99

Mch 29. Back bathed with alcohol & dusted with boracic acid:

Mch 28 Much Pulse weak & rapid, continues very restless & struggles continually. Seems quite weak. Mch 29 to Apr. 3 Out of restraint 2 days. Temp. from 98° to 104°. Pulse 120-150. Resp. 29-36. On Milk diet. Occasionally refuses milk. Apr. 1, 2, & 3rd fed by tube. Medicine given by mouth & hypodermically. Bowels more less frequently: usually once a day until Apr 3rd. Continues very restless & quite stupid part of time. So noisy when awake & sleep is still much disturbed. Had to be held in bed & put back in restraint Mch. 31. Apr 1 Has difficulty in swallowing; limbs cold. Apr 2 Seems better: Talks a little. Slight haemorrhage from bowels. Apr 3 Two slight haemorrhages from bowels: Appears to be in stupor. Pulse weak: Respiration difficult. Remained in comatose condition until 11:15 PM. When she died.

Died.

Personal and Medical History of

Personal and Medical History of Annie Bladon.

Whole No. 5769
Residence, St. Paul, Minn.
Date Admission, March 28th 1899
Admitted by Dr. R.M. Phelps hour, 6th P.M.
How Sent, Est. Bazille J. of P. Ramsey Co.
Sex, Female Age, 21 yrs.
Civil Condition, Single.
Children, none
Age Youngest Child, -
Occupation, Housework. (Father a carriage painter)
Degree Education, Common school.
Profession, Religion, Catholic
Habits, Not intemperate.
~~Nativity~~ Nationality, Iowa - (Father born in Bohemia - Mother Moravia)
Physicians Committing, F.H. Ondahl - V.J. Hawkins
Correspondents,

No. of Years, 1½.
Insane Relatives, None.
Cause Exciting, "Melancholia"
Cause Predisposing, Unknown.
Form, Stuporous Melancholia.
Accompanying Bodily Disorder, none mentioned
Suicidal or not, Has talked of it.
Date of this Attack, 6 Mos. ago.
Duration, 6 Mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 21 yrs.
Time of Leaving, August 12 - 1901
Time in Hospital, 2 yrs + nine 15 ds
Result, Improved
Discharged Feby 26 - 1902
By Board of Control

EXAMINATION ON ADMISSION BY DR. Bebb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Sluggish - confused.
MEMORY, Past Events, Impaired on some subjects.
Recent Events, " Special Subjects, Imp.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull. probably illusive.
REASONING POWER, Ordinary Subjects, Fair.
Special Subjects, Poor.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent.
DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any at this time.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Dead
Paternal Relatives,
Mother, Living.
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says none
HABITS, Drinking and Smoking, no.
HEADACHES, VERTIGO, OR CONVULSIONS, no.
OCCUPATION, Healthy or not, Packer in confectionary factory
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, —— PRESENT WEIGHT, —— USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, Cool - moist
TONGUE, Coatings or Promptness of Movement, Clear + prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size dilated - very ready response to light - & accom. R&L
SIGHT, Quite good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Says good.
COORDINATION, Arms, Fair Legs, fair. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, none
PATELLAR REFLEX, Diminished + delayed. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, distinct - hesitating - slow to commence - usually needs considerable urging
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Touch diminished
HEART, Murmurs, Strength, Sounds, Size, N.
Apex Beat, N. Regularity, regular.
ARTERIES,
Normal.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical.
Expansion fair -
B. Sounds bronchovesicular

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Labia majora hypertrophied - external genitals otherwise normal. Uterus normal position Cervix club-shaped.
MENSTRUATION, Cannot obtain history
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, good.
BOWELS, Present Condition, Quite regular.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Is indifferent: very stupid: as a rule face nearly devoid of expression - if spoken to loudly or quickly she sometimes shows a little interest, occasionally answering question - She seems to appreciate + enjoy any amusing incident + smiles - Very dreamy expression - Inactive - sitting idly about from morning until night. Physically gaining - moves with reluctance - Often leaves hands + herself in whatever position placed until it is moved. Picks in sprinkles with face + eyes -

Personal and Medical History of Annie Madon.

1899

This patient was brought here by Sheriff's deputy St. Flandrau, attended by Mr. & Mrs Hanson in fair physical condition, with the following history: No consanguinity nor heredity known in family: First symptoms of insanity manifested six weeks ago by acting strangely: Disease appears increasing: Is variable in rational intervals: Derangement manifested on subject of matrimony: Insists upon marrying a stranger: Not disposed to injure anyone: No destructive habits but wets bed: No previous peculiarities manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: Has been given laxatives & tonics - no effect.

Mch 8 '99 On personal examination - refuses to eat, talk or take exercise. On admission put upon Infirmary - (Ft. M. Rpt Complexion dark: hair light brown: eyes blue: Eruption on face: Is clean: Behavior quiet. Refused to speak.)

3/29/99 to 4/1/99 Summary 14 da. Records by Dr. Bebb. Temp. 99°-101°. Pulse 76-102 Resp. 18-24. Refused to walk or speak on admission Fed with tube: bowels constipated & salts given by tube as needed. enemata also given. Seems unable to urinate & necessary to catheterize her twice: usually sleeps well since first night is quiet in behavior; in fact quite stupid: Breath is very offensive & there is a continual discharge from mouth resembling pus streaked with blood: Does not talk: untidy in habits: at times refuses to walk & at others walks lame. Summary continued May 9th Visited by cousin July 5 & father & mother June 5. Appetite improving: bowels regular.

July 15 Trans. to D. Aug 17 Is improving mentally & physically: Appetite is good & bowels regular: sleeps well. Assists a little with ward work: Seldom speaks but will occasionally answer questions & shows by expression that she understands. Sept. 1 - Feb 28 1900 (Dr. Keyerdale) Very quiet. Untidy: Bowels regular: Menstruates regularly: Eats & sleeps well: Jan 12 Wt. 192 lbs. Takes out door exercise. Mch 1 - Nov 30: 1900. Neat: Has delusions: Is quite stupid but will at times answer questions Quite agreeable in behavior: General health good: Appetite good: Sleeps well: Menstruates regularly. Takes out door exercise. July 3-4 Visited by parents July 21 Vaccinated. Nov 13 Wt 135 lbs Dec 1 - Feb 28 1901 General health good: Does no work: Mch 3 Wt. 136 lbs

Mar 1 - June 1 - 1901 Mar. 31 patient tried to choke herself with a neck tie she had on; refused to eat is fed with a tube. April 4 transferred to Infirmary while there patient was put on ward & assisted with work; appetite fair; bowels regular; sleeps well; menstruates: habits neat; seldom converses: quiet in behavior. Apr. 18 transferred to D 3 from this time on through May refused to eat fed artificially until May 14 when she began to eat again. Appetite now seems quite good. May 30 Wt. 144 lbs

Personal and Medical History of Anna Madon

June 5 to Sept 1901 July 3-4 visited by father and mother, is quite clean in habits, assists with ward work, takes out door exercise, does not converse, but seems to understand when addressed, menstruates regularly, sleeps well, Aug. 12 went home.

Discharged

Personal and Medical History of Mary Haberkorn.

Whole No. 5270
Residence, St. Paul, Minn.
Date Admission, March 28th 1899.
Admitted by Dr Rm Phelps. hour, 6th PM.
How Sent, Ems. Bazille L of P. Ramsey Co.
Sex, Female Age, 37 yrs.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Domestic. (Father a merchant)
Degree Education, Common school.
Profession, Religion, Roman Catholic.
Habits, Unknown.
Nationality, Germany (Parents also born there)
Physicians Committing, Fredk Leavitt & Ara Whitney.
Correspondents,

No. of Years, 163
Insane Relatives, Mother, brother & sister.
Cause Exciting, ?
Cause Predisposing, Heredity & previous attack.
Form, Defective Imbecile
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not
Date of this Attack, about 10 days ago.
Duration, About 10 days.
No. of Attack, 2nd
No. of Admission, 2nd
Age First Attack, 31 yrs.
Time of Leaving, July 5. 1899
Time in Hospital, 3 m. 7 d.
Result, Discharged Feb. 7. 1900 Improved

EXAMINATION ON ADMISSION BY DR. Bebb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Slightly confused & slow.
MEMORY, Past Events, Quite good.
Recent Events, " Special Subjects, Rather poor.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Somewhat dull. Fairly correct.
REASONING POWER, Ordinary Subjects, Fair
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Mildly exalted - rather dreamy.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, About 10 days.
ONSET, Gradual or Sudden, gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, died consumption.
Paternal Relatives,
Mother, had puerperal mania.
Maternal Relatives,
Brothers and Sisters, Brother & sister insane - Sister in Minnesota Hospital 4 yrs.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches
OCCUPATION, Healthy or not, Domestic.
Detail Date, Duration, and Character of Previous Attack, if any,
Apr. 13/93. Duration 1 yr. In Hospital 1 mo. 16 da. Acute mania
Sleep, Appetite, and Bowels, Fair Fair Usually regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1 in. PRESENT WEIGHT, 110 lbs. USUAL WEIGHT, NUTRITION, Fair.
WOUNDS, Abnormalities and condition of Skin, Skin normal.
TONGUE, Coatings or Promptness of Movement, E
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal.
SIGHT, Quite good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Quite good.
COORDINATION, Arms, Fair Legs, Fair Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Slow & slightly slurred.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
ARTERIES,
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal - local tenderness.

MENSTRUATION, Always regular. More restless & nervous during menstrual period. Says often has pain over left ovarian region.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, good.
BOWELS, Present Condition, Usually regular - occasional laxatives given

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Mental grade probably always below average. Has appearance of a defective. Sister who came with her also peculiar. Answers questions readily & quite sensibly but is very silly & affected in manner often posing - talks & sings in dramatical way & watches spectators closely to note impression made upon them. Physical condition quite good.

Personal and Medical History of Mary Haberkorn.

1899

This patient was brought here by Sheriff's Deputy W. Claudrake, attended by Sister, in fair physical condition, with the following history:- Nothing known concerning consanguinity: Mother, brother & sister insane. First attack occurred in 1893 & patient was in this (Rochester) Hospital from Apr 13 '93 to May 21 '93 (for further particulars see Vol. VI Fol. 369 No. 3372.) First symptoms of present attack manifested about ten days ago. Disease appears increasing: is variable, with rational intervals at times. Derangement now manifested on subject of religion: Not disposed to injure anyone: No filthy nor destructive habits. Previous peculiarities noted - melancholia - was excited for some time preceding attack. No severe diseases nor injuries to head: No confinement nor restraint employed during this attack - On personal examination is in a continuous state of religious exaltation.

Mch. 28 On admission put upon Infirmary (G. H. Rpt. Complexion dark; eyes & hair brown: Skin in normal condition: Is clean: Behavior quiet: Speaks intelligently.)

3/28 to 4/11/99 Summary 14 day record by Dr. Bibb. Temp. 98 to 101.8 Pulse 66 to 114 Resp. normal: Appetite usually good: Mch 31 refused breakfast. Bowels inclined to be constipated & laxatives given as needed. Usually sleeps well: Patient talks quite sensibly. Apr 1 up on ward. Quiet in behavior: prays a great deal: Is occasionally noisy: uses nasal spray. July 5 '99. Taken home on trial No change in patient since last note.

Letter received from Sister Dec. 18th States that patient is "doing very nicely so far: "the best she knows how" - Not entirely recovered.

Discharged

Personal and Medical History of

Personal and Medical History of Hannah L. Rhode.

Whole No. 5771
Residence, Preston, Minn.
Date Admission, March 28th 1899.
Admitted by Dr. R. M. Phelps hour, 3:45 PM.
How Sent, Ed. Farrington Jo. P. Fillmore Co.
Sex, Female Age, 36 yrs.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Housework. (Father a farmer.)
Degree Education, Common school.
Profession, Religion, Lutheran.
Habits, Not intemperate.
Nationality, Minn. (Parents born in Germany.)
Physicians Committing, G. A. Love & J. H. Phillips M.D.
Correspondents, Wm. Rhode (bro.) Hutton, Minn.
E. A. Erickson Bro. in law - Henrytown Minn.

No. of Years, 164
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, "
Form, Acute mania
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, only by threats.
Date of this Attack, 3 wks ago.
Duration, About 3 wks.
No. of Attack, 1
No. of Admission, 1
Age First Attack, 36 yrs.
Time of Leaving, May 27. 1899
Time in Hospital, 2 mo.
Result, Discharged Dec. 27. 1899 - Improved
Miss M. C. Rhode 629 6th Ave. So. Minneapolis Minn.

EXAMINATION ON ADMISSION BY DR. Bebb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick - Confused.
MEMORY, Past Events, Impaired
Recent Events, " Special Subjects, do.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert. incorrect.
REASONING POWER, Ordinary Subjects, Imp.
Special Subjects,
Own Mental State, ?
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Extremely noisy & restless.
DELUSIONS, Systematized, Transitory, Special Subjects,
on subject of marriage.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.
LENGTH INVASION, 3 Mo.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives, Not obtained.
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Cannot obtain information
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework
Detail Date, Duration, and Character of Previous Attack, if any,
First attack.
Sleep, Appetite, and Bowels, Not good. Constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8 PRESENT WEIGHT, 118 lbs, USUAL WEIGHT, NUTRITION, Impaired
WOUNDS, Abnormalities and condition of Skin, a few small bruises on legs - skin normal.
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation,
SIGHT, Fair.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING,
COORDINATION, Arms, fair Legs, fair. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
ARTERIES,
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal - Uterus normal position.
MENSTRUATION, Usually regular & not painful recently.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, much disturbed.
BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment) Has acute attack of mania, is very restless & noisy & inclined to be destructive, suicidal & homicidal. Mind dwells much on "matrimony." Conversation incoherent. Physical condition much impaired & prognosis looks serious. Nutrition, appetite, sleep poor. Coughs & has slight fever. Urinalysis also reveals presence of albumen, a few blood corpuscles & epith. cells.

Personal and Medical History of Hannah C. Rhodes.

1899.

This patient was brought here by Sheriffs deputy E.A. Erickson attended by Mrs Mary Groth in fair physical condition, with the following history:- No consanguinity, heredity nor intemperance in patient nor his parents found. First symptoms of insanity manifested three weeks ago by mania on subject of marriage: Disease appears increasing: Not variable: Derangement now manifested by desire to marry, is so anxious to marry that she will follow any man she meets, even a black man: No disposition shown to harm any one. Habits neither filthy nor destructive. No previous peculiarities manifested: Had la Grippe three weeks ago: no head injuries sustained. No confinement nor restraint employed: no treatment pursued.

3/29/99. On personal examination had all appearance of acute mania. On admission put upon Infirmary Ward (Ward 1) Complexion dark: Hair dark brown: eyes blue: Skin in normal condition: A few small bruises on legs: Is clean: Behavior quiet: Has delusions.

3/29/99 to 4/11/99 Summary 14 da. record by Dr Robb. Temp. 98°-101°. Pulse 72-104. Resp. 16-28. On admission extremely noisy, pounding on door: Threatening suicide also to kill room mate & nurses. Broke top of heater & marred door: put in single room: Meh. 29-30 Took very little nourishment: Necessary to keep her in sheet part of time: Is menstruating Appetite very poor: necessary to feed her with tube part of time: Bowels inclined to be constipated: salts & enemata given as needed. Apr 6-9 Had difficulty in passing urine; necessary to catheterize her. Sleep much disturbed, some nights out of bed nearly all night & extremely noisy. Talks very incoherently. Meh 31. Complains of feeling chilly. Apr. 6 Complained of pain all over body. Apr 10 Visited by friend Sick record kept until April 29th Pulse 72-105. Resp. 18-28 Still necessary to feed her by tube much of time but gradually becoming quiet. Laxatives still given as needed. Apr. 16 Visited by sister & friends: From this time Continues very noisy part of time & sleep is variable During last week: From April 18-25 Slept quite well & is quieter. Apr 26 Temp. pulse & respiration normal. Is up on ward & talks fairly sensibly.

May 1 Seemed very weak: put to bed. May 8 up on ward tho still weak.

" 27 Went home on trial

Discharged.

Personal and Medical History of

Personal and Medical History of Ellen Mack.

Whole No. 5274

Residence, Austin Mower Co, Minn.

Date Admission, March 29th 1899.

Admitted by Dr. A. F. Kilbourne hour, 6th P.M.

How Sent, S. D. Washburn & Off. Mower Co.

Sex, Female Age, 30 yrs.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Housework (Farmer's daughter)

Degree Education, Catholic school.

Profession, Religion, Catholic.

Habits, Not intemperate -

Nationality, (Nativity) Mower Co, Minn - Father Germany. Mother Ireland.

Physicians Committing, Homer J. Pierson + A. W. Allen.

Correspondents,

No. of Years, 16?

Insane Relatives, None.

Cause Exciting, Menstrual derangement.

Cause Predisposing, Previous attacks.

Form, Recurrent mania

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, ?

Duration, ?

No. of Attack, 3rd

No. of Admission, 3rd

Age First Attack, 21.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Bebb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

not sluggish - confused

MEMORY, Past Events, Fair

Recent Events, Quite good Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Dull - illusive.

REASONING POWER, Ordinary Subjects, Impaired.

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Rather indifferent.

DELUSIONS, Systematized, Transitory, Special Subjects,

Does not express them now.

Is dull, silly, slow to comprehend - Some loss of mile forms

HALLUCINATIONS, No.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Relatives drink but she says not to excess.

Father, Living - has neuralgia -

Paternal Relatives,

Mother, d. about 15 yrs. ago. Had been an invalid for 6 or 7 yrs - was very nervous.

Maternal Relatives,

Brothers and Sisters, Sister very nervous -

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Had lung fever when 8 or 9 yrs old - + subject to colds since.

HABITS, Drinking and Smoking, Drank a great deal. Not subject to headache

HEADACHES, VERTIGO, OR CONVULSIONS, or Neuralgia

OCCUPATION, Healthy or not, Housework.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Inclined to constipation

Personal and Medical History of Ellen Mack.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7 in PRESENT WEIGHT, Not taken USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, Scar on neck from boil. Skin in normal condition -

TONGUE, Coatings or Promptness of Movement, Clear. Prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Size normal - Response good.

SIGHT, Good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Says eyesight is poor at times -

HEARING, good -

COORDINATION, Arms, fair - Legs, good - Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, decided of both hands - some of tongue.

PATELLAR REFLEX, diminished - Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, N.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, No Murmurs, Strength, Sounds, N. Size, N.

Apex Beat, N Regularity, Regular

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest Symmetrical. Expansion fair - T. Frm. Nor. B. Sounds normal



Jan. 1900

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Hypersemia of external genitals, otherwise normal. Hymen lax but intact. Uterus normal position. Commencing haemorrhoids

MENSTRUATION, Regular until 2 mos. ago - usually free from pain - Headache occasionally -

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Good.

BOWELS, Present Condition, Says regular

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Apparently always rather feeble minded - Says stood high in school. General health very good. Incoherent in conversation: Feebleminded + silly in manner.

Personal and Medical History of Ellen Brack.

1899

This patient was brought here by Sheriff's Deputy J.M. Galt, attended by Dr. Allen in good physical condition, with the following history: No history of consanguinity or hereditary known. Patient has been here twice before. From to from Feb'y 9 '98 to May 17 '98 For further particulars see Vol. 15 Fol. 165 No. + Vol. 18 Fol. 277 No. 2931. 1st Strict symptoms of present attack manifested by desire to be undressed + refusing to talk. When she does speak talks incoherently; Disease appears increasing: Derangement now manifested by refusal to talk, remains partly undressed. Has a staring vacant look: Not disposed to injure anyone but does not wish to be molested: Has burned clothing.
Before accession of disease wandered about, ran away from home + gave unsound reasons for her actions: No severe diseases nor head injuries sustained: Has received care + treatment only as above stated.
3/29/99 On personal examination stands staring, refuses to talk + is partly undressed. On admission put upon Infirmary Mst (Gth. Rpt Complexion dark: eyes + hair brown: Skin in normal condition: No marks scars nor bruises noted: Is clean: Very stubborn: Refuses to speak.)
3/29 to 4/12/99 Summary Notes 14 da, Rec. by Dr Bibb. Temp. 98-100. Pulse 60-114. Resp. 17-24. Appetite good: bowels quite regular: Very quiet most of time: Occasionally restless + out of bed + at times resists when having clothing changed: Is untidy in habits: Talks in a silly manner: Coughs a good deal: March 8 Refused to have temp. taken: attempted to fight: Sleeps well. Apr. 12 Trans to 1st.
May 20 Summary Continued Neater in habits + appearance: Assists with dining room work reads some: Takes outdoor exercise part of time: Menstruation regular: occasionally resists + June 27 fought + struggled when being dressed.
July 20 Attempted to escape when out walking. July 21 Trans. to C3. Aug 15 Takes outdoor exercise daily. Trans. to B3. Has improved some mentally + is more agreeable on ward: Assists with work. Dec. 1 '99 Very disagreeable + quarrelsome at times; cries + seems homesick: attends amusements + assists with work. Sept 1 - Feb 28 '1900 (Dr. Heyndale) Neat: Sleeps well: Takes outdoor exercise: Appetite fair: Bowels regular: works in center dining room. Jan 14. Wt. 143#. March - Nov 30 1900 Appetite good: bowels regular: expresses many strange ideas: Menstruates regularly: Refuses to do any work: Thinks she must rest up + go home: July 17 Vaccinated successfully July 24 Visited by brother: 2nd Spent day in town with brother July 28 began working in center dining room: Aug 2 Visited by brother: Aug 4 Becoming somewhat irritable + disagreeable: Sept 20 Expresses delusion that she had a wire in her shoe + it troubled her a great deal: Becoming disturbed - runs up + down + disturbs others Trans. to B3. Became more disturbed. Attacked nurses + struck patients Oct 16. Struck Mrs Cederburg: Oct 28 Trans. to B2. Nov 11. In restraint during

Personal and Medical History of

day. Very violent + noisy at times: Takes little nourishment Nov 30 no change Attempts to get out when door is opened. Dec 1. Feb 28 1901 Dec 12-16 Visited by sister: Fed by tube at times from Dec 4-18. Very quiet: Says very little: Is melancholy: Requires much attention: will not help herself. Feb 21. Improved mentally: Takes more interest in her surroundings Does some work in dining room - Wt. 141#. Improving rapidly to Feb 28.

Mar to June 1901 Mar. 1st. trans. to B.2 patient is agreeable, began working in center dining room. Mar. 25 trans. to A.3, Apr. 8 trans to D1 west. May 20 has been very disagreeable and profane trans. to B.2, May 29 very destructive, scolds at times, is in a condition of stuporous melancholia, refuses to answer questions. Wt. 144#. June to Sept. June 7 visited by sister, patient somewhat disturbed mentally, will converse intelligently at times, general health good, eats well, is still frequently restless at night, takes out door exercise, does no work. June 25 taken out for a drive by her sister, June 26 taken home by sister.
Aug. 19. Patient returned by sister and brother, very resistive and inclined to be violent, Aug. 30 trans. to B.2 West. Wt. 141 1/2 #.
Sept. to Dec. General health good, is at times quite disturbed mentally and violent, occasionally attacks nurses. Nov. 20 Wt. 141#.

Personal and Medical History of Nora O'Hara.

Whole No. 5293
Residence, St. Paul, Minn.
Date Admission, March 30th 1899.
Admitted by Dr. R. M. Phelps. hour, 6th PM
How Sent, Ex. Bazille & af. P. Ramsey Co.
Sex, Female Age, 27 yrs.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, None (Father a stone-mason)
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
Nationality, Ireland (Parents also born there)
Physicians Committing, Dr. Marcon & Hennegraves.
Correspondents, James O'Hara (Bro.) 238 Spruce St. St. Paul.
M. A. Nakes (Bro-in-law) 517 Main St. Winnipeg Canada

No. of Years, 166
Insane Relatives, None.
Cause Exciting, Depression following death of sister
Cause Predisposing, —
Form, Melancholia acute
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Not.
Date of this Attack, 2 mos. ago.
Duration, 2 months
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 27 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Jebb. Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
• ~~not~~ Sluggish & confused.
MEMORY, Past Events, fair
Recent Events, Special Subjects, do
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert but illusive.
REASONING POWER, Ordinary Subjects, Impaired
Special Subjects, "
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks she is detained here for immoral purposes.
Thinks that food given her is impure.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Says none.
Father, Thinks living & well.
Paternal Relatives, D. about 70 yrs. Doesn't know cause.
Mother,
Maternal Relatives,
5 Brothers and 2-1 Sisters, Thinks all well.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says none.
HABITS, Drinking and Smoking, Drank some but not to excess.
HEADACHES, VERTIGO, OR CONVULSIONS, Some occasional headaches. Some vertigo
OCCUPATION, Healthy or not, Working in hotel.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Slightly Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 PRESENT WEIGHT, 120 USUAL WEIGHT, NUTRITION, Fairly good - anaemic Circulation poor
WOUNDS, Abnormalities and condition of Skin, Small scar on left of chin. Skin moist & cool.
TONGUE, Coatings or Promptness of Movement, Clear.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size & responses normal.
SIGHT, good -
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good
COORDINATION, Arms, Fair Legs, Good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, of hands - more in right hand - slight of tongue -
PATELLAR REFLEX, About normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Indistinct & hesitating.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, Size, weak
Apex Beat, Regularity, Regular
ARTERIES,
94. Pulse weak & irregular
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair
B. sounds shallow

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal. Hymen lax. uterus retroflexed - tenacious leucorrhoeal discharge.
MENSTRUATION, Regular & scanty. often 6 wks apart Has dysmenorrhoea, pain comes on a few days before & ceases after. Pain extends across abdomen & back - Is relieved at outset of flow. also has headache.
OPHTHALMOSCOPIC EXAMINATION, Menstr. estab: at 13-14 yrs.
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Only fairly good - disturbed at times.
BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Uses very profane language - Complains about her family neglecting her - Has fixed delusions - Is always irritable & often resistive. Very melancholy - much depressed at times

Personal and Medical History of Nora O'Hara.

1899

This patient was brought here by Sheriff's deputy Wm. Hanson, attended by James O'Hara in fair physical condition, with the following history: No consanguinity nor heredity known in family: First symptoms of insanity manifested about two months ago, by depression & delusions of persecution & injury by others: Appears to be increasing: Variable, with no rational intervals: Derangement now manifested by delusions of persecution: Not disposed to injure any one: No filthy nor destructive habits: Had previous to attack a disposition to melancholy: No intemperance in patient nor in parents: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment, except sedatives, given. On personal examination shows a simple melancholic disposition On admission put upon B.M. (Gen. H. N. Pat. Complexion fair: hair auburn, eyes blue: Skin in good condition So clean: Behavior quiet: Answers questions intelligently.)

3/30/99

3/30 to 4/15/99 Summary 14 days record by Dr. Bibb. Temp. 98°-99°. Pulse & resp. about normal: Appetite very poor: Receives specials: From Apr 5 refused food & fed by tube Bowels constipated. To given laxatives as needed. Medicine refused. Was menstruating when admitted. remained in bed & complained of soreness in head: Rather stubborn & resistive: refused medicine & force required in taking her to dining room: Inclined to be imprudent. Remains in room by herself all day: Sleeps fairly well: Neat in habits: Talks to herself: does not converse but answers questions occasionally.

Apr 5. Complained of stomach trouble: emesis: Is quite often restless at night & sleeping does occasionally given. Summary Continued June 15th destroyed cap. Takes out door exercise: Very untidy in habits: Sometime uses profane language & scolds: Very much depressed at times. Sept 8 Visited by brother & brother-in-law. Sept. 30 No change since above note. Has delusion that hospital is a house of ill fame. Dec 1. Feb 28 1900 Jan 15 Wt. 104# Scolds & uses profane language: Appetite fair: Bowels regular: Takes out door exercise: Is very nervous. Mch 1 Nov 30 1900 Is quiet: Neat: appetite good: Bowels regular: Takes out door exercise. Apr 16 Complained of toothache: Teeth extracted July 1 Vaccinated: Aug 20 Assists with ward work. Nov 16 Wt. 136. Dec 1 - Feb 28 1901 General health good: Is quiet: Wt. 136#. Assists with work.

June 15

Mar. to Sept. 1901, General health good, neat in habits and appearance, bowels regular, takes out door exercise, assists with work on the ward, is very quiet and has little to say to those about her, gets along very nicely if not annoyed by the other patients, Aug 29 Wt. 136#. Sept. to Dec Patient remains the same in mental and physical condition, Nov. 30 Wt. 133#.

Dec to Feb 1904 No change. Wt about 131#. Usually agreeable on ward. Very quiet: rarely volunteers conversation: at times answers questions

Personal and Medical History of

Is delusional. assists with the work on the ward: takes exercise. General health very good: appetite good: bowels regular: sleeps well. menstruates regularly. Nov 27th Wt 145#. Jan 16th was visited by brothers-in-law. Neat & clean in habits and appearance. Attends Chapel and amusements occasionally.

Personal and Medical History of Catherine Lynch.

Whole No. 5277

Residence, Lanesboro, Minn.

Date Admission, April 12th 1899.

Admitted by Dr. R. A. Bibb. hour, 3 P.M.

How Sent, C.W. Farrington J of P. Fillmore Co.

Sex, Female Age, 35 yrs.

Civil Condition, Single

Children, none.

Age Youngest Child, –

Occupation, House-work.

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate.

~~Nativity~~ Nationality, Ohio - Parents born in Ireland.

Physicians Committing, D. H. Phillips & G. A. Lorr.

Correspondents, Wm Lynch -

No. of Years, 179

Insane Relatives, Sister – (admitted today)

Cause Exciting, Unknown.

Cause Predisposing,

Form, Chronic Mania (Secondary Dem.)

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Not.

Date of this Attack, 13 yrs. ago.

Duration, 13 yrs.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 22 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. R. A. Bibb *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Rather confused & slow.

MEMORY, Past Events, Fair

Recent Events, " Special Subjects, do

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Apparently correct but rather dull.

REASONING POWER, Ordinary Subjects, Fair.

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Usually indifferent.

DELUSIONS, Systematized, Transitory, Special Subjects,
None apparent but probably has some.

HALLUCINATIONS, none determined.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,
Mania - Somewhat dull & slow.

HISTORICAL.

LENGTH INVASION, About 13 yrs.

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
one cousin had convulsions - Father drank - Father dead - 80 yrs - had rheumatism was childish & did not sleep always irritable.

Paternal Relatives, Father's brother foolish used to "fall to ground" patient says

Mother, died - 60. Cancer of uterus.

Maternal Relatives, don't know about them

Brothers and Sisters, 8 Four dead & living. 2 bros. 1 sister living

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had severe sore throat - thinks it may have been diphtheria

HABITS, Drinking and Smoking, No.

HEADACHES, VERTIGO, OR CONVULSIONS, Occasional headaches only.

OCCUPATION, Healthy or not, Housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, Poor but very good bwls. Sayo sleeps Inquires Laxatives

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7½ PRESENT WEIGHT, 146 lbs USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, None Skin moist.

TONGUE, Coatings or Promptness of Movement, No coating - prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. size normal - response to light R. sluggish to accom. near poor quite good at distance.

SIGHT, not good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good.

COORDINATION, Arms, fair Legs, fair Finger to nose ~~Grasp~~, eyes shut - quite good.

TREMORS, Hands, Tongue, Facial Muscles, General, Slight of tongue.

PATELLAR REFLEX, Exaggerated Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Somewhat slurred & indistinct - Deliberate.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal - regular

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical.
Expansion fair
B. sounds somewhat tubular over R. apex

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Cervix club shaped & adherent to left. Uterus normal position & E

MENSTRUATION, always regular - quite painful. External genitals normal except hypertrophy of labial mucosa.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, good.

BOWELS, Present Condition, Regular with laxatives.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Says she has always had indigestion with nausea after eating. Complains of pain in back & limbs & numbness in limbs. Says she attended school until 20 yrs. old but always difficult for her to learn. Much more intelligent than sister, but probably always below average mentally. Case chronic mania with occasional acute maniacal attacks. Has been quite violent at times & is quite easily irritated. - General health fair.

Personal and Medical History of Catherine Lynch.

1899

This patient was brought here by Sheriffs deputy James Gallaghan attended by Wm Lynch in fair physical condition with the following history:- No history of heredity, consanguinity nor intemperance in parents nor in patient. First symptoms of insanity manifested about 15 years ago: Disease increasing: Not variable: Derangement now manifested by delusions on many subjects: Is disposed to injure others when in sudden passion: No filthy nor destructive habits: No peculiarities previously noted: No severe diseases nor injuries to head. No confinement nor restraint employed. No medical treatment pursued for years. On personal examination has all the appearance of chronic insanity. On admission put upon Infirmary. (Cty. Rpt. Complexion dark: hair brown: eyes blue: Skin normal condition: Vermin on body; very dirty; Behavior quiet: Has delusions.)

4/21/99 Summary 14 da. Record by Dr Bibb. Temp. 98°-100. Pulse 80-100 Resp. 20-28. Appetite good. Bowels constipated; requires laxatives regularly. Very dirty when received on ward. Sleeps well. Answers questions quite sensibly: Assists with ward work & in dining room: Takes out door exercise.

4/21/99 to 1/29/99 Summary continued Apr 28. Neat in habits & appearance. Trans. to B'. Appetite good. bowels regular. Sept. 1st Still assists with work. Is occasionally noisy & is inclined to be irritable & annoyed by other patients: Menstruation regular. Sept 1- Feb 28 1900 Visited by friends: Menstruates regularly: appetite good: Bowels constipated: Takes out door exercise: Jan 16 Wt. 167# Feb 28. Expresses many delusions: sensible most of time. Visits- Nov 30 1900 Neat: agreable & occasionally scold. Appetite good. Bowels occasionally constipated requires laxatives: Sleeps well. Takes out door exercis: Attends chapel & amusements: Assists with work.: July 13 Visited by friends & on 21 by brother & his wife. July 16 Vaccinated: Often expresses a wish to go home. Nov 16 Wt 167# Dec 1- Feb 28 1901. Bowels constipated. General health good: Talks & laughs to herself. Mch 1- Wt. 155# Mar. 1 June 1-1901 Assists with work on ward. No change in mental or physical condition. May 29 Wt. 150½#. June to Sept. Assists with the ward work, takes out door exercise, Sept. 2 Wt. 146#. Sept. to Dec. During quarter patient became very anaemic lost some in flesh. Nov. 22 Wt. 141#.

Sept 23rd Visited by brother. She is very quiet, rarely volunteers conversation but answers questions intelligently. At times she talks incoherently to herself. Habits neat and clean: appearance tidy. Works in laundry. Takes exercise: attends chapel and amusements. Appetite good: bowels regular: menstruates regularly: sleeps well.

Personal and Medical History of

Personal and Medical History of Mary Lynch #3

Whole No. 5278
Residence, Lansboro, Minn.
Date Admission, April 17th 1899.
Admitted by Dr. R. A. Bebb hour, 3 PM.
How Sent, E. N. Farrington J of P. Fillmore Co.
Sex, Female Age, 47.
Civil Condition, Single
Children, none
Age Youngest Child, –
Occupation, Housekeeper.
Degree Education, Common school.
Profession, Religion, Catholic
Habits, Not intemperate.
~~Nationality~~ Nativity, Ohio Parents born in Ireland.
Physicians Committing, J. H. Phillips & G. A. Love.
Correspondents, Jim Lynch (Bro.) Lansboro, Minn.

Nos. of Years, 171
Insane Relatives, None.
Cause Exciting, Unknown
Cause Predisposing,
Form, Chronic mania (Etc. demt)
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, About 15 years ago.
Duration, 15 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 27 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. R. A. Bebb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Not quick - confused.
MEMORY, Past Events, Poor
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull + illusive.
REASONING POWER, Ordinary Subjects, Poor
Special Subjects, "
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
&
DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none.
HALLUCINATIONS, Probably has none.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,
Power of attention impaired; slow, dull - maniacal.

HISTORICAL.

LENGTH INVASION, About 15 years.
ONSET, Gradual or Sudden, Gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption), See history of Sister (p. 189.)
Father,
Paternal Relatives,
Mother, Her statements are unreliable.
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Lung fever. diphtheria
HABITS, Drinking and Smoking, Drank whiskey + beer.
HEADACHES, VERTIGO, OR CONVULSIONS, Formerly severe headaches now better - not frequent now.
OCCUPATION, Healthy or not, Housekeeper
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Inclined to be constipated - given laxatives occasionally.

Personal and Medical History of Mary Lynch #3.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5½ PRESENT WEIGHT, 142½ USUAL WEIGHT, NUTRITION, Good
WOUNDS, Abnormalities and condition of Skin, Prominence at junction of 3rd rib on left side sternum.
TONGUE, Coatings or Promptness of Movement, no coating, prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal.
SIGHT, Says good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, no trouble
HEARING, good
COORDINATION, Arms, fair - fingers to nose poor. Legs, Quite good. Standing on one foot quite good. Grasp, Eyes shut good.
TREMORS, Hands, Tongue, Facial Muscles, General, No.
PATELLAR REFLEX, normal - equal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, not slurred but rather indistinct.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Faint aortic murmur.
Apex Beat, Regularity, S. sounds forcible especially accentuated over aortic area. Apex beat displaced to left. Regular.
ARTERIES,
Normal - Regular pulse
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Slight abdominal respiration
B. Sounds harsh + tubular especially over right side Percussion note hyperresonant especially over right side

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal. uterus slightly retroflexed - cervix club shaped.
MENSTRUATION, Regular + free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Has a goitre. More prominent on right side. General health fairly good. Attended school until over 20 yrs. of age + had not then completed arithmetic. Her appearance would also indicate that her mental ability had always been below average. During last 15 yrs mental failure has been more apparent. Case - chronic mania. Probably has delusions but cannot determine what they are.

Personal and Medical History of Mary Lynch #3

1899

This patient was brought here by Sheriffs Deputy James Gallagher attended by Tim Lynch, in fair physical condition, with the following history:- No history of Consanguinity, heredity nor intemperance in patient nor his parents: First symptoms of insanity manifested about 15 years ago: Disease appears increasing: Not Variable: Derangement now manifested by delusions on various subjects: Talks incoherently: Not disposed to injure anyone: No filthy nor destructive habits: No previous peculiarities manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: Has received no medical treatment for years. On personal examination Has appearance of Chronic mania.

11/1/99 On admission (Put upon Infirmary East (5th Rpt. Complexion dark: hair black: eyes brown: Skin in normal condition: Vermin on body: So dirty. Behavior quiet: Talks incoherently.)

11/2/99 Summary, 14 da. record by Dr Bobb. Temp. 98°-100° Pulse 72-100 Resp. normal:

11/15/99 Appetite good: bowels constipated requires laxatives frequently: Sleeps well: Menstruating when admitted: Very dull & quiet: Takes out door exercise: At times answers questions quite sensibly but seems embarassed & confused when addressed & it takes her sometime to collect her thoughts & she is often too nervous to answer. Sept 1st During intervening time has changed little: Is neat in habits & appearance: Conversation is usually incoherent. Is at times noisy: Menstruation regular:

Sept 1- Feb 28/1900. (Dr. Kyndale) Visited by friends on Nov 11. Menstruates regularly: Eats & sleeps well: Bowels somewhat constipated: Assists with ward work: Wt. 154#. Feb 16. Talks to herself: Expresses delusions: Appetite good: Attends amusements & chapel. Mch 1- Nov 30/1900 Untidy always agreeable: Talks to herself: Appetite good: Bowels regular: Sleeps well: Assists with work: Menstruates regularly: June 12 Visited by friends. " By brother. July 16 Vaccinated Nov 16 Wt 158#. Menstruates every three weeks. Dec 1- Feb 28/1901 Patient is quite intelligent: does not volunteer conversation: reads & is quiet & agreeable. Mch 1- Wt 160½

Mar 1- June 1- 1901 Works on ward: menstruates regularly. no change in mental or physical condition. May 29 Wt 164 3/4#.

June to Sept. Assists with ward work, neat and tidy, reads quite a good deal, at times talks to herself, attends amusements, takes out door exercise, Sept 2 Wt. 167#

Sept. to Dec. No change whatever during quarter.

Dec 1 to Feb 1903 Visited by brother Sept 23rd. Neat and clean: converses and answers questions sensibly, Works in laundry. Attends amusements: takes exercise: attends chapel. Appetite good. Bowels regular sleeps well: menstruates regularly.

Jan 22nd She sprained her left ankle while going down stairs. This was bandaged and liniments applied twice daily. Recovery uneventful.

Personal and Medical History of

Personal and Medical History of Pauline Tessmer.

Whole No. 5279
Residence, Olmsted Co, Minn.
Date Admission, April 12' 1899.
Admitted by Dr. R. M. Phelps. hour, 4 P.M.
How Sent, J.A. Leonard Jof P. Olmsted Co.
Sex, female Age, 31 yrs.
Civil Condition, married.
Children, Five
Age Youngest Child, Five months.
Occupation, Housewife.
Degree Education, Common school.
Profession, Religion, German Lutheran.
Habits, Unknown.
~~Nativity~~ Nationality, Germany. (Parents also from there)
Physicians Committing A.N. Stinchfield & C.T. Granger
Correspondents, F.H. Matthias, Lock Box 94. Rochester.
J. & Carl Trunke (stepbrothers) R.D. Rochester, Minn.

No. of Years, 17?
Insane Relatives, None.
Cause Exciting, Unknown
Cause Predisposing,
Form, Chr. melancholia
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Not.
Date of this Attack, 2 yrs. ago.
Duration, 2 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 29 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. A. J. Stricker *Date of* 5/7/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Dull.
MEMORY, Past Events, Does not answer.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull.
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed - restless praying - She is obstinate & does not express any delusions but probably is disturbed in religious matters - She prays incoherently.
DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.
LENGTH INVASION, Several years.
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Patient will not give any information.
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4 PRESENT WEIGHT, 133½ USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, Skin Moist - elastic.
TONGUE, Coatings or Promptness of Movement, Moist. readily protruded.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. size normal. response to light fair. to accom. good.
SIGHT, fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, not disturbed
HEARING, fair.
COORDINATION, Arms, fair Legs, fair - She is obstinate ~~Grasp~~, will not assist in making special tests.
TREMORS, Hands, Tongue, Facial Muscles, General, None.
PATELLAR REFLEX, Normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Distinct.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Normal.
HEART, Murmurs, Strength, Sounds, Size,
Soft ~~blowing~~, systolic murmurs at apex
Apex Beat, Regularity, Sounds strong, full - Size not increased - Apex beat normal
Is regular
ARTERIES,
No signs of disease.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair
B. Sounds - No signs of disease.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal, except laceration of perineum extensive lateral laceration of cervix - Slight leucorrhoea - uterus retroflexed
MENSTRUATION, Says usually regular - free from pain -
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, fair.
BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient is in fair general health. Appears preoccupied & does not converse or answer questions. At times she is restless & prays incoherently & cries. She has probably always been below the average mentally & corresponds to the type of melancholia.

Personal and Medical History of Pauline Tessmer

1899

This patient was brought here by sheriff Vine in fair physical condition with the following history: No history of consanguinity nor heredity. First symptoms of insanity manifested two years ago; by jealousy without cause. Disease appears increasing lately. Not variable. Derangement manifested by jealousy of husband + wandering away from home. Has talked of killing her two children. No filthy nor destructive habits. No peculiarities previously manifested except jealousy of husband. No severe diseases nor injuries to head. No confinement nor restraint employed. No treatment pursued. On personal examination patient cannot speak English, nothing worthy of mention learned.

4/12/99 On admission put upon Infirmary (Gen'l Rpt. Complexion dark. Hair brown; eyes blue; skin hot + dry. Is clean. Behavior quiet. Does not speak English.)

4/13/99 to 4/24/99 Summary 14 da. Record by Dr Bebb. Slight rise of temp. noted. pulse 67 to 92. Resp. about normal. During first few days refused a few meals; after Apr. 16 Appetite improved + continues quite good. Bowels constipated. Laxatives + enemata given as needed. Receives medicine. First night staid up all night after which slept well. Breasts hard + swollen, breast pump used + liniment applied. She is occasionally noisy + at times seems very melancholy. Occasionally complains of having rheumatism in arms + back. Apr. 19. Visited by minister.

Summary continued - Apr 29 Visited by husband. May 28 Husband visited her several times during month. Patient quite restless, cries a great deal. Complains of aching allover. Has slight rise of temperature. Appetite fair. Has had severe pain in knee. To day up on ward. May 30 Refused to eat.

June 8 Since last note has been eating but one meal a day. To day fed by tube.

July 1 Sleeps well usually. Takes out door exercise. Is dressed + up on ward tho quite disturbed + inclined to be violent. Liniment still applied to breasts. Most of time is fed twice a day. Visited frequently by husband. July 26 Trans to Br. Sept. 1 Neat in habits + appearance. Is very ugly + resistive part of time. Sometimes attacks nurses. Received gynecological treatment. Throws dishes in dining room + is destructive. Is very obstinate at times, especially about refusing to go to bed. Is very restless much of time + does not sleep well. Gyn. treatment continued. Wt. 111#. No change to date.

Sept 1 - Feb 28 1900 - Visited by husband on Sept 25 + 26. Nov 16 + by friends on Oct 6. Untidy. Talks to herself but does not converse. Is destructive + violent. Strikes at others. noisy at times. Menstruates regularly. Takes out door exercise. Jan 17. Wt. 113# March 1 - Nov 30 Untidy, destructive + noisy + at times violent. General health good. Eats + sleeps well. Bowels regular. May 10 Visited by friend. May 28 by husband.

Personal and Medical History of Pauline Tessmer.

July 21 Vaccinated. Aug 19 + 20 Visited by friends + husband. Nov 20 Wt 104#. Dec 1 - Feb 28 1901. General health good. Wt. 101#.

Mar 1 - June 1 - 1901 Patient at times is noisy and inclined to be destructive to her clothing; talks and laughs to herself; does not converse with nurses or other patients; is obstinate and sometimes violent. Appetite good sleeps well, menstruates regularly. Clean in habits untidy in personal appearance; takes out of door exercise, attends no amusements. Assists in dining room. May 30 Wt. 109#. June to Sept. July 17 - Aug 14. menstruated, assists with the work in the dining room, at times quite disturbed, cries + scolds. Sept. 1 Wt. 103#. Sept. to Dec. Nov. 21 visited by husband Nov. 28 menstruating, Nov. 30 Wt. 110#.

Personal and Medical History of Theresa Neidenstrauser

Whole No. 5280
Residence, South St. Paul, Minn.
Date Admission, April 12' 1899
Admitted by Dr. R. M. Phelps hour, 5th P.M.
How Sent, J. P. Moran Dept. Dakota Co.
Sex, Female. Age, 28 yrs.
Civil Condition, married
Children, Five
Age Youngest Child, 3½ mos.
Occupation, housewife.
Degree Education, None.
Profession, Religion, Catholic.
Habits, Not intemperate.
~~Nationality~~ Nativity, Germany (Parents also born there)
Physicians Committing, H Van Brock & J. C. Fitch.
Correspondents, Jos. Neidenstrauser, S. St. Paul, Minn.

No. of Years, 173.
Insane Relatives, None.
Cause Exciting, The puerperium.
Cause Predisposing, Confinement.
Form, Melancholia
Accompanying Bodily Disorder,
Suicidal or not, Not.
Date of this Attack, April 8' 99.
Duration, 4 days.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 28 yrs
Time of Leaving, 31st December 1902
Time in Hospital, 3 yrs 8 mos 19 days
Result, Died: Pulmonary Tuberculosis

EXAMINATION ON ADMISSION BY DR. A. J. Strickler *Date of* 5/24/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Dull.
MEMORY, Past Events, Fair.
Recent Events, Poor Special Subjects, Poor.
PERCEPTIVITY, Alert or Dull, Correct or Illusive, Dull.
REASONING POWER, Ordinary Subjects, Below average.
Special Subjects, Fair.
Own Mental State, Does not appreciate his condition.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Depressed.
DELUSIONS, Systematized, Transitory, Special Subjects, Would not talk about them.
HALLUCINATIONS, Would not answer.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 4 days.
ONSET, Gradual or Sudden, Sudden.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Living Fell on the ice 3 yrs ago.
Paternal Relatives,
Mother, Living
Maternal Relatives,
Brothers and Sisters, 4 brothers
√ Sisters youngest 3½ yrs, mos.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, Frontal headaches
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Sleeps fair. Bowels tend to Constipation. She refused food at times & is fed mechanically.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1 in PRESENT WEIGHT, 131 USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, Recent superficial wound of right leg - slight. Skin soft & moist
TONGUE, Coatings or Promptness of Movement, Grayish coating. protrudes promptly.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size moderate. Response to light poor to accom. fair
SIGHT, Fair.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Right eye has a slight tendency to turn upward & outward.
HEARING, Slightly impaired in right ear.
COORDINATION, Arms, Fair Legs, Fair, - Standing eyes shut Grasp, sways
TREMORS, Hands, Tongue, Facial Muscles, General, Fine fibrillary tremors of tongue.
PATELLAR REFLEX, Not exaggerated. Other Reflexes, normal.
ARTICULATION, Slurred, Hesitating, Slow, Hesitating & slow.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Fairly good.
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity, Sounds fair
Relative area of dullness not increased apex beat normal - Irritable
ARTERIES,
No change detected
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair
B. Sounds show no signs of disease

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. 1025 Reaction, acid Color and Appearance, Yellow cloudy
Dr. Dec 19/901. Passed Dec 19/901. Albumen, present (heat) a trace (nitric acid) Sugar, a trace Fehling's sol & Bennett's O.
Casts and Crystals, pus present. (Caught) a trace renal mucous casts: epithelium, a few cells: oxalate lime - a few crystals: a few uric acid crystals.
GYNECOLOGICAL EXAMINATION, External genitals normal, except laceration of perineum, extensive lateral lacerations of cervix with base ulceration of both lips. Cystic degeneration of cervix above.
MENSTRUATION, History of menstruation not obtainable.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleeps well at night.
BOWELS, Present Condition, Tend to constipation.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment): There is some Enlargement of the thyroid especially on right side. The patient refuses to take any food at times. Lies quietly in bed in a sullen mood & will not answer questions. Her mind is apparently occupied - She looks in an abstracted manner into space. She has an acute cystitis - She has probably never been more than of average intelligence. Her mental disorder resembles acute mel ancholia with moderate depression.

Personal and Medical History of Theresa Neiderstrasser.

1899

This patient was brought here by sheriff's deputy J.J. McCormick attended by her husband, in fair physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor parents: First symptoms of insanity manifested April 8 when she became violently suicidal, without premonitory symptoms: Disease appears stationary: So variable: Derangement now manifested by constant fear: Twice jumped through the window breaking the panes: She also injured a cow claiming it was the cause of her trouble: Not disposed to harm anyone: No filthy nor destructive habits: No peculiarities previously manifested: No severe diseases nor injuries to head: Was visited by Mot St. Paul physician: Has never been confined or restrained. On personal examination is nervous, suspecting. Claims she is prompted to perform vagaries by something which she refers to her head, her husband states that the last two menstrual periods have been very severe, & that when she committed the acts described her face was very red & congested. Dec Admission put upon Infirmary (S.H.N. Rpt Complexion dark: Hair brown: Eyes gray. Skin hot & dry: Small mole on left side of face: 2 small scars on back & a cut on left knee 3 on right leg. Caused by jumping through window: Small bruise on right leg: Is dirty: Behavior quiet: Talks intelligently but says at times she cannot control herself, she is so nervous.)

April 12 (Summary Nurse's 14 Day Record by Dr. Bell) Has cuts on left wrist & right leg. (See above) Disturbed first few nights: later slept well: Appetite good first week: Temp. & pulse normal: bowels constipated: sores on limbs bandaged, but she removes bandages: eyes inflamed: treated: Is very cross: extremely noisy and at times resistive. Has many delusions & imagines someone is trying to kill her. After first week appetite poor: fed mechanically at times: extremely melancholy & talks of suicide: May 17 & 30: In bed: seems weak: sores on limbs dressed daily: Is inclined to be irritable but is much quieter than at first: seldom speaks: (Summary Nurse's Notes Cont. by Dr. Bell)
May 30 Is able to be up part of day: remains very quiet: June 4 Bladder irrigated daily for several weeks: June 15 Up on ward: still very quiet: never speaking to anyone: Appetite improving: Oct. 30 Little change since last note: at times appetite has failed. Has been fed by tube: This morning had ejuation = Alexander's ejuation & repair & cervix & perineum: Result good: took nourishment well. Nov. 17 perineal stitches removed: some pain & a little pus around perineal wound: Nov. 25 Commenced to sit up: most of time while in bed was quiet & depressed, rarely speaking except in answer to questions: eat: appetite quite good: bowels constipated: slept quite well: anaemic, pale & listless. Lacking ambition: Quite indifferent to her surroundings: Visited by husband

Personal and Medical History of Theresa Neiderstrasser

a few days after operation: talked with him quite freely & cried a great deal especially when shown photographs of children: She had thought them dead: husband's visit made her very restless & anxious to go home & for a few days she appeared to exert herself: talked more freely, pleading to be allowed to go home: after a few days she lapsed into her former condition = indifferent: scarcely spoke: often refused meals & will only eat after considerable coaxing & persuasion. Sept 1- Feb 28 1900 Nov 22 Improving: Takes nourishment regularly: Sleeps well: Sits up in bed during day: pulse & respiration normal: Dec 4 Up on ward: very quiet. Dec 30 Quiet & melancholy: Seldom speaks & is indifferent to surroundings: Appetite poor Bowels moved by cathartics. Nov 28 no change: gives electrical treatments & massage. Mch 1- Nov 30 1900. Very quiet: rarely speaks even to answer questions: more melancholy: Sits quietly in a corner day after day. Bowels rather constipated: May 30. Has improved somewhat. Does some work in laundry. June 12 Refused to go to dining room to meals. Trans to A3. 16 Not so well as usual: Trans. to Infirmary. July 1 Vaccinated. Does no work now. Sept 30 Very melancholy- Dec 1- Feb 28 1901- General health fair: Very quiet & melancholy. Feb 15 Wt. 115#
Mar to June 1901 No change in mental or physical condition. May 30 Wt. 109#.
June to Sept. July 17 tran. to B 3 west, patient is very melancholy, says very little to those about her, will not answer questions, Aug. 24 Wt. 102#. Sept to Dec. 1901 Patient menstruates regularly, is constipated requiring frequent cathartics, refuses out door exercise, very obstinate about going to meals frequently has to be fed by a tube. Nov. 30 Wt. 105#.
Dec 1-01 Wt 108#. Jan. 2-01 Patient visited by husband. No change.
Patient failing slightly. May 31st '02. Very melancholy.
Aug. 23rd " gradually. Wt. 99#. Nov. 23rd failing rapidly.
coughs a good deal: expectorates some. Wt 81½#
Died Dec. 31st 1902 Cause of death Pulmonary Tuberculosis.

Died.

Personal and Medical History of Ida M. Cameron.

Whole No. 5283

Residence, Winona Co. Minn.

Date Admission, April 13th 1899.

Admitted by Dr. R. A. Babb hour, 4 PM.

How Sent, H.L. Buck J. of P. Winona Co.

Sex, female Age, 42

Civil Condition, single

Children, one

Age Youngest Child, 2 years old.

Occupation, None – (Father a farmer.)

Degree Education, reads + writes.

Profession, Religion, Not a church member.

Habits, Not intemperate.

~~Nativity~~ Nationality, Pennsylvania (Parents also from there)

Physicians Committing, D.A. Stewart + C.R. Robbins

Correspondents,

No. of Years, 176

Insane Relatives, None.

Cause Exciting, Lactation in infancy.

Cause Predisposing,

Form, High Grade Imbecile.

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Not.

Date of this Attack, Jan 1 99 – Became more marked.

Duration, always feeble minded.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, –

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. A. J. Strickler Date of 5/24/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Fairly clear

MEMORY, Past Events, Fair

Recent Events, Good Special Subjects, fair.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Fairly active – correct.

REASONING POWER, Ordinary Subjects, Fair.

Special Subjects,

Own Mental State, Does not appreciate her condition.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Not depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any delusions – appears feebleminded, having little individuality

HALLUCINATIONS, None apparent.

ILLUSIONS, Thinks she came here to be treated for pelvic trouble

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 2 yrs. always weak-minded.

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Died at 78 – Cancer of bowel,

Paternal Relatives,

Mother, living 74.

Maternal Relatives, married.

Brothers and Sisters, * one sister nerv. ill – (nervous exc.)

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Typhoid at 8 yrs. Mumps + whooping cough, goitre – her neck is full + prominent

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, None

OCCUPATION, Healthy or not, Housewife.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Appetite good: bowels regular: Sleeps well.

Personal and Medical History of Ida M. Cameron.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2 PRESENT WEIGHT, 85½ USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Skin moist + elastic.

TONGUE, Coatings or Promptness of Movement, Slight gray coat: readily protruded.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. normal size Response good.

SIGHT, Fair

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Not disturbed

HEARING, Fair.

COORDINATION, Arms, Fair. Legs, Fair. Movement ~~Grasp~~ fairly well co-ordinated.

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Left Exaggerated. Other Reflexes, Elbow jerk weak.

ARTICULATION, Slurred, Hesitating, Slow, Speech not impaired.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Fair

HEART, No Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity Sounds full + distinct. Sup not increased – First sound roughened – Regular.

ARTERIES,

No change detected



CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds, Expansion fair Chest symmetrical Resonance somewhat impaired over both lungs at apex especially left. Respiration sounds rather shallow.

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

5/1/99. GYNECOLOGICAL EXAMINATION, Laceration of cervix + perineum – ulceration of cervix. extreme tenderness on touch – Profuse leucorrhoea – Uterus retroflexed.

MENSTRUATION, always regular until recently. Painful at onset. pain localized – present only in pubic region. Flows non from one to five weeks during menstruation.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Good.

BOWELS, Present Condition, regular.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). General health + nutrition are fairly good. She has always been feebleminded but since birth of last child 2 yrs. ago has been irritable + slightly violent at times. She has some reasoning power but approaches a high grade imbecile.

Personal and Medical History of Ida M. Cameron.

1899. This patient was brought hre by sheriff Alb. Schumann attended by her mother, in fair physical condition, with the following history:- No history of heredity, consanguinity or intemperance in patient nor parents. Has always been feeble-minded but first symptoms of insanity manifested January 1st 1899 by violence toward Mother sister & child: Disease not variable: Broods over death of father & in relation to child: Threatens life of family & child: Is disposed to injure others: No filthy nor destructive habits: Had severe illness in infancy: Never confined nor restrained in any way. No treatment pursued. On personal examination is depressed, and melody, feebleminded. On admission put upon Infirmary (G.H.M. Rpt.
11/13/99 Complexion dark: hair black part gray: eyes brown: Is clean: Behavior quiet: Seems rather weak-minded but answers questions fairly well
11/13/99 to 11/28/99 Summary 14 da. record by Dr. Bros. Temp. shows continuous moderate rise: averaging 99°. Pulse & respiration about normal. Appetite good. Bowels usually regular: Reports occasional laxatives: Was menstruating when admitted: Sleeps well: Is quiet in behavior: Talks quite sensibly Is very neat in habits: Summary continued May 19 Complained of tooth ache - tooth extracted by Dr Stricker: May 23 Complained of severe pain in face: face swollen. May 29 Visited by Mother July 5 Visited by friend. by relatives on July 11, & by Sister on July 20: Was transferred to A2 on June 25.
Augr tooth extracted. Aug 22 Trans to Infirmary (recreation) Sept 1 Continues quiet & neat in appearance: Appetite good: Bowels regular: Menstruation regular. Augr. Operated upon for appendectomy & ventro-fixation Reaction good: some emesis, but rested Well most of night & made good & uneventful recovery: Was quiet & pleasant & appreciative & followed directions carefully: (See above)
Sept 1- Feb 28 1900 (Dr. Heyndale) Sept. 3 Operated upon by Dr W. J. Mayo: Alexander's Operation. Remained in bed from 3rd to 17th recovery uneventful. Sept 20. Quiet & agreable: works on ward: Neat: Appetite good: Takes outdoor exercise. Jan 11. Visited by friends. Jan 19 Wt. 103#. Feb 7. Visited by brother-in-law. & on 11 by Mother.
March 15 Nov 30 1900. Very quiet & agreeable: appetite good: bowels regular: sleeps well: works in center dining room: Usually agreeable. May 18 Visited by sister & two friends. Somewhat irritated after visit May 29. Went to city to visit friend. June 14 Had tooth filled. July 16 Began working on assistant physician's flat. July 3 Visited by mother & friend. July 17. Vaccinated successfully. July 24 Taken to dentists Nov 17. Wt. 117. Dec 1- Feb 28. General health good. Assists in Center dining room also in mending room. Feb 28 Wt. 116½#

Mar. to June Mar. 13. Patient had abscess lanced and dressed this morning. No change in her general condition May 30 Wt. 115#. June to Sept. Patients mental and physical condition remains unchanged Aug. 30 Wt. 115#.

Personal and Medical History of Ida M. Cameron

Sept to Dec 1901. Nov. 19 visited by sister, general health good, eats and sleeps well, takes out door exercise, is somewhat irritable and scolds at times, works regularly in center dining room, patient is somewhat feeble minded Nov. 19 Wt. 114½#.
Dec to Feb 1903 No change. Wt about 115#. Jan. 9/02 Patient visited by friend. Aug 2/02 Visited by sister, also on Dec. 30th and Jan 1st 03.

Personal and Medical History of Mary Graf.

Whole No. 5784

Residence, Brownsville, Minn.

Date Admission, April 14 1899.

Admitted by Dr. T. M. Phelps hour, 4 P.M.

How Sent, L. Budahl J. of P. Houston Co.

Sex, Female Age, 60

Civil Condition, married

Children, 12 -

Age Youngest Child, 19 yrs.

Occupation, Housewife - (Husband a blacksmith.

Degree Education, Can read.

Profession, Religion, Catholic.

Habits, Not intemperate.

Nationality, Ireland (Parents also born there.)
Became resident of State 40 yrs. in 1856.

Physicians Committing, W. W. Freeman & F. N. Whitney.

Correspondents,

No. of Years, 17 -

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing, Previous attacks.

Form, Paranoia (Dementia)

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, Jan. 1 1899.

Duration, 3½ mos.

No. of Attack, 3rd

No. of Admission, 2nd admission.

Age First Attack, 40 yrs. old.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. ..... *Date of* .....

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - quick.

MEMORY, Past Events, Impaired Fair -

Recent Events, " Special Subjects,

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

REASONING POWER, Ordinary Subjects, Imp -

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Irritable, restless -

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks people dance on her at night - That there is an evil power around & everyone is in league with that power. Has fixed delusions of persecution. Thinks evil is put in her food & clothes. Shakes the "evil" out of her clothing every morning.

HALLUCINATIONS, No.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 1896

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Cannot obtain history from her. Living 78.

Paternal Relatives,

Mother, Died 65 yrs.

Maternal Relatives,

Brothers and Sisters,
Children - 12 - 10 living -

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
?

HABITS, Drinking and Smoking, ?

HEADACHES, VERTIGO, OR CONVULSIONS, No.

OCCUPATION, Healthy or not, housekeeper

Detail Date, Duration, and Character of Previous Attack, if any,
21 yrs. ago - for 10 - 12 wks. 2nd Sec Feb. 38 -
This is Apparently a continuation of 2nd attack.

Sleep, Appetite, and Bowels,

Personal and Medical History of

57841
40/209

Mrs Mary Graf

Copy of Order for Hearing Petition of George A. Graf husband & Mary Graf, insane for appointment of said George Graf as guardian for her as being insane; served and service admitted. Petition & heard Jan 26. 1901.

(Papers filed with commitment papers.)

ACTERISTICS.

SUAL WEIGHT, NUTRITION,
w from operation. Varicose veins.
t. deviates to right White coating.
' - respond slowly to light - fairly well accom
results

v. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, fine tremors of hands, tongue & facial muscles.

PATELLAR REFLEX, diminished Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, rapid - hesitating.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Normal.

HEART, Murmurs, Strength, Sounds, Size, forcible at apex normal at base.
Apex Beat, Regularity, regular.

ARTERIES,
Pulse weak.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Has complete laceration of perineum & wide circular laceration of cervix. Localized swelling above cervix. erosion of os. loose adhesions. cystocele. Prolapse & retroflexion of uterus corrected by operation July 15. 99.

MENSTRUATION, Menopause past about 10 yrs.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, fairly good - not sometimes disturbed.

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Occasionally answers questions sensibly but conversation usually rambling & incoherent. Very obstinate & irritable often resisting & attacking nurses. Very restless about halls most of time almost always with a book & looks & talks to the pictures. Whispers to herself & to crucifix - praying for will power to be kept off. Gestures & language is often vulgar & obscene.

Personal and Medical History of Mary

Whole No. 5784

Residence, Brownsville, Minn.

Date Admission, April 14 1899.

Admitted by Dr. T. M. Phelps hour, 4 PM.

How Sent, L. Bubahl J. of P. Houston Co.

Sex, Female Age, 60

Civil Condition, married

Children, 12 -

Age Youngest Child, 19 yrs.

Occupation, Housewife - (Husband a blacksmith.

Degree Education, Can read.

Profession, Religion, Catholic.

Habits, Not intemperate.

Nationality, Ireland (Parents also born there.)

Physicians Committing, W. W. Freeman + F. N. Whitney.

Because resident of State 1855 or 1856.

Correspondents,

No. for

Insan

Cau

Ca

F

Accompanying

Suicidal or not, Not.

Date of this Attack, Jan. 1 1899.

Duration, 3½ mos.

No. of Attack, 3rd

No. of Admission, 2nd admission.

Age First Attack, 40 yrs. old.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. ..... *Date of* .....

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Confused - quick.

MEMORY, Past Events, Impaired Fair -

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Alert Illusive.

REASONING POWER, Ordinary Subjects, Imp -

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Irritable, restless -

DELUSIONS, Systematized, Transitory, Special Subjects,

Thinks people dance on her at night - That there is an evil power around + everyone is in league with that power. Has fixed delusions of persecution. Thinks she is put in her food + clothes. Shakes the "evil" out of clothing every morning.

HALLUCINATIONS, No. (see above)

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 1896

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Cannot obtain history from her. during 70.

Paternal Relatives,

Mother, Died 65 yrs.

Maternal Relatives,

Brothers and Sisters,

Children - 12 - 10 living

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

?

HABITS, Drinking and Smoking, ?

HEADACHES, VERTIGO, OR CONVULSIONS, No.

OCCUPATION, Healthy or not, Housekeeper

Detail Date, Duration, and Character of Previous Attack, if any,

21 yrs. ago - for 10 - 12 wks. 2nd Att. Feb. 88 - This is probably a continuation of 2nd attack.

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, ——— PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Scar on abdomen from operation. Varicose veins.

TONGUE, Coatings or Promptness of Movement, Skin cool - dry - wrinkled. Fairly prompt - deviates to right - White coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - respond slowly to light - fairly well to accom.

SIGHT, Fair

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Arcus senilis

HEARING, Fair.

COORDINATION, Arms, Fair Legs, Fair. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, fair tremors of hands, tongue + facial muscles.

PATELLAR REFLEX, diminished Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, rapid - hesitating.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Normal.

HEART, Murmurs, Strength, Sounds, Size, Forcible at apex normal at base.

Apex Beat, Regularity, regular.

ARTERIES,

Pulse weak.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest asymmetrical

Expansion normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Has complete laceration of perineum + wide circular laceration of cervix. Localized swelling above cervix. erosion of os. loose adhesions. Cystocele. Prolapse + retroflexion of uterus corrected by operation May 15. 99.

MENSTRUATION, Menopause past about 10 yrs.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, fairly good - not sometimes disturbed.

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Occasionally answers questions sensibly but conversation usually rambling + incoherent. Very obstinate + irritable often resisting + attacking nurses. Very restless about bed most of time almost always with a book + looks + talks to the pictures. Whispers to herself + to crucifix - praying for evil power to be kept off. Dress + language is often vulgar + obscene.

Personal and Medical History of Mary Graf

1899

This patient was brought here by Sheriffs Deputy Blesnd, attended by Miss Dessi Graf in fair physical condition, with the following history:- No history of consanguinity, heredity or intemperance in patient nor in parents. First attack occurred twenty years ago lasted 18 weeks - Second attack June 1898 & patient was at this hospital from June 7 '98 to (For further particulars see Vol. M Fol. 269 No. 5056.) First symptoms of present attack manifested January 1st 1899 by running away & by delusions: Disease appears increasing, is variable: With rational intervals but becomes easily excited & maniacal: Derangement now manifested by imagining evil spirits are around house & premises: Not inclined to injure anyone: No filthy habits but destroys furniture: No peculiarities previously manifested: No severe diseases nor injuries to head: Has received hospital care & treatment as above stated & sedative treatment for last few months. On personal examination exhibits a very excitable condition full of illusions of all kinds, ghosts, hobgoblins, etc.

4/19/99 On admission put upon 6[3] M. 6th Ward. Complexion fair: eyes brown, hair gray; Skin in normal condition: A few small bruises on back & on right leg; Is clean: Fought while being bathed: Has delusions.)

4/14/99 Summary 14 days. Record by Dr Robb. Temp. usually subnormal, averaging 98°. Pulse 76-90
4/30/99 Respiration normal: Appetite good: Bowels inclined to be constipated: Requires occasional laxatives: Sleeps well: Coughs some: Is given medicine: Conversation incoherent: Has many delusions: is fairly quiet but at times very obstinate - Apr. 20-25 Refuses to take outdoor exercise

Summary Continued: May 27 Neat in habits & appearance: Is very talkative & obstinate and at times irritable & inclined to fight. June 15 Attempted to elope.
July 4 Visited by daughter & son in law. July 14 Trans. to Infirmary for operation
July 15 Operated upon: Trachelorrhaphy to relieve prolapse of uterus (Second operation for laceration of perineum & repair of cervix advised.) She took anesthetic well: reaction good & recovery uneventful. Aug 3 Up on ward: physical condition good: Temp. pulse & resp. normal: Appetite good: While in bed was less restless & irritable than when up: at times complained bitterly because kept on liquid diet. Sept 1 - Feb 28 1900 Neat: Appetite good: Bowels regular: Take outdoor exercise: uses very profane language: Scolds a great deal: Frequently tries to escape when door is opened. Sleeps quite well. Jan 13 133 lbs. Feb 1 - Visited by brother Mch 1 - Nov 30 1900 Mch. Is careless disagreeable & profane: Has delusions, - Thinks everyone in league with evil one to torment her: Mchg. Extremely disturbed Mch 16 Visited by husband: Very much excited - Apr 5 & 7. Destructive & profane & noisy: Given cold bath: Mch 27 Visited by a friend. Apr 30 July 2 Vaccinated: Aug 14 Visited by son: Aug 30 Very much disturbed at times: Delusions seem to excite her: & she swears. Given plunge baths occasionally for sedative effect.

Personal and Medical History of Mary Graf.

General health good: Takes outdoor exercise: Nov 21. Wt. 102. 29 Visited by friend. Dec - Feb 28 1901. Wt. 116 lbs. Occasionally noisy & profane: General health good. Mar. to June 1901 May 14 visited by husband, no changes in either mental or physical condition, Wt. 117#

June to Sept. Patient remains unchanged in general condition Aug. 30 Wt. 96½#.
Sept. to Dec. Nov. 25 general health fair, eats and sleeps fairly well, takes out door exercise, has many delusions, very profane and vulgar in her languages, scolds a great deal, cries frequently. Wt. 95#.
Dec to Feb 1, 1903 No change. Wt about 94#. May 29th '02 Patient failing slightly. Wt 88#. June 5/02 visited by husband & daughter. Failing gradually - Coughs a great deal.
Sept. 1st 1902 Patient taken home by husband.

Personal and Medical History of Mary Sturmvod. (or Maria)

Whole No. 5285

Residence, St. Paul, Minn.

Date Admission, April 14' 1899.

Admitted by Dr. A. W. Phelps hour, 6th P.M.

How Sent, C.W. Bazille & of P. Ramsey Co.

Sex, Female Age, 54 yrs.

Civil Condition, Married

Children, One

Age Youngest Child, 27 yrs.

Occupation, Housewife - (Husband a Stone-mason)

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate.

~~Nationality~~ Nativity, Austria (Parents also born there)

Became Resident of State of Minn in 1895

Physicians Committing, Frank A. Hunter - H.R. Wilmot.

Correspondents,

No. of Years, 178

Insane Relatives, Sister insane.

Cause Exciting, Senility

Cause Predisposing, Heredity probably.

Form, General Paresis

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, 2 yrs. ago.

Duration, 2 yrs.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 52 yrs.

Time of Leaving, Jan. 9' 1901.

Time in Hospital, 1 yr 8 mos. 26 dys.

Result, Died. Exhaustion in senile Dementia.

EXAMINATION ON ADMISSION BY DR. R. A. Babb. *Date of*

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Poor

Recent Events, " Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull - illusive.

REASONING POWER, Ordinary Subjects, Poor

Special Subjects, "

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
May has delusions but cannot determine as her conversation is always disconnected & incoherent.

HALLUCINATIONS, do.

ILLUSIONS, do.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Can obtain no information from her.

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Complains of headache.

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Unsatisfactory

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. PRESENT WEIGHT, 126# USUAL WEIGHT, NUTRITION, Impaired - feeble

WOUNDS, Abnormalities and condition of Skin, Dry & wrinkled

TONGUE, Coatings or Promptness of Movement, Coated - fairly prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Contracted - responses imperfect.

SIGHT, Impaired

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Impaired.

COORDINATION, Arms, Poor Legs, do. Gait quite unsteady. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Tremor of hands & tongue.

PATELLAR REFLEX, Exaggerated Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Slurred. hesitating. slow.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, No 1 Murmurs, Strength, Sounds, Weak 1, Size,

Apex Beat, Regularity,

Very restless so cannot examine carefully.

ARTERIES,

Sclerotic - Pulse weak

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical

Expansion limited.

B. sounds superficial & rapid.

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

GYNECOLOGICAL EXAMINATION, Mucous urin. red & inflamed - extensive laceration of cervix & perineum ant. lip of hypertrophied - Leucorrhoea present - local Eudemia - Cervix bleeds on touch large cystocele & rectocele.

MENSTRUATION, History of menstruation not obtainable.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Very restless and disturbed usually.

BOWELS, Present Condition, Inclined to constipation.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Physical condition much impaired - feeble. with many evidences of senile changes - Mental condition probably due to senile degeneration. General appearance much like that of a General Paretic.

Personal and Medical History of Mary Stimmell (or Nikia)

1899

This patient was brought here by Sheriffs deputy Hansen attended by husband, in fair physical condition, with the following history:- No history of consanguinity, one sister insane: No intemperance in patient nor in parents: First symptoms of insanity manifested two years ago by loss of memory & rambling talk: Disease appears increasing: Not variable: Derangement now manifested by childishness, Not disposed to injure anyone: habits filthy: Nervous peculiarity irritability of temper. No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued. On personal examination exhibits lethargy & lack of sensibility. On admission put upon Infirmary Ward (Gen'l Dept. Complexion
4/14/99 fair: hair gray: eyes gray: Skin in normal condition: No marks, scars nor bruises, In very dirty: Behavior quiet: Does not speak English.)

4/14/99 Summary 14 da. record by Dr. Bebb. Has slight rise of temp. Pulse 80-102. Resp. 19-27.
4/24/99 Appetite good: bowels inclined to be constipated; requires laxatives: Sleep often disturbed: sometimes sleeps very little: Is very restless & out of bed most of day. often noisy: untidy in appearance & habits: Talks little English.

Summary continued May 10 Trans. to A'. May 30 Takes out door exercise. June 30 very troublesome on ward. & extremely noisy at times, disarranges beds, undresses herself during day & wears locked shoes: Is out of bed greater part of night. sometimes given sleeping dose. Appetite very good. Often resists when taken out doors. July 4 Visited by husband & son. Very irritable at times & inclined to interfere with other patients. July 30 Fought Nurses & struck Mrs. Conley - no injuries - Aug 4 Trans. to B2. Is in restraint at night. Aug 23 Seems to be weak: put to bed in restraint in order to keep her there. Temp. 99. Pulse 68. Resp. 20. Medicine given: A few bruises noticed on body. Head bruised by Mrs Garoy who pushed patient down Goes to Infirmary.
Aug 23-26 little Change. Still remains in bed. Continues much as as above stated.
Aug 29 up on ward. Sept 1 - Feb 28 1900 very irritable & noisy; untidy in habits speech incoherent: appetite fair: bowels somewhat constipated: Sleeps rather poorly. Now received small cut on head during night: cause unknown: Appetite fair Bowels somewhat constipated. Jan 5. Wt. 100#.
Apr 15. Very irritable: Requires a great deal of attention. Appetite good. July 23 Vaccinated: Aug. 30 Visited by friends: appetite poor, fed by nurses. Nov 16 85½#
18 Fell out of chair: no injury 22 Fell out of bed during night bruising eye.
29 Visited by priest: very weak & feeble. Dec 15. Very feeble: failing rapidly. Has bed sores despite careful attention given her: very bad odor.
Jan 6'01 Refused nourishment. Has difficulty in swallowing. Jan 9. Died at 3.30 AM.
Nov. 29 Visited by priest. Dec. 1 sick in bed. requires a great deal of attention has to be fed. Appetite good. Died. Sleeps well. Is very quiet. Does not converse. Has bed sores on back which are treated daily, these bed sores grew progressively worse during Dec & Jan - Died Jan 9- at 3.30 A.M.

Died

Personal and Medical History of

Personal and Medical History of Minnie Werth.

Whole No. 5287
Residence, Washington Co. Minn.
Date Admission, April 15th 1899.
Admitted by Dr. R. M. Phelps hour, 6th P.M.
How Sent, F. T. Wilson Supt of P. Washington Co.
Sex, Female Age, 22 yrs.
Civil Condition, Single.
Children, none
Age Youngest Child, –
Occupation, Domestic (Father a farmer)
Degree Education, Common school.
Profession, Religion, Lutheran.
Habits, Not intemperate.
Nationality, Wash. Co. Minn. (Parents born in Germany)
Physicians Committing, B. J. Merrill & E. L. Boleyn.
Correspondents, Aug. Werth. Afton, Minn.

No. of Years, 180
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, "
Form, Melancholia Ag.
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 Admission, 1st
Age First Attack, 20 yrs.
Time of Leaving, April 13, 1904
Time in Hospital, 4 y. 11 m. 29 d.
Result, Died (Pernicious Anaemia). (4 dys.)

EXAMINATION ON ADMISSION BY DR. A. F. Stricker *Date of* 5/24/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused.
MEMORY, Past Events,
Recent Events, } Does not answer Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull.
REASONING POWER, Ordinary Subjects,
Special Subjects, } Does not answer,
Own Mental State, Does not appreciate
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.
DELUSIONS, Systematized, Transitory, Special Subjects,
Not apparent.
HALLUCINATIONS, Not apparent
ILLUSIONS, "
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother, } Will not give any information.
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No information.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Domestic.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 PRESENT WEIGHT, 136 USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, Skin moist + oily.
TONGUE, Coatings or Promptness of Movement, Moist + red. Protruded readily.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - not dilated - Response to light fair - to accom. good.
SIGHT, Fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Slight impairment, convergence at intervals.
HEARING, Fair.
COORDINATION, Arms, Fair Legs, Fair, (Patient obstinate ~~Grasp,~~ + did not assist in exam-
TREMORS, Hands, Tongue, Facial Muscles, General, None.
PATELLAR REFLEX, Not exaggerated Other Reflexes, Not disturbed.
ARTICULATION, Slurred, Hesitating, Slow. Not disturbed
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Seems hypersensitive
HEART, No Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity, Sounds Strong Size not increased - Apex beat 2 in. below + a little to right of nipple rate - irritable.
ARTERIES,
No apparent change
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds, No signs of disease detected
Chest symmetrical
Expansion fair



CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

6/19/99 GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact - Uterus anteflexed + adherent to right. Leucorrhoea
MENSTRUATION, History of menstruation not obtainable.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleeps fairly well at night
BOWELS, Present Condition, Tend to constipation

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She is in fair general health. There are apparently occasional spasms of vaso motor system shown by irregular areas of dilated capillaries causing a deep flush with sharply outlined edges. She seems hysterical as shown by remaining in unnatural positions + general behavior. She laughs in a silly way without apparent cause. Her condition belongs to the type Melancholia with agitation.

Personal and Medical History of Minnie Werth.

1899.

This patient was brought here by Sheriffs deputy August Werth, in fair physical health, with the following history: No history of consanguinity, lunacy or intemperance in parents or in self: First symptoms of insanity manifested about two years ago: Disease is increasing: Is variable: Has tried to injure her mother: No filthy nor destructive habits: Peculiarities previously manifested - excessive laughter & quarrelsome disposition contrary to former habit. No severe diseases nor injuries to head manifested: Has never been in confinement nor restraint: Has received no treatment: On personal examination refuses to talk, is anaemic, has fits of laughter.

4/15/99 On admission put upon Infirmary (Gen. Pat. Complexion fair: hair light: eyes gray: Skin in normal condition: No marks, scars nor bruises noted. Is dirty: Behavior quiet: Has delusions but will not talk much.

4/15/99 to 4/30/99 Summary 14 da. record by Dr. Bebb. Temp. 99⁸- 101⁹- Pulse 79-105 Resp. 17- 30. Appetite good. Bowels inclined to be constipated: Requires laxatives. Sleeps well. First day nurse unable to urinate, catheterized: Face flushed. Very restless & silly in manner. Is quiet & talks very little & when she does speaks incoherently. Summary continued May 1 - Sept 1 99 Patient neat in habits & appearance. Very quiet & at times decidedly stupid: bowels regular. Menstruation regular. Sept 1 - Feb 28 1900 Eats & sleeps well. Goes riding & walking: Very untidy: Jan. 18 146#. Feb 28 Visited by friend. Very quiet: Does no work: very inactive March 1 - Nov. 30 1900 Neat in habits has delusions: usually quiet: At times very disagreeable: Eats & sleeps well. bowels regular menstruates regularly: Takes out door exercise: May 19. Fought nurse: July 20 Vaccinated Sept 28 Wt. 129. Oct 16 visited by friends. Dec 1 - Feb 28 1901. Appetite good: bowels regular: menstruates regular: Takes no interest in anything: Does not converse: Abstinate & disagreeable Neck & wt. 135#. March 1 - June 1 1901 Does no work. menstruates regularly. No change in mental or physical condition. May 30. 137 1/2 # Wt.

June to Sept. June 26, July 24 menstruated, very untidy and filthy, noisy most of the time, takes out door exercise, Sept. 1 Wt. 136 1/2 #.

Sept. to Dec. No change during quarter, Nov. 30 Wt. 143 #.

Dec to Feb 1902 Patient sings to herself a great deal: sometimes talks to herself. Doesnot converse or answer questions. Is very destructive. Untidy in habits and appearance: expectorates a great deal: Takes out door exercise but does no work: Laughs to herself in a silly way: doesnot attend chapel and amusements: appetite good. sleeps well: menstruates regularly. Nov. 27th. Wt. 133 #.

Personal and Medical History of

Personal and Medical History of Sarah A. Simons.

Whole No. 5289
Residence, Danville, Minn.
Date Admission, April 21 1899.
Admitted by Dr. A. W. Phelps. hour, 3 P.M.
How Sent, Geo. A Wilson & of P. Wagon Co.
Sex, Female Age, 36.
Civil Condition, married
Children, 3.
Age Youngest Child, 3½ years.
Occupation, Housework.
Degree Education, Common school.
Profession, Religion, Not a church member
Habits, Not intemperate.
~~Nationality~~ Nativity, Minnesota (Father. Ohio.)
Physicians Committing, D. Shumway & Dr. L. Taylor.
Correspondents,

No. of Years, 18?
Insane Relatives, None.
Cause Exciting, Childbirth (1st attack)
Cause Predisposing, Previous attacks,
Form, Melancholia with Suicidal Tendency
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Attempted by drowning
Date of this Attack, About a week ago.
Duration, one week.
No. of Attack, 2nd
No. of Admission, 2nd here. (Trans. from St Peter)
Age First Attack, 36 yrs.
Time of Leaving, Aug. 19. 1899.
Time in Hospital, 3 m. 28 d.
Result, Discharged Feb. 7. 1900 Improved

EXAMINATION ON ADMISSION BY DR. Webb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear- not sluggish.
MEMORY, Past Events, Quite good.
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Not dull- fairly correct.
REASONING POWER, Ordinary Subjects, Quite good
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Mildly depressed & rather irritable.
DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none-
HALLUCINATIONS, Probably none
ILLUSIONS, "
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, one week.
ONSET, Gradual or Sudden, Gradual-
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Very nervous-
Paternal Relatives,
Mother, died Cancer.
Maternal Relatives,
Brothers and Sisters, 3 children.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Thinks had sunstroke some years ago.
HABITS, Drinking and Smoking, no
HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo & nervous headaches
OCCUPATION, Healthy or not, housekeeper.
Detail Date, Duration, and Character of Previous Attack, if any,
May 1896 1 yr. 7 mos. Puerperal insanity
Sleep, Appetite, and Bowels,

Personal and Medical History of Sarah A. Simons

PHYSICAL CHARACTERISTICS.

HEIGHT, ——— PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION, Quite good-
WOUNDS, Abnormalities and condition of Skin, None. skin normal.
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation,
SIGHT, good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING,
COORDINATION, Arms, Quite good Legs, Quite good- Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal-
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
ARTERIES,
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Uterus & external genitals normal.
MENSTRUATION, Regular- & free from pain. &
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Quite well.
BOWELS, Present Condition, Rather constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Melancholy with suicidal tendencies Restless but usually quiet & talks quite intelligently- is reserved & does not care to say much- Physically is in pretty good condition.

Personal and Medical History of Sarah A. Simons.

1899

This patient was brought here by Sheriff's deputy Frank Collins attended by Cora Long, in fair physical condition, with the following history: No consanguinity, heredity nor intemperance in family: First symptoms of insanity manifested in May 1896 & patient was sent to St. Peters Hospital. was transferred to this (Rochester) Hospital July 6' 96 & remained until Feb 19' 98. (For further particulars of case see Vol. 30 Fol. 321 No. 4439) First symptoms of present attack manifested about a week ago with hysterical symptoms, crying & morbid fears. Disease appears increasing. Is variable. Derangement now manifested by morbid fears in the direction of injury to herself & children. She has attempted to destroy her clothing, children's hair etc. Not disposed to harm anyone: Has attempted suicide by drowning. No previous peculiarities manifested. No severe diseases nor injuries to head sustained. Has received hospital care & treatment as above stated.
On personal examination is evidently in better condition mentally than at any time for past week, due probably to fact that she slept last night through and of sulfonal: but from her appearance taken with her history we believe that she is on the eve of another explosion of insanity & that it will not be safe to herself & children to delay her return to hospital.

4/21/99 On admission put upon Infirmary ward. (Gtd Opt. Complexion dark, hair black: eyes brown: Skin in normal condition. No marks, scars nor bruises. Is clean: Behavior quiet: Talks intelligently)

4/21/99 to 5/5/99 Summary 14 da. record by Dr. Bebb. During first week had slight rise of temperature all the time. Pulse 78-100. Resp. normal. Second week Temp. Pulse & Resp. normal. Appetite fair: bowels usually regular: takes occasional laxatives: usually sleeps well. Is quiet in behavior: Talks quite sensibly but says very little. Takes out door exercise. Is inclined to be irritable. May 5th Struggled with Mr. Berg & attempted to take his keys. Occasionally cries & is much depressed.

June 1- Neat in habits & appearance. Appetite good: bowels regular: Is quite restless at times and is very melancholy June 5 Monday. June 8 Went to patients picnic at Mr. Smarts & while there hid in shed & eloped. Was found the following day at her sisters in Dodge Center & brought back by Miss Morris.

June 12 Monday. Aug 9. Has improved very much mentally during the last few months: Now talks quite sensibly most of time & is fairly cheerful. & occupies herself with various kinds of work. Is occasionally rather melancholy but her suicidal impulses seem now to be latent. She is very anxious to go home. Aug 19. Allowed to go home on trial

Discharged.

Personal and Medical History of

Personal and Medical History of Rosa Ryba.

Whole No. 5291
Residence, Steele Co. Minnesota.
Date Admission, April 24 1899
Admitted by Dr. P. M. Phelps hour, 3 P.M.
How Sent, W. A. Eggleston Supt. Steele Co.
Sex, Female Age, 29 yrs.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Housewife.
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
Nativity, Nationality, Bohemia (Parents also born there.)
Physicians Committing, Dr. Adair & Dr. M. Smith.
Correspondents,

No. of Years, 184
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing,
Form, Recurrent mania.
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, April 23 '99
Duration, 1 day
No. of Attack, 3rd
No. of Admission, 3rd
Age First Attack, 25 yrs.
Time of Leaving, Oct. 11. 1899
Time in Hospital, 5 m. 18 d.
Result, Discharged Jan. 31. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. R. A. Babb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, somewhat confused at times - usually quite clear - not quick.
MEMORY, Past Events, Quite good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert & usually quite correct.
REASONING POWER, Ordinary Subjects, Fair
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.
DELUSIONS, Systematized, Transitory, Special Subjects,
Cannot determine if systematized. Probably has transitory delusions - do.
HALLUCINATIONS, Yes. People from outside.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Says brief.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Says no heredity.
Father, living - well.
Paternal Relatives,
Mother, living - healthy
Maternal Relatives,
Brothers and Sisters, well.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None
HABITS, Drinking and Smoking, drank moderately
HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo at times. Formerly had frequent headaches - not so often now.
OCCUPATION, Healthy or not, Housekeeper.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, usually regular - slight tendency to constipation.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, —— PRESENT WEIGHT, —— USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, Scar on upper part of left shoulder-blade - Eruption on face & other parts of body.
TONGUE, Coatings or Promptness of Movement, Light coat - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal - responds to light slowly - to accom. good.
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good
COORDINATION, Arms, Quite good. Legs, good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Hands & tongue - facial muscles twitch some.
PATELLAR REFLEX, About normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal
ARTERIES,
N.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Normal - Somewhat round-shouldered.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Labia minora hypertrophied - hymen intact uterus normal position -
MENSTRUATION, regular. & free from pain
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleeps well.
BOWELS, Present Condition, usually regular.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Physical condition in general fairly good. Previous mental grade probably below average. Appearance that of high grade imbecile.

Personal and Medical History of Tosa Tytka.

1899.

This patient was brought here by sheriffs deputy Mr. A. McAndrews attended by Mrs. Anna Jenkins + Drr. Warner, in fair physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor in parents known. First attack of insanity occurred four years ago. This is patients third admission here first from Apr. 25 95 to Mar 21/99. (Vol. 28 Fol 181. No. 4074) 2nd from Jan. 25 98 to Mar 26 - 98 (See Vol. 38 Fol. 175 No. 4961.) First symptoms of present attack manifested yesterday (Apr. 23) when patient became violently insane. Disease appears increasing: so variable with irregular, rational intervals. Derangement now manifested by a condition of general exaltation. So disposed to injure others: habits filthy + destructive: No previous peculiarities manifested: No severe diseases nor injuries to head: Has received hospital care + treatment as above stated - On personal examination condition seems to be progressing. On admission put upon B3 W (Ward Pt. hair brown: eyes gray: skin normal condition: scar on back of neck: So clean: Behavior quite noisy: Refused to speak.)

4/24/99 Summary 14 da. Record by Dr Bibb. First week appetite very poor: Slight use of temp. pulse + resp. normal: 2nd week. Temp also normal. appetite improved. Bowels inclined to be constipated, given laxatives which she refuses at times: usually sleeps quite well, has an occasional restless night. So inclined to be noisy at times, cries + sings. Resists + attacks nurses. So untidy in habits: Sometimes answers questions sensibly but has delusions - Apr. 27 Trans. to B2. Continues to be noisy at times.

C Apr 29 extremely noisy pounding on door during night. So gradually becoming quieter in behavior, however, + neater in appearance: goes walking. Summary continued May 10 Trans. to C3. June 26 Visited by father - Aug 16 Trans. to B3 Aug 31 Appetite Very fair: Takes outdoor Exercise So very talkative but is not otherwise disturbed. Still has occasional noisy spells but is becoming more quiet. Sept 1. - Oct 11 99 Laughs + is very silly much of time: Assists with ward work: Bowels constipated. Oct 8 Menses. Oct 10 Visited by father + taken home on trial.

Discharged.

Personal and Medical History of

Personal and Medical History of Emily Lind.

Whole No. 5297

Residence, St. Paul, Minn.

Date Admission, April 24th 1899.

Admitted by Dr. A. W. Phelps. hour, 6.45 PM

How Sent, E. W. Bazille & of Co. Ramsey Co.

Sex, Female Age, 33 yrs.

Civil Condition, married. (Separated from husband)

Children, 2-

Age Youngest Child, 4 yrs.

Occupation, Domestic. (Father a carpenter)

Degree Education, Common school.

Profession, Religion, Not a church member.

Habits, Not intemperate.

~~Nationality.~~ Nativity, Minn. (Parents born in Sweden)

Physicians Committing, C. J. Woodway - H. R. Minnick

Correspondents,

No. of Years, 185

Insane Relatives, Maternal cousins.

Cause Exciting, Domestic trouble & separation from children.

Cause Predisposing, Possibly heredity.

Form, Chronic Mania.

Accompanying Bodily Disorder, anaemia,

Suicidal or not, Attempted 2 yrs. ago by turning gas on in room.

Date of this Attack, 3 yrs. ago.

Duration, 3 yrs.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 30 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. R. A. Bess. Date of

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Quite good

Recent Events, " Special Subjects,

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

REASONING POWER, Ordinary Subjects, Fair

Special Subjects, "

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Yes. Thinks people affect her through electricity & other means.

HALLUCINATIONS, Probably none.

ILLUSIONS, "

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation, Melancholia with delusions

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, died - Hemiplegia - Died in 2 days -

Paternal Relatives,

Mother, died - Pneumonia

Maternal Relatives,

Brothers and Sisters, One own brother - 3 step brothers - One step brother died apoplexy -

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had typhoid fever when a child & again when about 20 yrs. Diphtheria at 17 yrs. of age.

HABITS, Drinking and Smoking, No.

HEADACHES, VERTIGO, OR CONVULSIONS, Occasional headaches & dizzy spells.

OCCUPATION, Healthy or not, Servant.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Inclined to constipation.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2½ PRESENT WEIGHT, 117 USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, Linear scar on back of right hand - Also scar on back of left ear

TONGUE, Coatings or Promptness of Movement, Prompt - Clear.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal size & response.

SIGHT, Good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Pain at times.

HEARING, good

COORDINATION, Arms, Quite good - Legs, good. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, of hands - Tremor & twitching of facial muscles at times.

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Less acute over lower part of body.

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity, Regular
Sounds normal at apex - Mark at base

ARTERIES,
Normal - Pulse regular,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion fair
B. Sounds shallow

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal except laceration of perineum - Erosion & irregular laceration of cervix uteri slightly retroflexed & adherent to left. Posterior lip of cervix short. Endometritis - white leucorrhoeal discharge, profuse & offensive.

MENSTRUATION, Irregular, always - sometimes every three weeks. usually from 3-4 days - attended with little pain. Subject to frontal headaches.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Days sleep is disturbed.

BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Melancholia with suicidal tendency & many delusions. Physical condition quite good. Previous to attack probably of only fair degree of intelligence. Expression determined & rather sad. Evidently has considerable pent up anger on account of her circumstances & the usage which she imagines she received. As a rule controls herself quite well - occasionally relieves her feelings & becomes very irritable & angry & accuses those whom she imagines influence & wrong her.

Personal and Medical History of Emily Lind.

1899

This patient was brought here by Deputy Hanson, attended by Miss Ward, in fair physical condition, with the following history:- No consanguinity known: Cousins on Mothers side insane: First symptoms of insanity manifested three years ago, by delusions: Disease appears increasing: Is variable - on certain occasions hears voices. Derangement now manifested by delusions of persecution & hearing voices. Not disposed to injure anyone: No disposition shown toward filthy or destructive habits: No previous peculiarities manifested: No severe diseases nor injuries to head: Was confined in County jail for ten days. Cause of disease domestic trouble & being separated from children: Has received no treatment. On personal examination is maniacal. On admission put upon Inf. (Gen. Rpt. Complexion dark. Hair brown: eyes brown: Skin in normal condition: Is clean: Behavior quiet: Talks intelligently.)

4/24/99 Summary Notes 14 da Record by Dr Bess. Temp. 98-99° Pulse 54-70. Resp. normal.

5/8/99 Appetite good: Bowels usually regular: Requires occasional cathartics: Talks readily: Takes outdoor exercise. May 7 up on ward: quiet: neat in habits & appearance. Summary Continued June 15 Fought nurses. Expresses delusions & is occasionally violent Aug 1 Trans. to C3. Patient usually quiet. Takes out door exercise, occasionally complains of toothache: Is becoming more sociable, plays games & visits with other patients. Receives gynaecological treatments. Imagines that people are trying to kill her & that other patients hypnotize her.

Sept 1- Feb 28 1900. Neat: appetite good: bowels common but constipated: Menstruates regularly: Very irritable at times: expresses delusions: very irritable Jan 15 Wt. 111#. Very profane & expressed delusions of persecution.

March 15. Neat: reads: assists in work. Thinks people persecute her.

July 21 Vaccinated: Augst Attacked nurses: Nov. 26 Wt. 111#. Occasionally violent: General health good. Feb. 12/1901 Two teeth extracted Feb 28 Wt 98#. General health good: Says she is being telephoned to by many people. Writes many letters to strangers. Mar to Dec 1901 general health good, bowels regular, menstruates regularly, takes out door exercise, does no work, but plays games on the ward, attends amusements, reads some and writes letters, neat in habits and appearance, has a great many delusions of persecution Nov. 30 Wt. 105#.

Dec. to Feb. 1903. No change. Wt about 103# Jan. 22 nd '02 visited by friend

Personal and Medical History of

Personal and Medical History of Lena Nelson.

Whole No. 5297.
Residence, Bath, Freeborn Co, Minn.
Date Admission, May 3rd 1899.
Admitted by Dr. P. M. Phelps hour, 6 P.M.
How Sent, H. Blackmer Dep. Sheriff Freeborn Co.
Sex, Female Age, 32 yrs.
Civil Condition, married.
Children, one
Age Youngest Child, 11 yrs old.
Occupation, Housewife (Husband a farmer)
Degree Education, None.
Profession, Religion, Baptist.
Habits, Not intemperate.
~~Nativity~~ Nationality, Denmark (Parents also born there)
Physicians Committing, G.W. Barck - Ada Mage -
Correspondents,

No. of Years, 190
Insane Relatives, None.
Cause Exciting, Suppressed Menstruation + Chronic metritis
Cause Predisposing, ———
Form, Sub-acute mania -
Accompanying Bodily Disorder, Suppressed Menstruation + Chron. Metritis.
Suicidal or not, Not.
Date of this Attack, December 96.
Duration, about 2½ yrs.
No. of Attack, 1st
No. of Admission, 2nd
Age First Attack, 31 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Bebb *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick but confused.
MEMORY, Past Events, Quite good.
Recent Events, " Special Subjects, Imp.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Not dull - Illusive.
REASONING POWER, Ordinary Subjects, Fair.
Special Subjects, Impaired.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Usually indifferent, often irritable -

DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any but sometimes calls for husband as tho she thought him near.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Living - well.
Paternal Relatives,
Mother, Thinks she is living.
Maternal Relatives,
Brothers and Sisters.
1 son living 1 not one child.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says none.
HABITS, Drinking and Smoking, No.
HEADACHES, VERTIGO, OR CONVULSIONS, Occasional slight headaches.
OCCUPATION, Healthy or not, Housekeeper
Detail Date, Duration, and Character of Previous Attack, if any,
See previous history.
Sleep, Appetite, and Bowels, Good Good Regular

Personal and Medical History of

Lena Nelson — Pltff
vs
5297 M Lena Nelson — Deft

Copy of Order for Hearing Petition of Complaint of Plaintiff in above action praying that the bonds of matrimony between herself & Lena Nelson be dissolved - answer for appointment of guardian for ~~the~~ be duly filed within regular 30 days - ~~insane, served and~~ service ~~admitted~~ on Dr. K. August 1/1901

(Papers filed with commitment papers.)

ACTERISTICS.

SUAL WEIGHT, NUTRITION, Good.
. protruded reluctantly.
sig normal - response normal.
. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Especially of head.
PATELLAR REFLEX, Exaggerated - especially in L. leg Other Reflexes, -
ARTICULATION, Slurred, Hesitating, Slow. Not slurred but talks in a measured precise manner.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Forcible
Accentuated 2nd sound over Anti. Area.
Apex Beat, Regularity, Regular & very rapid
ARTERIES,
Pulse weak - rapid.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical -
Expansion fair
B. sounds normal
EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

6/13/99 GYNECOLOGICAL EXAMINATION, External laceration perineum external genitals otherwise normal uterus retroflexed
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Regular.
BOWELS, Present Condition, regular

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Answers most question quite sensibly but is impatient & irritable. Easily annoyed & troubles with emotion & anger. Is not communicative & regards inquiries as impolite & inquisitive. Has sense of well-being - Is well & regards everything relating to herself quite favorably. Acts suspicious & is disdainful & sarcastic. Spends most of time making lace. Very obstinate at times. Will not respond to exam. Thinks pretty silly & rude. Very bizarre in conversation & manner

Personal and Medical History of L.

Whole No. 5297.

Residence, Bath, Faribault Co, Minn.

Date Admission, May 3rd 1899.

Admitted by Dr. P. M. Phelps hour, 6 P.M.

How Sent, H. Blackmer Dep. Sheriff Faribault Co.

Sex, Female Age, 32 yrs.

Civil Condition, married.

Children, one

Age Youngest Child, 11 yrs old.

Occupation, Housewife (Husband a farmer)

Degree Education, None.

Profession, Religion, Baptist.

Habits, Not intemperate.

Nationality, Denmark (Parents also born there)

Physicians Committing, G.W. Barck & A.G. Madge.

Correspondents,

Cause 1.

Cause Predisposing,

Form, Sub-acute

Accompanying Bodily Disorder, Influenza.

Suicidal or not, Not.

Date of this Attack, December 96.

Duration, about 2½ yrs.

No. of Attack, 1st

No. of Admission, 2nd

Age First Attack, 31 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Phelps Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick but confused.

MEMORY, Past Events, Quite good.

Recent Events, " Special Subjects, Imp.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Not dull. Illusive.

REASONING POWER, Ordinary Subjects, Fair.

Special Subjects, Impaired.

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Usually indifferent, often irritable.

DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any but sometimes calls for husband as tho she thought him near.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, living. well.

Paternal Relatives,

Mother, Thinks she is living.

Maternal Relatives,

Brothers and Sisters, 1 son living lost one child.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says none.

HABITS, Drinking and Smoking, No.

HEADACHES, VERTIGO, OR CONVULSIONS, Occasional slight headache.

OCCUPATION, Healthy or not, Housekeeper

Detail Date, Duration, and Character of Previous Attack, if any,
See previous history.

Sleep, quick Appetite, good and Bowels regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, PRESENT WEIGHT, USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, Moist & cool.

TONGUE, Coatings or Promptness of Movement, White coating. Protruded reluctantly.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - response normal.

SIGHT, Good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good

COORDINATION, Arms, fair Legs, fair. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, especially of head.

PATELLAR REFLEX, Exaggerated. especially in L. leg Other Reflexes, 0

ARTICULATION, Slurred, Hesitating, Slow, Not slurred but talks in a measured precise manner.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, forcible
Accentuated 2nd sound on Aortic area.
Apex Beat, Regularity, Regular & very rapid

ARTERIES,
Pulse weak - rapid.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical.
Expansion fair
B. sounds normal

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

6/12/99 GYNECOLOGICAL EXAMINATION, Extensive laceration perineum external genitals otherwise normal uterus retroflexed.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Regular.

BOWELS, Present Condition, Regular

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Answers most question quite sensibly but is impatient & irritable. Easily annoyed & troubles with emotion & anger. Is not communicative & regards inquiries as impolite & inquisitive. Has sense of well-being. Is well & regards everything relating to herself quite favorably. Acts suspicious & is disdainful & sarcastic. Spends most of time making lace. Very obstinate at times. Will not respond to exam. Thinks Drs silly & rude. Very reserve in conversation & manner

Personal and Medical History of Dena Nelson.

1899

This patient was brought here by Sheriff M. Mitchell, attended by Jens Nilson & Anda Jenson, in fair physical condition, with the following history- No history of consanguinity, heredity or intemperance in patient nor her parents: First attack of insanity occurred from 2½ to 3 yrs ago, & patient was in this hospital from May 28 '98 to Oct 31 '98. (For further particulars see Vol. 38 Fol. 161 No. 5049.) Disease appears increasing: Is not variable: Derangement now manifested by delusions on all subjects: Is not disposed to injure anyone: No filthy nor destructive habits noted. No previous peculiarities shown: No severe disease nor injuries to head: Has received hospital treatment as above stated. On personal examination Appears about same as at time of previous commitment.

5/3/99 On admission sent upon Infirmary (Gen Rpt.) Complexion dark: Hair & eyes brown: Skin in normal condition: Is clean: Behavior quiet: Has delusions)

5/3/99 to 5/17/99 Summary 14 days record by Dr. Bebb. Temp. 98²-101. Pulse 90-98. Resp. normal: Appetite good: bowels inclined to be constipated: requires laxatives & enemata: Sleeps well: May 7 Emesis. Is very cross about taking laxatives refused enema May 8. Is usually quiet in behavior: Remains in her room most of time doing fancywork. Takes outdoor exercise: Is occasionally noisy. Summary continued June 17. Visited by friend. Also July 3. June 23 Trans. to B³. Aug 31 Neat in habits & appearance: Appetite continues good. Is quite noisy, singing much of time - also scolds a great deal & uses profane language. Is very stubborn: Often answers questions quite sensibly but will not converse: express delusions. Sept 1 - Feb 28 1900 Neat: takes outdoor exercise: Appetite good: Sleeps well: Bowels regular: Talks very little: laughs & sings: reads some: Is obstinate & disagreeable on ward at times: Sept 1. Visited by lady friend: Oct 10 by husband June 12 Wt. 109½ Feb 6 Visited by husband. Mch 1 - Nov 30 1900 Neat. Has delusions: usually quiet: stubborn & disagreeable: Appetite good: Sleeps well: July 20 Vaccinated. Nov 15 Well behaved: ankle found to be badly swollen. Nov. 19. patient claimed to have been injured by Viola Berg several days before Very lame. Trans. to Infirmary. Dec 1. Trans. to D'. Swollen ankle practically well Dec 9 Trans. to Infirmary: Climbing stairs seems to affect ankle. Badly swollen again: bandaged: General health good: neat: quiet.

Dec 14 Ankle again well. Trans to A³. Quiet & contented. Feb 15 became violent & destructive. Trans to D'. Mch 4 '01 Wt. 107 3/4.

Mar 1 - June 1 - 1901 Does no work. No change in mental or physical condition. May 30 Wt. 111 #. June to Sept. June 14 visited by husband, June 19 by friends, does no work, attends no amusements, takes out door exercise, Sept. 1 Wt. 106#. Sept. to Dec. No change during quarter Nov. 30 Wt. 107 #.

Personal and Medical History of

Sept 9th Visited by friends. Nov. 8th attacked nurse 3 different times: struck her with heel of shoe: Held for a time and secluded 6 hours. She is in this way occasionally violent quite delusional: talks to herself in a noisy way a great deal. Sometimes answers questions intelligently, but is delusional concerning her religion. She also has religious delusions. Her general health is good. Sleeps well: bowels regular. Appetite good: does no work: takes exercise. Dec 1st Wt 132½ #. Jan. 28th had an attack of facial erysipelas: was secluded and treated with ichthyol. Uninterrupted recovery.

Personal and Medical History of Minnie Miller.

Whole No. 5300

Residence, Hay Creek, Minn.

Date Admission, May 6th 1899.

Admitted by Dr. T. M. Phelps. hour, 6.45 PM.

How Sent, Asst Keeper St. of P. Goodhue Co.

Sex, Female Age, 43 yrs.

Civil Condition, Single.

Children, nn

Age Youngest Child, nn

Occupation, Dressmaker (Father a farmer.)

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate.

~~Nationality~~, Native Minn. (Parents born in Germany)

Physicians Committing, B. Jacking + G. Millner.

Correspondents,

No. of Years, 193.

Insane Relatives, None.

Cause Exciting, Probably overwork.

Cause Predisposing, Previous attack.

Form, Melancholia Agitans

Accompanying Bodily Disorder, Rapid pulse.

Suicidal or not, Attempted it by manual strangulation.

Date of this Attack, About one month ago.

Duration, One month.

No. of Attack, 2nd

No. of Admission, 1st

Age First Attack, 43 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Bebb *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, Fair.

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Rather dull + illusive.

REASONING POWER, Ordinary Subjects, Fair.

Special Subjects, Poor.

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

Thinks she was mesmerized.

HALLUCINATIONS, None

ILLUSIONS, "

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Says none. Father, Died. Renal calculus - 10 yrs ago.

Paternal Relatives,

Mother, Died When she was 5 yrs old. Thinks Childbirth

Maternal Relatives,

7 Brothers and 3 Sisters, 1 sister sick 10 yrs.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Had typhoid fever when 13.

HABITS, Drinking and Smoking, Drank wine occasionally.

HEADACHES, VERTIGO, OR CONVULSIONS, Formerly subject to sick headaches.

OCCUPATION, Healthy or not, housekeeping + sewing.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Poor Appetite, Good and Bowels, ?

Copy of order for hearing petition for appointment of Ben Gerlach as Guardian for Minnie Miller, received May 9 '99.

5300

RISTICS.

EIGHT, NUTRITION, Quite good

e normal - Response fair.

d her sense. Doctors told her eyes were paralyzed.

Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, normal. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, normal

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, No Murmurs, Strength, Sounds, Size, Apex normal Aortic Mark

Apex Beat, Regularity, Regular

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds, Normal



CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact. Uterus normal position.

MENSTRUATION, Regular but every three weeks - lasting from 4 - 5 days. not painful now. was years ago & took treatment for her trouble - Subject to headache - 2-3 yrs ago appeared

~~OPHTHALMOSCOPIC EXAMINATION,~~ Leucorrheal discharge - absent now.

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Restless - does not sleep well.

BOWELS, Present Condition, Requires laxatives occasionally

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment) Pinches her arms until bruised. Claims she does it because nervous - also barks like a dog + does other peculiar things but does not express delusions about them - Gen. health quite good. Goitre 20 yrs ago. small one now - Complains of difficulty in swallowing. Movements are often very nervous - Constantly begs to be allowed to go home.

Personal and Medical History of Minnie Miller.

Whole No. 5300

Residence, Hay Creek, Minn.

Date Admission, May 6th 1899.

Admitted by Dr. P.M. Phelps. hour, 6¼ P.M.

How Sent, Asst Keeper D. of P. Goodhue Co.

Sex, Female Age, 43 yrs.

Civil Condition, Single.

Children, none

Age Youngest Child, none

Occupation, Dressmaker (Father a farmer.)

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate.

~~Nationality~~, Nativity, Minn. (Parents born in Germany)

Physicians Committing, B. Jacking + G.B. Millner.

Correspondents,

No. of Years, 193.

Insane Relatives, None.

Cause Exciting, Probably overwork.

Cause Predisposing, Previous attack.

Form, Melancholia Agitans

Accompanying Bodily Disorder, Pupil fixed.

Suicidal or not, Attempted it by manual strangulation.

Date of this Attack, About one month ago.

Duration, One month.

No. of Attack, 2nd

No. of Admission, 1st

Age First Attack, 43 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Bebb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, Fair.

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Rather dull + illusive.

REASONING POWER, Ordinary Subjects, Fair.

Special Subjects, Poor.

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

Thinks she was mesmerized.

HALLUCINATIONS, None

ILLUSIONS, "

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Says none

Father, Died - Renal calculus - 10 yrs ago.

Paternal Relatives,

Mother, Died When she was 5 yrs old. Thinks Childbirth

Maternal Relatives,

7 Brothers and 3 Sisters, 1 sister died 10 yrs.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Had typhoid fever when 13.

HABITS, Drinking and Smoking, Drank tea occasionally.

HEADACHES, VERTIGO, OR CONVULSIONS,

Formerly subject to sick headaches.

OCCUPATION, Healthy or not, housekeeping + sewing.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Poor Appetite, Good and Bowels, ?

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5in PRESENT WEIGHT, 116# USUAL WEIGHT, NUTRITION, Quite good

WOUNDS, Abnormalities and condition of Skin, None.

TONGUE, Coatings or Promptness of Movement, Clear - prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. size normal - Responses fair.

SIGHT, Fair

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Says eyes have troubled her some. Doctors told her eyes are paralyzed.

HEARING, Good.

COORDINATION, Arms, Fair Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, normal. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, normal

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, No Murmurs, Strength, Sounds, Size, Apex normal Aortic Mark

Apex Beat, Regularity,

Regular

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal



CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact. Uterus normal position.

MENSTRUATION, Regular - but every Three Weeks - lasting from 4 - 5 days. not painful now. - was years ago & took treatment for her trouble - Subject to Headache 2-3 yrs. ago. Appeared ~~OPHTHALMOSCOPIC EXAMINATION,~~ Leucorrheal discharge - absent now.

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Restless - does not sleep well

BOWELS, Present Condition, Requires laxatives occasionally

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment) Pinches her arms until bruised; Claims she does it because nervous - Also barks like a dog + does other peculiar things but does not express delusions about them - Gen. health quite good. Goitre 20 yrs. ago. small one now - Complains of difficulty in swallowing. Movements are often very nervous - Constantly begs to be allowed to go home.

Personal and Medical History of Minnie Miller.

1899

This patient was brought here by Sheriffs deputy P. Landquist, attended by Amelia Miller + Wm. Miller, in fair physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor his patents: First attack of insanity occurred about twenty years ago, lasted about four months: First symptoms of present attack manifested about one month ago by nervous prostration + insomnia: Disease appears increasing: Is variable, with rational intervals: Derangement now manifested on subject of religion. Not disposed to injure anyone. Has threatened to be destructive: No perverse peculiarities manifested: No severe diseases nor injuries to head. Manual restraint has been employed during the nights of the past week. Has received tonic + laxative treatment. On personal examination answers irrationally, appears dull + stupid, eyes have a staring expression; head sways from side to side; pulse is rapid.

May 5/99 On admission put on Infirmary Mat (5th Ward) Complexion dark: hair brown: eyes brown: Small scars on left arm + knee where she bit herself: Several large bruises on legs + arms + one on chest where she says she struck herself. Is clean: Behavior quiet: Talks intelligently but says she gets angry + wants to kill herself.)

5/5/99 to 5/19/99 Summary 14 da. record by Dr. Bebb. Temp. about normal: Pulse 88-100 Resp. normal. Appetite good: Bowels constipated: Frequently requires laxatives, cathartics + enema. Tonic given. Slept well after first night +, When she was very noisy + out of bed pounding herself + striking head against wall - put in restraint. May 7 Up on ward. Talks very rationally - Takes outdoor exercise, usually quiet on ward, occasionally irritable. May 19 Visited by father. Summary Continued July 2 Visited by priest July 26 Trans to B2. Worries a great deal + do often nervous + excited: appetite good: Sleeps poorly: Neat in habits + appearance. Is becoming more restless during night + is at times quite noisy. Makes a peculiar barking sound which greatly annoys other patients Aug 1 Trans. To C3. Aug 15 To B3. Frequently expresses desire to go home. Refuses to take medicine at times. Visited Sept. 14 + Oct 3 by friends. Sept. 20 by priest. Oct. 3 by brother. Nov 30 No change to date. Barks like a dog at times at night. Dec + Feb 28 1900 Neat. Takes out door exercise:

Jan 9. Visited by priest. Jan 10 By lady friend Jan 15 Wt. 115#. Appetite good sleeps well: Usually extremely nervous. begs constantly to be sent home. occasionally profane March 1 Visited by friends March 8 Very excited + disturbed in behavior one hour. May 29. Visited by friend. Very nervous + frequently asks to go home. July 29 Vaccinated. Oct 8 Occasionally complains of headache. In bed three days: Dec 1- Feb 28 1901 Wt. 111# General health good. More quiet of late. Mar. to June 1901, June 26 visited by two lady friends, No change in general condition, Wt. not taken, June to Sept. Aug. 24 visited by lady friends, general health and mental condition unchanged. Aug. 31 Wt. 111#.

Personal and Medical History of Minnie Miller

Sept to Dec 1901 General health good, takes out door exercise, eats and sleeps quite well, occasionally has very severe attacks of head ache, at times assists a little with the ward work, is delusional, has suicidal tendency, constantly asks to be taken home. Sept. 30 visited by friends, Nov. 30 Wt. 111#.

Dec to Feb. 1902 No change. Wt about 115#. Aug. 21-02 Visited by two friends,

Personal and Medical History of Mrs. Manda Wagner.

Whole No. 5302

Residence, Alma City, Minn.

Date Admission, May 9th 1899.

Admitted by Dr. R. A. Bebb. hour, 3 P.M.

How Sent, G. A. Wilson Co. of B. Waseca Co.

Sex, Female Age, 25 yrs.

Civil Condition, married.

Children, one.

Age Youngest Child, born Mch 22 '99.

Occupation, Housewife. (Husband a farmer)

Degree Education, Common school.

Profession, Religion, Lutheran

Habits, Not intemperate.

~~Nationality~~ Nativity, Germany (Parents also born there)

Physicians Committing, Dr. McMahon & M. P. Taylor. Has been resident Dr. of State Hosp. since Aug. 1894

Correspondents, Oscar Wagner, Alma City, Minn.

No. of Years, 195

Insane Relatives, None.

Cause Exciting, Confinement.

Cause Predisposing,

Form, Melancholia following Puerperal M.

Accompanying Bodily Disorder, Pale, anaemic, emaciated, subjects,

Suicidal or not, Not.

Date of this Attack, Mch. 25' 1899.

Duration, 1 mo. 2 wks.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 25 yrs.

Time of Leaving, July 12. 1899

Time in Hospital, 2 ms. 3d.

Result, Discharged Oct. 31. 1899
Recovered.

EXAMINATION ON ADMISSION BY DR. R. A. Bebb *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Sluggish & confused

MEMORY, Past Events, Rather poor.

Recent Events, Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Dull - illusive.

REASONING POWER, Ordinary Subjects, Poor

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects, probably

Thinks that people are offended with her

HALLUCINATIONS, Says sometimes she hears 'everything'

ILLUSIONS, Dark people.

The gross signs above being lacking, specify concerning Power of Attention, ~~Moral~~ Impaired and Ethical Failure, Slow~~ness~~ ~~or~~ Dull~~ness~~, Silliness, Loss of Will Power, Slight Melancholy, ~~or Exaltation,~~ Mild Delusions

HISTORICAL.

LENGTH INVASION, 1 mo. & weeks.

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

None.

Father, Living & well.

Paternal Relatives,

Mother, Living & well.

Maternal Relatives,

7 Brothers and 7 Sisters,

1 Child living. 1 dead.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Had measles, mumps, Whooping cough - No serious illness.

HABITS, Drinking and Smoking, Drank some.

HEADACHES, VERTIGO, OR CONVULSIONS, Has headaches. Says had vertigo & convulsions after birth of last child

OCCUPATION, Healthy or not, Housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Fair Appetite, Fair and Bowels, Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, ——— PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION, Fair. Circulation poor anaemic.

WOUNDS, Abnormalities and condition of Skin, none. Skin moist & cool. Circulation impaired - cheeks flushed.

TONGUE, Coatings or Promptness of Movement, Slight coat

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - dilated - response fair.

SIGHT, Good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Impaired

COORDINATION, Arms, Fair Legs, Poor. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None - or slight.

PATELLAR REFLEX, Exaggerated. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Slurred & indistinct - hesitating & slow.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Exam. not noted.

ARTERIES,

Pulse feeble.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical
Expansion fair
B. sounds normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, labia minora hypertrophied. Laceration of perineum. Hyperaemia of cervix & vagina: uterus normal position.

MENSTRUATION, Irregular - sometimes misses a month - severe headache previous to menstruation & pain in pelvic & left ovarian regions throughout menstruation.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Apparently below average mentally even before attack. Physical condition only fair. Quite good weight but muscles not firm. Circulation poor. Skin moist & cool - even cheeks which are flushed. Probably melancholia following the puerperia & probably due to much loss of blood.

Personal and Medical History of Mrs. Manda Wagner.

1899

This patient was brought here by sheriffs deputy Frank Collins attended by G. F. Schuerschmidt. + Oscar Wagner, in fair physical condition, with the following history: No consanguinity, heredity nor intemperance in patient nor in parents: First symptoms of insanity manifested Mch 25/99. by refusing to talk or eat: Disease appears stationary: Is not variable: Manifested as above stated: No filthy nor destructive habits: No peculiarities previously noted: No severe diseases nor injuries to head: Has been confined to room since birth of child: Has received ordinary treatment for relief of puerperal mania: On personal examination is pale, anaemic, emaciated: pulse full

5/9/99 On admission put upon Infirmary (5th Apt.) Complexion dark: hair + eyes brown: Skin in normal condition: Is dirty: Behavior quiet: Would not walk: Refused to talk.)

5/9/99 to 5/23/99 Summary 14 da. Record by Dr Bibb. Temp. 98 2-10 Pulse 76-104 Resp. 17-27. Appetite good: Bowels constipated, laxatives given: Sleeps well: Is fed by nurses. May 18 Complained of pain in back + abdomen: May 19 Do. May 23 Up + dressed Very weak + put back to bed. May 23 Up on ward. Very quiet, appetite fair: Neat in habits + appearance: Quite stupid at times + very melancholy: Circulation very poor: Face always flushed extremities cold. Summary Nurses Notes by Dr A. F. Strickler-

1899 June 1st Remains quite weak but has a fair appetite. Prefered to remain in bed all day. Very much depressed: would cry when spoken to: Took very little interest in her surroundings. would not converse nor answer questions. Visited by father and husband.

June 12 Was encouraged to get up out of bed. Took some out door exercise. Appetite improved some + She seemed more cheerful but She was still much depressed, + tho She would answer ordinary questions would usually cry before conversation was ended. Was taking Gynecological treatments. Husband visited her July 12th and though he was advised not to remove her from the Hospital, thought he could take care of her at home + She was allowed to go with him.

Letter received from husband dated Nov: 3rd, 1899. States that patient has "completely recovered" + is engaged "in her former occupation as usual."

Discharged

Personal and Medical History of

Personal and Medical History of Jessie E. Wilson.

Whole No. 5303
Residence, Steele Co. Minn.
Date Admission, May 9th 1899
Admitted by Dr. R. A. Sibbs hour, 3 P.M.
How Sent, W.A Eggleston & J. of P. Steele Co.
Sex, Female Age, 33.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Book-keeping (Father a farmer)
Degree Education, Liberal.
Profession, Religion, Methodist.
Habits, Not intemperate.
~~Nationality~~ Nativity, Steele Co. Minn. (Father born in New York. Mother N. Scotia
Physicians Committing, W.C. Eustis & F.C. Baier.
Correspondents, Father Mr. Wm. Wilson. Owatonna, Minn.

No. of Years, 196
Insane Relatives, None.
Cause Exciting, Probably overtaxed her mind while book-keeping
Cause Predisposing, unknown
Form, Melancholia
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, Jumped from a window
Propensity not now active.
Date of this Attack, About 2 years ago.
Duration, About 2 years.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 31 yrs.
Time of Leaving, July 13. 1899
Time in Hospital, 2 m. 4 d.
Result, Died. Pyelo nephritis

EXAMINATION ON ADMISSION BY DR. R. A. Sibbs *Date of* 5/7/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused & rather sluggish.
MEMORY, Past Events, Fair
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Rather dull but fairly correct after having time to think.
REASONING POWER, Ordinary Subjects, Quite good.
Special Subjects, Very difficult to express herself.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Variable. often depressed. is irritable & violent at times.
DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, ~~Impaired~~ Moral and Ethical Failure, Slowness or Dullness, Silliness,
Loss of Will Power, ~~Worked~~ Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Says about 2 yrs.
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
None - she says.
Father, Living - quite well. 56-7.
Paternal Relatives, Says nervous but not insane
Mother, Living - Father says he hardly knew which to bring mother or daughter - mother very nervous.
Maternal Relatives, Nervous but not insane
Brothers and Sisters, All well - Sister nervous, active & restless
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Scarlet fever at 10 yrs - Diphtheria at 15 yrs.
Has had nasal trouble since. Trouble with bladder now.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, Pain in head - Vertigo some time ago.
OCCUPATION, Healthy or not, Canvassing for books.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, ~~Impaired~~ Good Appetite, ~~Worked~~ Good and Bowels, Constipated

Personal and Medical History of Jessie E. Wilson.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in PRESENT WEIGHT, 98 USUAL WEIGHT, NUTRITION, Fair
WOUNDS, Abnormalities and condition of Skin, N.
TONGUE, Coatings or Promptness of Movement, Quite prompt. no coat.
PUPILS, Equality, Size, Response to Light, and Accommodation,
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Light seems to hurt head at times. Glasses aggravated trouble.
HEARING, Good.
COORDINATION, Arms, Fair Legs, not good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Says has twitching of tongue - eyes, & in different parts of body.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Hesitating & cannot express herself well on account of twitching. - Slow.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Exam. not noted
ARTERIES,
do
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
do.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Much tenderness at junction of uterus & cervix. Uterus retroflexed. external genitals normal - hymen lax - haemorrhoids - tumor in bladder - probably tubercular in origin.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Restless & does not sleep well.
BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Troubled with somnambulism. Fell from window injuring spine. Says she was paralyzed from her waist down, & it was 3 mos. before she could walk. Still has pain at end of spine after long sitting. Shortly before she came to hospital she first had trouble in expressing herself.

Personal and Medical History of Jessie E. Wilson.

1899

This patient was brought here by sheriff's deputy Wm. H. Wilson attended by Mrs Young, in fair physical condition, with the following history:- No consanguinity, heredity nor intemperance in patient nor her parents: First attack occurred about two years ago: Mind deranged upon religious subjects: Disease appears increasing: Is variable: Is worse at a certain time each month: Derangement now manifested by excited & violent behavior: becomes very cross when opposed: Not disposed to injure anyone: Jumped from a window, probably with suicidal intent: No disposition to filthy or destructive habits shown: Has seemed for several years overoccupied with religious impressions: No severe diseases nor injuries to head manifested: No confinement nor restraint employed: No treatment pursued: On personal examination is easily excited, answers questions very slowly & appears to remember very poorly. On admission put upon Infirmary (Gen'l. Rpt Complexion dark: hair & eyes brown, condition of skin normal: No marks, scars nor bruises: Is clean: Behavior quiet but very nervous: Talks intelligently.)

June 1st Summary Nurses Notes by Dr. A. F. Strickler Patient seems very much confused & is untidy in habits: has a fair appetite: Apparently understands what is said to her, but hesitates in making replies to questions. Visited by friends. Physically was not well. Urine contains a great deal of desquamated epithelium and pus and was occasionally streaked with blood. Complained of pain in bladder & region of kidneys. June 30th became quite stupid & was unable to be about the ward. Refused meals. Had to be catheterized. Was fed mechanically with stomach tube. Very restless & would not remain in bed. Bladder irrigated three times daily. Urine contained large quantity albumen & blood corpuscles: Patient very constipated. After a few days seemed a little brighter. talked freely & rationally. Examined gynecologically by Dr Mays. During next few days gradually became stupid again. muttered incoherently to herself. Became restless & her face and chest were covered with bright rash, which disappeared in a few days when the constipation was relieved. She then became unable to retain her food, tho' she was on milk diet. Became much weaker. Albumen increased in urine & at times there was quite free hemorrhage. Visited by mother, who remained till her death. July 13th. at one o'clock a. m. Permission was obtained from mother & bladder & kidneys were examined in the morgue. Bladder walls were much thickened, especially the posterior walls. Mucous membrane was entirely destroyed being replaced by false membrane. Bladder contained about 3oz of thick pus mixed with blood. Left kidney about normal in size and weight capsule thickened & adherent in patches. Somewhat congested. On section, cortex showed parenchymatous change: pelvis was full of thick pus & the pyramids were destroyed. Same conditions existed in right kidney, but pelvis was full of clotted blood. Her mother states that after her fall her bladder trouble began & it had always been necessary to catheterize her from that time. Urine became infected and no doubt the infection traveled up the ureters to the kidney, which caused her death.

Personal and Medical History of Jessie E. Wilson

Died

Personal and Medical History of Magdalena Costa.

Whole No. 5304

Residence, Stillwater, Minn.

Date Admission, May 9th 1899.

Admitted by Dr. P.M. Phelps hour, 6th P.M.

How Sent, T.L. Wilson Sheriff Washington Co.

Sex, female Age, 44 yrs.

Civil Condition, Widow.

Children, None (one dead)

Age Youngest Child, -

Occupation, Housewife

Degree Education, Can read & write.

Profession, Religion, Lutheran.

Habits, Not intemperate.

~~Nativity~~ Nationality, Switzerland (Parents also born there)

Physicians Committing, H. Rhodes & G.M. Waties.

Correspondents,

No. of Years, 19?

Insane Relatives, Remote ancestors

Cause Exciting, Theft of $30.00

Cause Predisposing, Previous attack.

Form, Recurrent Mania Ac -

Accompanying Bodily Disorder, Nervousness.

Suicidal or not, Not.

Date of this Attack, About 2 mos. ago.

Duration, About 2 mos.

No. of Attack, 2nd

No. of Admission, 2nd

Age First Attack,

Time of Leaving, May 26. 1900

Time in Hospital, 1 yr. 17 d.

Result, Disc. Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Bebb. *Date of* 5/22/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quite clear. not sluggish.

MEMORY, Past Events, Quite good.

Recent Events, " Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Not dull but rather slow. Quite correct.

REASONING POWER, Ordinary Subjects, Quite good

Special Subjects, "

Own Mental State, "

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Somewhat depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

Does not express any now.

HALLUCINATIONS, On admission heard her relatives talking to her.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, dead.

Paternal Relatives,

Mother, died - dropsy.

Maternal Relatives, Uncle & Aunt paralyzed - uncle was an inebriate - died of rheumatism - one of consumption

Brothers and 2 Sisters & three died when babies. 2 sisters living. 1 child - died brain fever. ill 8 days. Meningitis

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Had operation for haemorrhoids before previous admission.

HABITS, Drinking and Smoking, Moderate.

HEADACHES, ~~VERTIGO~~, OR ~~CONVULSIONS~~,

OCCUPATION, Healthy or not, Housework.

Detail Date, Duration, and Character of Previous Attack, if any,

2nd attack. Had 1st in Switzerland about 14 yrs. ago. soon after husband was drowned. Was in hospital 8 mos.

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3in PRESENT WEIGHT, 116 lbs. USUAL WEIGHT, NUTRITION, Quite good

WOUNDS, Abnormalities and condition of Skin, Skin moist & cool.

TONGUE, Coatings or Promptness of Movement, Slight coating - protrudes promptly.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - Responses fair.

SIGHT, Good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good.

COORDINATION, Arms, Fair Legs, Fair. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands & tongue.

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Slow but distinct.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, normal

HEART, Murmurs, Strength, Sounds, Size, ~~not~~ not distinct

Apex Beat, Regularity, regular.

ARTERIES,

Pulse weak but regular.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest Symmetrical.

Expans. limited at base especially on L. Side
Had pleurisy - Still fluid in left lung.
Scales with L. Lung 1/4 upr. ago.
Physician thought she had Consumption then. When in hospital in Switzerland. Dr. that she had acute Pneumonia & my cured something into her arm.



CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Hyperaemia of vaginal orifice & laceration of perineum - external genitals otherwise normal. Uterus laceration & general hyperaemia of cervix, uterus slightly retroflexed - with posterior adhesions. Endometritis with offensive leucorrhoeal discharge

MENSTRUATION, Too frequent - usually every three wks. Sometimes flows profusely for a week

~~OPHTHALMOSCOPIC EXAMINATION,~~ Dysmenorrhoea. Considerable pain previous to menstrual period - aching in back & limbs & general malaise. somewhat relieved when flow commences.

Subject to frontal headaches.

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Quite good.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Mental condition fairly good. Seems not to be free from delusions & converses quite sensibly. Thinks husbands sudden death cause of first attack.

Personal and Medical History of Magdalina Kasts.

1899.

This patient was brought here by sheriffs deputy Louis Boy, attended by Mrs Fiscundent, in fair physical condition, with the following history:- A probable history of consanguinity & heredity: No information concerning intemperance in patient nor parents. First attack of insanity occurred several years ago & patient was in this hospital from (to ((For further particulars see Vol. Fol. No.) First symptoms of present attack manifested about two months ago. Disease appears increasing in variable with rational intervals: Derangement now manifested by queer actions, immoderate singing, laughing etc: hollering at midnight etc. Not disposed to injure anyone: Is filthy & destructive in habits: No peculiarities previously manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued. On personal examination shows nervousness of an erratic character. On admission put upon Infirmary (Gen. Ref. Complexion dark: hair & eyes brown: Skin normal condition: Is clean: Behavior quiet: Talks fairly well says she knows she is not well mentally)

May 9- vs. Insm. 14 dar. record by Dr Bibb. On admission rather noisy: slept fairly well: Temp. about normal: May 20 97° Pulse 65-88. Resp. normal. Appetite quite good: May 10 Noisy all night but usually slept well: Bowels constipated: requires laxatives: untidy in appearance: rather troublesome:

May 17. Up on hall several times but necessary to keep her in bed. May 22. Becoming very noisy & resistive. Kept in bed: July 26 Trans. to Annex

Aug 18 Wt. 118. Dept. 26. Threw cup in dining room, breaking it. Dec 9 Had three teeth extracted. Nov 23 There has been a gradual improvement in her condition, is much less disturbed: Talks more sensibly, is quiet in behavior altho occasionally quite despondent: Sleeps well: Receives medicine: Neat in habits & appearance: Works in laundry.

Nov 27. Trans. to A3 Nov 28 In bed with headache & slight cold.

Dec 1- Feb 28 1900. (Dr Heyrodt) Quiet & agreeable on ward: Talks very little: Appetite good: Sleeps well: Bowels somewhat constipated: Works in laundry: Takes outdoor exercise: Dec 29. Does not seem as well & more careless. Dec 29 Jan 17. Wt. 112# Feb 7. Complains of pain in left side. Trans. to Infirmary - has pleurisy of left side: Feb 28 In bed still Course of disease uneventful. Tuch 1- May 28 1900. Quiet: depressed: converses readily: reads & does fancywork: May 3 teeth extracted: Has visited by nephew: May 6 Taken home to sister in So. Dakota.

Letter from sister July 25 1900. States that patient is as well as she ever was.

Discharged.

Personal and Medical History of

Personal and Medical History of Louisa Peterson.

Whole No. 5305

Residence, Belle Creek Minn.

Date Admission, May 9th 1899.

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

How Sent, Rural Hallw Dep't Goodhue Co.

Sex, Female Age, 73 yrs.

Civil Condition, married.

Children, 4 living & four dead.

Age Youngest Child, all of age.

Occupation, None. (Farmer's Wife)

Degree Education, Common school.

Profession, Religion, Lutheran.

Habits, Unknown.

~~Nationality~~ Nativity, Sweden (Parents also born there.)

Became resident of State in 1861

Physicians Committing, R.R. Jones & M. Shane.

Correspondents, John Peterson Wader, Goodhue Co. Minn.

No. of Years, 198

Insane Relatives, Unknown.

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form, Senile Dem.

Accompanying Bodily Disorder, Severe headaches

Suicidal or not, Has threatened it

Date of this Attack, About 2 yrs. ago.

Duration, 2 yrs.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 71 yrs.

Time of Leaving, June 11 - 1901.

Time in Hospital, 2 yr 1 mos 2 Ds

Result, Died. Phlegmanous erysipelas.

EXAMINATION ON ADMISSION BY DR. ..... *Date of* .....

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events,

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2 PRESENT WEIGHT, 117 lbs, USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin,

TONGUE, Coatings or Promptness of Movement,

PUPILS, Equality, Size, Response to Light, and Accommodation,

SIGHT,

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING,

COORDINATION, Arms, Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Laceration cervix & perineum. Uterus retroflexed & atrophied - hypertrophy of cervix.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Personal and Medical History of Louisa Peterson.

1899

This patient was brought here by Sheriff Pf Lundquist attended by Jno A. Peterson, son in fair physical condition, with the following history: No history of consanguinity, heredity unknown; Nothing known concerning history of intemperance in patient nor parents. First symptoms of attack manifested about two years ago, by various delusions. Disease appears increasing. Not variable. Derangement manifested on various subjects; - thinks people are trying to harm her. That other people are in distress & need her assistance; is melancholy & emotional & wanders about aimlessly. Patient tries to hurt others when she is restrained. Has threatened but never attempted suicide. Has no very filthy habits but is destructive of clothing. Previous to accession of disease had a very quick temper. No severe disease nor injury to head. Is occasionally confined to room. No treatment pursued. On personal examination claims to suffer from severe headaches. Pulse 74. Very emotional & talkative. Talks to herself & is restless. On admission put upon Infirmary (G.H.M. Rpt. Complexion dark. Hair brown, part gray. Eyes gray. Skin normal condition. Is dirty. Behavior quiet. Talks intelligently but is easily excited.

May 9. xs. Sum. 14 da. Record by Dr. Bebb. On admission very quiet. Temp. pulse & resp. about normal. Temp. subnormal twice. Appetite continues good. Bowels constipated, requires laxatives. Sleeps well. Quite restless at times.

June 1 - Sept. Patient usually very quiet. Talks much to herself in an undertone. Is neat in habits but destructive at times. June 2 Trans. to Annex.

June 3. Complained of being ill. Remained in bed one day. Very restless at times especially when bathed & in going up & down stairs. June 21 Cut wrist. injury not serious. Aug 18. Wt. 130. Aug 25 Head cut at bed time probably while going up stairs. Six stitches taken. Is gradually becoming more disturbed. untidy in habits & appearance. Expresses many delusions. Will not converse. General health fairly good although she is rather feeble. Takes outdoor exercise. Wound on head healed nicely. Sept 1 - Feb 28 1900 Untidy. Very destructive & resistive. Eats & sleeps well. General health good. Takes outdoor exercise. Wanders about ward & tosses rugs about. Dec 30 Visited by brother Jan 1 Wt. 127#. Jan 9. Struck by Mrs Ohman with shoe bruising left side of face & eye. No severe injury received. Feb 25 General health good. Has many delusions. Feb 1 - Nov 30 1900 Untidy. Very cheerful but is restless & at times violent & destructive. Wears locked shoes. Bowels regular. General health good. Takes outdoor exercise. July 23 Vaccinated. Aug 24 Visited by relatives. Sept. 16. Fell on stones hurting right leg. Exam. by Dr. Linton & measured daily. Oct 13 Up on ward. Walks with a little limp.

Oct 26. Patient slipped on a rug & fell suffering Colles fracture of left arm; hand & knee-wrist badly swollen. Arm bandaged & hot applications used; patient would not keep splint on so a plaster cast was applied. Nov 5. Visited by husband.

Personal and Medical History of

Nov 20. Up & dressed daily. Nov 24 Plaster cast applied. Arm looks well. Put in metallic splint. Measured daily. Dec 1 - Feb 28 1901 Trans. Jan 1. to B' Feb 1. Fell from bench & bruised arm, lip & cheek. Feb 4 Fell bruising forehead, cheek & wrist. Feb 5 Put to bed. Seems too feeble to sit up. Feb 7 Visited by two daughters-in-law. Physically very well. Pleasant & answers questions addressed to her. Appetite fair. Untidy & dirty. Feb 16. Trans. to A'. Put to bed. Feb 28. Somewhat stronger & unable to walk about.

Mar 1 - June 1 - 1901 No change in condition until May 20. small sore formed on right instep, some pus present and slight swelling and congestion about it; was put to bed and foot dressed with peroxide and bichloride dressings. Tem. 104. May 24 Transferred to Infirmary with Tem. 103 given hypodermics injections of asceptoline & second noticed large blebs about the inflamed area, one several inches in diameter formed about the ankle and about the lower part of the leg; this rapidly became purulent; large ulcers formed and the subcutaneous tissue sluffed away and the muscles of the calf become infiltrated with pus. Case diagnosed as phlegmonous erysipelas. As there is a case of expected confinement on the Infirmary patient was transferred to A 1. During her stay on Inf. patient was given cathartics, stimulants, strychnine & brandy and put on milk diet; leg dressed twice daily. Painted the area of ulcers with iodine. Ulcers cleansed with peroxide & bichloride bovinine applied. Tem. range was from 99 to 104. Pul. 85 to 115 Resp. 18 to 27. Frequent baths given to reduce temperature. One large abscess formed over sacrum several small ones over back; before death several large blebs formed in different parts. Last four days patient refused nourishment and medicine, glands on left side of neck became swollen making it difficult to swallow. June 10 became quite stuporous. Died June 11 at 5:30 A. M.

Dead

Personal and Medical History of Mary Arett

Whole No. 5306
Residence, Lansing, Mower Co Minn.
Date Admission, May 9th 1899
Admitted by Dr. P.M. Phelps hour, 6th PM
How Sent, S.S. Washburn Dep. Sh. Mower Co.
Sex, Female Age, 38 yrs.
Civil Condition, Married.
Children, Seven.
Age Youngest Child, Died Jan. 99 aged 4 mos.
Occupation, Housewife (Husband a farmer)
Degree Education, Can read & write.
Profession, Religion, Lutheran
Habits, Not intemperate.
~~Nationality~~ Nativity, Born (Parents born in Norway)
Physicians Committing, F.E. Daugherty - Ed. Washburn.
Correspondents, Geo Arett Austin, Minn.

No. of Years, 199
Insane Relatives, None.
Cause Exciting, Loss of child.
Cause Predisposing, Unknown.
Form, Melancholia agitans.
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, Not.
Date of this Attack, About 2 mos. ago.
Duration, About 2 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 38 yrs.
Time of Leaving, June 3. 1899
Time in Hospital, 2 mo. 23 d.
Result, Discharged Oct. 31. 1899 Recovered

EXAMINATION ON ADMISSION BY DR. Bebb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - quick.
MEMORY, Past Events, Impaired.
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert - incorrect.
REASONING POWER, Ordinary Subjects, Impaired
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed & agitated.

DELUSIONS, Systematized, Transitory, Special Subjects,
Probably in fear of impending danger. Moans & is restless & attempts to escape.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 2 mos.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Not ascertainable
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
7 Children
No
HABITS, Drinking and Smoking, No.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housekeeper
Detail Date, Duration, and Character of Previous Attack, if any,
First attack.
Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, PRESENT WEIGHT, USUAL WEIGHT, NUTRITION, Fair
WOUNDS, Abnormalities and condition of Skin, Several small bruises on legs. Skin warm & dry.
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation,
SIGHT,
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING,
COORDINATION, Arms, fair Legs, fair Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, of hands.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Refuses to talk.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
ARTERIES,
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION,

MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Fairly well.
BOWELS, Present Condition, Excellent

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Previous mental grade probably about normal. Present trouble appears to be melancholia agitans - Moans, walks floor & attempts to escape - Expression & entire attitude one of deep depression - Picks nervously at hair until she has quite a bald spot above forehead.

1899 Personal and Medical History of Mary Arett.

This patient was brought here by Sheriffs deputy N. Nicholson attended by Geo. Arett. in fair physical condition, with the following history: No history of insanity. Nothing known concerning consanguinity. First symptoms of insanity manifested about two months ago: Disease appears increasing: So variable. Patient is worse at night. Derangement now manifested by walking floor & moaning for hours at a time: Attempts to escape. Not disposed to injure anyone. No peculiarities previously noted. No severe diseases nor injuries to head. No confinement nor restraint employed. No treatment pursued. On personal examination is constantly walking up & down, moaning, & attempting to escape. Has a melancholy expression. On admission put upon Infirmary Ward (Gitts Pt.) Complexion dark: eyes brown: hair gray: Skin hot & dry. Several small bruises on legs: Is dirty. Behavior very maniacal. Would not talk.)

May 9 - 23. Dim. 14 da. used by Dr. Bebb. Was extremely restless: struggled when bathed: Was put in restraint. May 10. in restraint, extremely noisy & restless all night. did not sleep any. Visited by husband & brother-in-law. May 11. Muscle. During first week temp. slightly elevated. Pulse 90 - 140. after that normal. Appetite grew poorer & fed with tube once. Bowels constipated. Slept well at night but very noisy during day. In restraint for several days. May 16 Complained of pain in side. Taken out of restraint. Hypos. & sleeping doses given as needed. Lavage of bladder daily. Improved gradually during second week and. altho noisy still at times. not so restless. May 23 Visited by husband & brother in law who took her walking. Also visited by husband on 26-27 & 31. June 3 Appears anxious & depressed & worries a good deal. Appetite good. Visited by husband & taken home.

Discharged.

Personal and Medical History of

Personal and Medical History of Laura B. Sullivan

Whole No. 5312

Residence, Rosemount, Minn.

Date Admission, May. 23rd 1899.

Admitted by Dr. A. F. Strickler hour, 2 PM.

How Sent, T. P. Moran & of P. Dakota Co.

Sex, Female Age, 16 yrs.

Civil Condition, Single.

Children, –

Age Youngest Child, –

Occupation, Student (Father a farmer.)

Degree Education, 2nd year in high school.

Profession, Religion, Not a church member.

Habits, Not intemperate.

Nationality, Minnesota (Father Newfoundland, Mother Minn.)

Physicians Committing, Dr. Fitch + A.M. Adist.

Correspondents, Wm Sullivan (Father) Rosemount Dakota Co.

Grandfather – Hon. M.H. Sullivan Hastings, Minn.

No. of Years, 20 ?

Insane Relatives, None.

Cause Exciting, Overwork at time of maturing.

Cause Predisposing, Unknown.

Form, Acute Mania (Hysterical) (Subacute)

Accompanying Bodily Disorder, Constipation.

Suicidal or not, not.

Date of this Attack, About one year ago.

Duration, About one year.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 15 yrs.

Time of Leaving, Dec. 9. ~~1900~~ 1899

Time in Hospital, 6 m. 17 d.

Result, Discharged July 27. 1900
Recovered

EXAMINATION ON ADMISSION BY DR. A. F. Strickler Date of May 24 '99

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Confused

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, } Will not reason

Special Subjects, }

Own Mental State, }

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Talks about men + Chloride of lime.
Impossible to fix her attention

HALLUCINATIONS, Not apparent

ILLUSIONS, do.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Several years.

ONSET, Gradual or Sudden, Sudden

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, b. nervous

Paternal Relatives,

Mother, living

Maternal Relatives, Maternal aunt insane.

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), She has disposed more marked at times + is said to have always had asthma

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Has worked about a farm

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Always wakeful + restless. Bowels regular.

CHAS. SIMPSON, M. D., Minneapolis.
CHAS. B. PILLSBURY, M. D., Owatonna.
O. C. TARBOX, M. D., Princeton.
H. MORELL, M. D., Slayton.
J. S. SHRADER, M. D., Delano.
P. A. HILBERT, M. D., Melrose.
ADELE S. HUTCHISON, M. D., Minneapolis.

W. W. DROUGHT, M. D., President, Fergus Falls.
JOHN B. BRIMHALL, M. D., Secretary, St. Paul.

STATE OF MINNESOTA.

STATE BOARD OF MEDICAL EXAMINERS.

Delano Minn May 30 1899

Mr W. J. Sullivan
Rochester Minn

Dear Sir Your message received this P.M.; in reply to your request will state that I kept no record of Laura's case and must answer you wholly from memory
Mrs Sullivan consulted me about Laura nearly two years ago at that time I found her a tall slim girl very bright mentally with a deformity of the chest walls encroaching upon the heart she was anaemic and suffering from asthmatic attacks attributable at that time to the deformity of the chest walls Temperature normal, pulse accelerated, suffering from Amenorrhoea or delayed menstruation The treatment at that time was Blaud's Pills tonics Cod liver oil ext and position and calisthenics for the deformity under which treatment she gradually improved This treatment was kept up for 3 or 4 months or possibly longer About one year after I first knew her mrs Sullivan again consulted me stating that she was not right mentally and saying that she had Hallucinations and was talking about strange things entirely foreign to her disposition

Appearance, Complexion of considerable pain. Could not sleep. Was quite whispering most everything. accompanied by hysterical fits of crying that could not be stopped. She was not at home during this time.

← left side

SLEEP, Present Amount and Character, Awake + noisy.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She has always been nervous + at time of puberty became bold + frivolous. Her condition at present resembles most closely hysterical mania.

Pers

Whole No.

Residence, (

Date Admission,

Admitted by Dr. (

How Sent, T. P. Mo

Sex, Female

Civil Condition, Sing

Children, –

Age Youngest Child, –

Occupation, Student (Fa

Degree Education, 2nd year in

Profession, Religion, Not a church

Habits, Not intemperate.

Nationality, ~~Nativity~~ Minnesota (Father Newyork, Mother Minn)

Physicians Committing, Dr. Fitch + Asst. Asdist.

Correspondents, Wm Sullivan (Father) Rosemount. Dakota Co.

Grandfather - Hon. M.K. Sullivan Hastings. Minn.

(Subacute)

last step.

About one year ago.

bout one year.

o. of Attack, 1st

No. of Admission, 1st

Age First Attack, 15 yrs.

Time of Leaving, Dec. 9. ~~1900~~ 1899

Time in Hospital, 6m. 1 d.

Result, Discharged July 27. 1900

Reconsidered

EXAMINATION ON ADMISSION BY DR. C. J. Strickler *Date of* May 24 '99.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Confused

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, Special Subjects, Own Mental State, } Will not reason

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Talks about men + "Chloride of lime". Impossible to fix her attention

HALLUCINATIONS, Not apparent

ILLUSIONS, do.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Several years.

ONSET, Gradual or Sudden, Sudden

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, living, nervous

Paternal Relatives,

Mother, living

Maternal Relatives, Maternal aunt insane.

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), She has dispepsia more marked at times + is said to have always had asthma

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Has worked about a farm

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Always wakeful + restless. bowels regular

CHAS. SIMPSON, M. D., Minneapolis.
CHAS. B. PILLSBURY, M. D., Owatonna.
O. C. TARBOX, M. D., Princeton.
H. MORELL, M. D., Slayton.
J. S. SHRADER, M. D., Delano.
P. A. HILBERT, M. D., Melrose.
ADELE S. HUTCHISON, M. D., Minneapolis.

W. W. DROUGHT, M. D., President, Fergus Falls.
JOHN B. BRIMHALL, M. D., Secretary, St. Paul.

STATE OF MINNESOTA.

STATE BOARD OF MEDICAL EXAMINERS.

_____ 189__

I found her at that time with her menstrual function restored and her general health restored to a certain extent temperature normal and but Pulse still accelerated mentally I could discover nothing wrong and accepted statements of mrs Sullivan in regard to her mental condition as fact and treated her for that condition shortly after this she moved away and I lost track of her until you telephoned me this P.M.

That is a statement of her case as near as I can recall it from memory Any thing more that I can do for her I would gladly do and if there is any thing further you wish to know dont hesitate to ask me I hope her condition is nothing serious and trust that all will come out right in the end

Kindly remember me to Mrs Sullivan

Sincerely Yours
J. S. Shrader

Complains of conscious pain. Could not sleep. Was quite whispering most everything. Accompanied by hysterical fits of crying that could not be stopped. She was not at home during this time.

SLEEP, Present Amount and Character, Awake + noisy.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She has always been nervous + at time of puberty became bad + frivolous. Her condition at present resembles most closely hysterical mania.

Personal

Whole No. 53
Residence, Rose
Date Admission, Ma
Admitted by Dr. A. J.
How Sent, P. P. Mora
Sex, Female
Civil Condition, Singl
Children, –
Age Youngest Child, –
Occupation, Student (Father a farmer.)
Degree Education, 2nd year in high school.
Profession, Religion, Not a church member.
Habits, Not intemperate.
Nativity, Nationality, Minnesota (Father Newyork. Mother Minn.)
Physicians Committing, H. Fitch + Asst. Asst.
Correspondents, Wm Sullivan (Father) Rosemount. Dakota Co.
Grandfather - Hon. M.K. Sullivan Hastings. Minn.

...peiencel)(Subrescent)
...Disorder, Lowest stage.
... or not, Not.
Date of this Attack, About one year ago.
Duration, About one year.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 15 yrs.
Time of Leaving, Dec. 9. ~~1900~~ 1899
Time in Hospital, 6 m. 17 d.
Result, Discharged July 27. 1900
Recovered

EXAMINATION ON ADMISSION BY DR. A. J. Stricker *Date of* May 24'99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused.
MEMORY, Past Events, Confused
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert.
REASONING POWER, Ordinary Subjects,
Special Subjects, Will not reason
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Talks about men + "Chloride of lime".
Impossible to fix her attention
HALLUCINATIONS, Not apparent
ILLUSIONS, do.
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.
LENGTH INVASION, Several years.
ONSET, Gradual or Sudden, Sudden
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, L. nervous
Paternal Relatives,
Mother, living
Maternal Relatives, Maternal aunt insane.
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), She has dyspnoea more marked at times + is said to have always had asthma
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Has worked about a farm
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Always wakeful + restless. Bowels regular.

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...5/30/99

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OFFICE OF
DR. J. C. FITCH.

HASTINGS, MINN., May 26th 1899

Mr. Wm J. Sullivan.
Rochester.

Dear Sir,

Mrs Oliver telephoned me to day stating that you wished me to write you concerning your Daughters sickness last Sunday. The only observable trouble at that time was an Acute Vaginitis which yielded readily to treatment, but seemed to give her undue anxiety & alarm. A preparation for local use containing a little Cocaine, with a Dose of Iron Quinine & Strychnia, acted very nicely and soon gave relief.

Hoping that Edna is rapidly improving. I am as ever -

Yours - J. C. Fitch.

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Personal

Whole No. 53
Residence, Rose
Date Admission, Ma
Admitted by Dr. A. J
How Sent, T. P. Mora
Sex, Female
Civil Condition, Single
Children, –
Age Youngest Child, –
Occupation, Student (Father a farmer.)
Degree Education, 2nd year in high school.
Profession, Religion, Not a church member.
Habits, Not intemperate.
Nativity, Nationality, Minnesota (Father Newyork. Mother Minn)
Physicians Committing, Dr. Stitch + Asst. Asst.
Correspondents, Wm Sullivan (Father) Rosemount. Dakota Co.
Grandfather - Hora M.K. Sullivan Hastings. Minn.

(Principal) (Subaccount)

Disorder, Conceit stup.

Or not, Not.

Date of this Attack, About one year ago.

Duration, About one year.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 15 yrs.

Time of Leaving, Dec. 9. 1899

Time in Hospital, 6 m. 17 d.

Result, Discharged July 27, 1900
Recovered

EXAMINATION ON ADMISSION BY DR. A. J. Stricker Date of May 24 '99.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Confused
Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, Will not reason
Special Subjects,
Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Talks about men + "Chloride of lime".
Impossible to fix her attention

HALLUCINATIONS, Not apparent

ILLUSIONS, do.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Several years.

ONSET, Gradual or Sudden, Sudden

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, b, nervous

Paternal Relatives,

Mother, living

Maternal Relatives, Maternal aunt insane.

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), She has disposition more marked at times + is said to have always had asthma

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Has worked about a farm

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Always wakeful + restless. Bowels regular.

d Medical History of

PHYSICAL CHARACTERISTICS.

UTRITION,
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EASUREMENTS,
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Appearance,

+ left side

Rosemount Minn 5/30/99

Doctors Phillips & Stricker
Rochester Minn.

Gentlemen: On account of my being absent from home for over six months last fall winter & spring I thought our girls mother would give some & later account of her actions:
The day
I It was about one year ago Laura commenced to act strange. During the months of July & august last she attempted to commit Suicide one way and another and also Compeained of Considerable pain. Could not sleep. Was quite whispering most everything. accompanied by hysterical fits so crying that could not be stopped. I was not at home during this time.

Dave a letter from Laura's physician Dr Phillips of Rochester Minn in regard to her case. Have not data to get it now but will get it if necessary. Dave is nothing

SLEEP, Present Amount and Character, Awake + noisy.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She has always been nervous + at time of puberty became bold + frivolous. Her condition at present resembles most closely hysterical mania.

Personal

Whole No. 5

Residence, Ro

Date Admission,

Admitted by Dr

How Sent, T. P. Moran

Sex, Female

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Student (Father a farmer.)

Degree Education, 2nd year in high school.

Profession, Religion, Not a church member.

Habits, Not intemperate.

Nationality, ~~Nativity~~, Minnesota (Father Newyork. Mother Minn.)

Physicians Committing, Dr. Fitch + Asst. Addit.

Correspondents, Wm Sullivan (Father) Rockmount. Dakota Co.

Grandfather. - Hon. M.K. Sullivan Hastings. Minn.

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... not, not.

Date of this Attack, About one year ago.

Duration, About one year.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 15 yrs.

Time of Leaving, Dec. 9. ~~1900~~ 1899

Time in Hospital, 6m. 17d.

Result, Discharged July 27. 1900
Recovered

EXAMINATION ON ADMISSION BY DR. C. F. Stricker Date of May 24 '99

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Confused

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects,

Special Subjects, Will not reason

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Talks about men + "Chloride of lime".
Impossible to fix her attention

HALLUCINATIONS, Not apparent

ILLUSIONS, do.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Several years.

ONSET, Gradual or Sudden, Sudden

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, b, nervous

Paternal Relatives,

Mother, living

Maternal Relatives, Maternal aunt insane.

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), She has dyspepsia more marked at times + is said to have always had asthma

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Has worked about a farm

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Always wakeful + restless. Bowels regular.

d Medical History of

PHYSICAL CHARACTERISTICS.

5 ft, 5 in. PRESENT WEIGHT, ——— USUAL WEIGHT ... NUTRITION,

... what deformed,

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... Resistance to light fair - ... to accommodation good.

... must be made.

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... Appearance,

... to left side

Laura B. Sullivan Co

For a long time Laura has talked so incessantly that she did not or could not be induced to properly chew her food. On one or two occasions last winter ate such quantities of apples and other fruit as to make her sick throwing up the fruit in chunks. Her mother protested both to the amount Eaten and also to her swallowing everything whole.

III Always had a weak stomach and when suffering from any slight indisposition seemed to always want to drink water trying subject to vomit. She washed the dishes on the evening. May 19th. Hoping this may be some benefit to Laura. Yours Respt. Wm J. Sullivan

Dr Stricker Del Laura's letter in Encl. of envelope

Clara Tolman Laura's letter saying was very Confused

SLEEP, Present Amount and Character, Awake + noisy.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She has always been nervous + at time of puberty became bold + frivolous. Her condition at present resembles most closely hysterical mania.

Persona

Whole No.

Residence,

Date Admissio

Admitted by

How Sent, T. D. Moore

Sex, Female

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Student (Father a farmer.)

Degree Education, 2nd year in high school.

Profession, Religion, Not a church member.

Habits, Not intemperate.

Nationality, Nativity, Minnesota (Father Newfoundland, Mother Minn.)

Physicians Committing, Dr. Fitch + A.M. Adsit.

Correspondents, Wm Sullivan (Father) Rosemount, Dakota Co.

Grandfather - Hon. Mich. Sullivan Hastings, Minn.

...isorder, Lowest stage.

... or not, not.

Date of this Attack, About one year ago.

Duration, About one year.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 15 yrs.

Time of Leaving, Dec. 9. 1899

Time in Hospital, 6 m. 17 d.

Result, Discharged July 27. 1900
Reconvicted

EXAMINATION ON ADMISSION BY DR. C. J. Strickler *Date of* May 24 '99.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Confused

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, Special Subjects, Own Mental State, } Will not reason

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Talks about men + "Chloride of lime".
Impossible to fix her attention

HALLUCINATIONS, Not apparent

ILLUSIONS, do.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Several years.

ONSET, Gradual or Sudden, Sudden

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, d, nervous

Paternal Relatives,

Mother, living

Maternal Relatives, Maternal aunt insane.

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), She has dyspnoea more marked at times + is said to have always had asthma

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Has worked about a farm

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Always wakeful + restless. bowels regular.

d Medical History of

PHYSICAL CHARACTERISTICS.

... 5 ft. 5 in. PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION,

...NDS, Abnormalities and condition of Skin, Lower portion of chest - right side - somewhat depressed. Skin - moist - elastic.

TONGUE, Coatings or Promptness of Movement, Grayish coat. Protrudes promptly.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Moderate dilatation. Response to light fair - response to accomodation good.

SIGHT, Fair

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Not impaired

HEARING, Fair

COORDINATION, Arms, Fair Legs, Fair. Special test ~~Creep~~, cannot be made.

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Exaggerated Other Reflexes, present

ARTICULATION, Slurred, Hesitating, Slow, Distinct.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Apparently normal

HEART, No. 1 Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity, Sounds clear distinct - Size not increased Apex beat normal - Regular

ARTERIES,
No change detected.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest flat on right side, with a prominence at lower end of sternum. Exp. fair B. Sounds - over left upper lobe loud dry rales.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Uterus markedly antiflexed + inclined to left side

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Awake + noisy,

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She has always been nervous + at time of puberty became bold + frivolous. Her condition at present resembles most closely hysterical mania.

Personal and Medical History of Laura B. Sullivan.

1899

This patient was brought here by her father Wm J. Sullivan, as Sheriffs deputy attended by Mrs. Fred Oliver, in fair general health, with the following history:- No history of heredity consanguinity nor intemperance in patient nor her parents: First symptoms of insanity manifested in June 1898 when she became very depressed: Disease appears increasing, no rational intervals: Derangement manifested on no special subject: No filthy nor destructive habits: No peculiarities previously manifested except that she has always been extremely nervous: No severe diseases nor injuries to head: No confinement nor restraint employed No special treatment pursued. On personal examination is excitable, incoherent, constantly talking: Cannot sleep.
On admission put upon Infirmary (2nd N. Ppt. Complexion fair: hair light brown: eyes blue: Skin hot and dry: No marks, scars nor eruptions noted: Small bruise on arm: There has been some injury of sternum or ribs, on right side last few ribs protrude some: Behavior very maniacal: Talk incoherent: to clean.

May 22 - June 7. Temp. of 14 da. rec. by Dr. Bebb. On admission very much disturbed altho slept well: May 23. Excited, out of bed often & awake all following night: Visited by father: Has constant elevation of temp., higher in afternoon. Pulse 86-130. Resp. 17-29. Coughs & expectorates a good deal. Appetite good. Bowels constipated & Sonic given: May 25 gran regulata
Visited by father: Continues much disturbed restless & noisy & at times, awake all night: Fed by nurse: After May 31 taken out doors daily for several hours, also given hot baths & massage daily: Some days much quieter: Talks much of time in a rambling, incoherent, excited manner: Is quite destructive: June 20 Up on ward & very noisy & violent at times. Appetite has improved: Aug 1 Visited by grandfather: Gradually becoming quieter but still much confused mentally. Appetite very poor, has lost in weight, is pale & exhausted from her long extended restlessness. Aug 17 Instead of continued improvement hoped for a constant physical failure noted & patient is pale & thin. Sept. 25 Has continual elevation of temp. Pulse accelerated: appetite good. Oct. 19 Physical condition still very poor & indications of nervous trouble becoming prominent: limbs are quite helpless & she requires support in walking: Has an enlarged gland forming under right arm, quite painful, painted daily. Nov. 8 Abscess large & inflamed. Treatment continued daily: Nervous disturbance peripheral in origin & temporary: Has largely overcome inability to use limbs altho she complains of stiffness. Nov. 17 Abscess opened: boracic acid compresses applied & arm painted. During the past few weeks a slight mental improvement noticed but with the recovery of her intelligence she seemed to realize her condition & has become very much discouraged & very melancholy & her impaired physical condition & the pain from the abscess increase this depression. Dec. 8 From time of last note she has

Personal and Medical History of

1899

continued quiet & depressed: talks freely & sensibly & is more interested in her surroundings but continues quite inactive & moves about in a hesitating listless manner: Her mind also wanders easily: She is rather untidy in habits: appetite good: requires laxatives sleeps well. Abscess is still discharging some, hot compresses applied & arm painted twice a week with iodine.

Dec 9 Visited by father & taken home on trial.

Discharged

Personal and Medical History of Katie Hogenson

Whole No. 5317
Residence, Houston Co. Minn.
Date Admission, May 25 1899
Admitted by Dr. R. A. Bebb hour, 900 P.M.
How Sent, L. Budahl Dep. P. Houston Co.
Sex, Female Age, 24 yrs.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Housekeeper.
Degree Education, Common school.
Profession, Religion, Not a church member.
Habits, Not intemperate.
~~Nationality~~ Nativity, Minn. (Houston Co.) (Parents born in Norway)
Physicians Committing, L. K. Overgaard & O. F. Fischer.
Correspondents,

No. of Years, 210
Insane Relatives, Mother's sister
Cause Exciting, Unknown.
Cause Predisposing,
Form, Subacute Mania
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Not.
Date of this Attack, 6 yrs. ago.
Duration, About 6 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 18 yrs.
Time of Leaving, Apr. 20, 1900
Time in Hospital, 10 m. 26 d.
Result, Disc. Nov. 6. 1900 Rec.

EXAMINATION ON ADMISSION BY DR. Bebb, assisted by Dr Stickler *Date of* 5/26/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Appears fairly active.
MEMORY, Past Events, } Refuses to answer.
Recent Events, } Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Not dull.
REASONING POWER, Ordinary Subjects, Below average.
Special Subjects,
Own Mental State, Does not appreciate her condition.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent. Slight exaltation.
DELUSIONS, Systematized, Transitory, Special Subjects,
Does not answer questions.
HALLUCINATIONS, do.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Several years
ONSET, Gradual or Sudden, Gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Hemorrhoids. Has a fullness over thyroid. Has a follicular pharyngitis
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Tend to constipation—
Sleep disturbed.

Personal and Medical History of Katie Hogenson

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. 7in. PRESENT WEIGHT, — USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, Skin moist & Elastic
TONGUE, Coatings or Promptness of Movement, Thick white coating - readily protruded.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Normal size - Response fair.
SIGHT, Apparently not disturbed.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Not impaired.
HEARING, Apparently not impaired.
COORDINATION, Arms, Fair Legs, fair. All special tests good.
TREMORS, Hands, Tongue, Facial Muscles, General, None.
PATELLAR REFLEX, decreased & delayed. Other Reflexes, do.
ARTICULATION, Slurred, Hesitating, Slow, Refuses to speak. Occasionally whispers a few words.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Apparently normal.
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity, & Strong & distinct
Size & apex beat normal. Regular
ARTERIES, No change detected
Tension high - pulse full.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest Symmetrical.
Expansion fairly good.
Occasionally has pain in region of heart.
Slight Vesicular murmur with occasional whistling rales just below left clavicle on right side.
EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

GYNECOLOGICAL EXAMINATION, External genitals normal. Cervix club shaped - slightly adherent to left. Leucorrhoea whitish & tenacious.
MENSTRUATION, History of menstruation cannot be obtained now.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Fair.
BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She is in apparently good health. Mentally she is excited at times, especially at night. Her condition resembles mania with moderate excitement. She has talked absentmindedly for six years past.

Personal and Medical History of Katie Hogenson.

1899

This patient was brought here by Sheriffs deputy N. H. Forsyth attended by Miss Nora Abrahamson, in fair physical condition, with the following history:- No history of consanguinity, hereditary nor intemperance in patient nor her parents. First symptoms of insanity manifested six years ago by absentminded talk. Disease appears increasing & is rehable, with rational intervals in evening after days (Papers state that 1st attack occurred 3 years ago & lasted one month) Derangement now manifested on no particular subject but reads song books & Bible. Not disposed to injure anyone. No filthy nor destructive habits. No peculiarities previously manifested. No severe diseases nor injuries to head. No confinement nor restraint employed. Received treatment for irregular menses & hæmorrhoids - effects unsatisfactory. On personal examination is well nourished, very slender, prominent features, head round. On admission put upon Infirmary. (Gt. Rft. Complexion fair; Hair light: eyes gray; Skin in normal condition. No marks, scars, nor bruises noted: So clean. Behavior quiet. Refuses to Talk.)

May 25 - June 8. Summ. 14 da. Record by Dr. Bell. On admission very quiet, rested well during night. Temp. slightly elevated most of time: pulse & resp. normal. Appetite fair: Bowels constipated. usually sleeps quite well: usually very quiet; talks very little: Quite resistive & attacks nurses & room mate: Very noisy at times. June 8 Appetite has improved. bowels regular: Takes outdoor exercise: Rarely talks, refuses to answer questions. Is very quiet. June 26 & July 26. Menstr. Aug 30 1899 Quieter & less resistive: Is inclined to be silly, laughs to herself without cause & and appears quite nervous, flushing easily. Oct. 20 Menstr. regular. Dec. 1 '99 Patient continued as above reported until middle of november. since then she takes a little more interest in things & is more agreeable, tho still sits in one position unoccupied, the greater part of time. Sept 1. Apr 25 1900 Neat. quiet. seldom speaks Appetite fair. Bowels regular. Coughs & expectorates. Apr 20. Went home.

Letter received from husband July 28 1900 States patient doing nicely - Improved.

Discharged

Personal and Medical History of

Personal and Medical History of Sarah Sinnert. (Sarah Morani)

Whole No. 5318

Residence, Olmsted Co, Minn.

Date Admission, May 25th 1899

Admitted by Dr. A. F. Stricker hour, 7 P.M.

How Sent, J.A. Leonard J of P. Olmsted Co,

Sex, Female Age, 32.

Civil Condition, Married.

Children, ?

Age Youngest Child, ?

Occupation, Housewife.

Degree Education, Common school.

Profession, Religion, Catholic

Habits, Not intemperate.

~~Nationality~~ Nativity, Cyota Minn. (Parents born in Ireland)

Physicians Committing, H.H. Witherstine & C.D. Granger

Correspondents, Husband.

No. of Years, 2 11

Insane Relatives, None

Cause Exciting, Unknown

Cause Predisposing, Previous attacks.

Form, Recurrent Mania

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Yes. Tried to jump from window.

Date of this Attack, About a week ago

Duration, About one week.

No. of Attack, many

No. of Admission, 5th

Age First Attack, about 18.

Time of Leaving, Nov. 8. 1899

Time in Hospital, 5 m 14 d.

Result, Discharged May 26. 1900 Improved.

EXAMINATION ON ADMISSION BY DR. Stricker Date of May 26 '99

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Good
Recent Events, " Special Subjects, fair.

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

REASONING POWER, Ordinary Subjects, fair.
Special Subjects, fair.
Own Mental State, Apparently appreciates her condition.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Has shown no evidence of their presence
She has no moral nor ethical appreciation.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,
Sleeps fairly well - Bowels regular.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, — PRESENT WEIGHT, — USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Skin moist & elastic.

TONGUE, Coatings or Promptness of Movement, Moist, red, protruded readily.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - response to light & accomodation fair.

SIGHT, fair

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, fair

COORDINATION, Arms, fair Legs, fair. Special tests Grasp, result in quick & accurate results

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Slightly increased. Other Reflexes, normal.

ARTICULATION, Slurred, Hesitating, Slow, Distinct.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Apparently normal.

HEART, No Murmurs, Strength, Sounds, Size, Normal

Apex Beat, Regularity,
Not increased - Apex beat normal
Regular

ARTERIES,
No signs of disease.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
No signs of disease.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Lac. per. - Ext. gen. oth. nor.
Lac. cervix. Cervix is hard - Uterus not freely movable -

MENSTRUATION, Cystic degen. of cervix. Has dysmenorrhea -

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps fairly well.

BOWELS, Present Condition, Regular.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She appears in good general health. has suffered from recurrent attacks of mania for a number of years. She has probably always been below the average mentally.

Personal and Medical History of Sarah (Moran) Dwyer.

1899

This patient was brought here by Sheriff Tine, in ~~good~~ general health, with the following history. No history of consanguinity, heredity nor intemperance in patient nor parents. First symptoms of insanity occurred at age of 18 yrs. This is patients 5th Commitment here. as follows:- 1st time from May '86 to June '87 2nd from June '89 to Dec. '92 - 3rd time from June '94 to June 13/95. 4th from May '96 to May 29/97 (for last commitment see Vol. 30 Fol. 173 No. 4394. First symptoms of present attack manifested about one week ago: Disease appears stationary: Is variable with irregular rational intervals: Derangement now manifested by threatening suicide Cannot be controlled nor Kept at home: Is disposed to injure others; Destroys furniture: She showed peculiarities before accession of disease: No severe diseases nor injuries to head: Has been confined in room at home during this attack & at hospital as above stated. No further facts noted on personal examination On admission put upon B3 W. (6th Rpt Complexion dark: hair black; eyes brown: Skin in normal condition: Is rather dirty; Behavior quiet. Talks intelligently but is rather excited)

May 28 - June 8 - Trans. 14da. record by Dr. Bibb. On admission very talkative & noisy: Slept fairly well. Temp. pulse & resp. about normal: Bowels usually regular: Neat in habits: Took outdoor exercise. Much of time very excitable & boisterous & often used vulgar language: Complained of being nervous & of being disturbed very much by Miss Clay Visited on 25th & 28th by husband: after June 1 became somewhat quieter in behavior & lay down a good deal: Daily agreeable & expressed no delusions: conversation quite sensible. June 8 Visited by sister & nephew: June 11. Taken home by husband. June 30 Returned For a few days complained of sore throat & difficulty in breathing also pain in head. Temp. 98.9. Extremely noisy & excitable part of time.

July 4-6. Very noisy, destructive & profane & quite troublesome. Trans. to C3 on 6th. Gradually became quieter & July 20 Trans. to A2 W.

Aug 14. Became ill during night: Trans. to Infirmary. On 17th Trans. to C2. Daily quiet here: Habits neat: appetite good: Mixed with other patients. Sept 16. Trans. to A2. Nov. 8 Taken home by husband.

Discharged.

Personal and Medical History of

Personal and Medical History of Mrs Anna Storley

Whole No. 5322
Residence, Woodville, Minn.
Date Admission, May 29th 1899.
Admitted by Dr. R. M. Phelps hour, 6th P.M.
How Sent, G.A. Wilson & asst. Waseca Co.
Sex, Female Age, 30 yrs.
Civil Condition, married.
Children, 2
Age Youngest Child, —
Occupation, Housewife.
Degree Education, Common school.
Profession, Religion, Lutheran.
Habits, Not intemperate.
~~Nationality~~ Nativity, Norway (Parents also born there)
Physicians Committing, H.G. Blanchard & G.A. Swartwood.
Correspondents,

No. of Years, 215
Insane Relatives, Father & one aunt.
Cause Exciting, Unknown
Cause Predisposing, Heredity & previous attacks
Form, Acute Melancholia
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, January 1899.
Duration, About 4 mos.
No. of Attack, 3rd
No. of Admission, 2nd here.
Age First Attack, 23 years.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Stricker *Date of* May 30 99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Sluggish.
MEMORY, Past Events, Fair
Recent Events, Poor Special Subjects, Poor.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull.
REASONING POWER, Ordinary Subjects, Below average.
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
About normal.
DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any
HALLUCINATIONS, do
ILLUSIONS, do
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, No.
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, fair Appetite, good and Bowels, Tend to be constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 PRESENT WEIGHT, 132 lbs. USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, Skin moist
TONGUE, Coatings or Promptness of Movement, Irregular. Coated with gray patches. Pearlike.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal size - responses fair.
SIGHT, Good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, Fair Legs, Fair, Special Grasp Prat. fair.
TREMORS, Hands, Tongue, Facial Muscles, General, None
PATELLAR REFLEX, Normal Other Reflexes, -
ARTICULATION, Slurred, Hesitating, Slow, Distinct.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, No disturbance detected
HEART, No Murmurs, Strength, Sounds, Size, Strong Normal
Apex Beat, Regularity, Regular.
ARTERIES,
No sign of disease.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair
No signs of disease.



CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

6/14 GYNECOLOGICAL EXAMINATION, Laceration of perineum, external genitals otherwise normal - extensive laceration of cervix - anterior lip hypertrophied - Endometritis with profuse whitish, mucopurulent discharge
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, good.
BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She is dull & indifferent: Says she has pain on right side of body as tho she had been lying on it a long time. She does not express any delusions & is quiet. Eats well, & is contented. Says she had to work at home & her brother wanted to get rid of her so sent her here.

Personal and Medical History of Mrs. Anna Storey.

1899

This patient was brought here by Sheriffs deputy Frank Collins attended by Dr. Halverson in fair physical condition with the following history: No information concerning consanguinity; father + one aunt insane: No history of intemperance in patient nor parents. Patient had first attack, a slight one in 1894, + second in 1896 + was in this hospital from to (for further particulars see Vol. Fol. No.) First symptoms of present attack were manifested in January 1899, began to act strangely - slighted her work - troubled with sleeplessness. Disease appears increasing & variable with irregular rational intervals: Derangement now manifested by stubbornness, desire to stay out of doors all night. + threats of violence: No disposition to filthy or destructive habits shown. Patient appears to have lost all interest in her children + household. No severe diseases nor injuries to head: Has received no treatment since leaving this hospital - No confinement nor restraint employed. On personal examination is morose + melancholy + refuses to answer questions. On admission put upon Infirmary R. (-Y.H.N. Rpt. complexion fair: hair red: eyes gray: Skin in normal condition: No marks scars nor bruises: Is dirty: Behavior quiet: Answers questions intelligently but only speaks when spoken to.)

May 29 - June 12. On admission very quiet: sometimes answered questions but briefly + did not seem to care to talk: Pulse + resp. normal. slight rise of temp. at times: appetite good: bowels rather constipated. sleep quite good: Up + dressed after first two days: Physical condition seemed quite good: Neat in habits + appearance + rather dull + slow. Helped a little with work. Took outdoor exercise:

June 13 Trans. to A'- Meuets, regular: Aug 31. Commenced to work in Congregate dining room. Sept 1 - Feb 28 1900. Appetite good: bowels regular: Takes outdoor exercise: Behavior quiet: In good general health: Still works in dining room.

March 1 - Nov 30 1900. General health good.: Behavior quiet. July 13 Vaccinated: Oct 15 Tooth extracted: Wt. 147½#. Menstruation regular: Still works in dining room. Very quiet: does not talk. Sept 1 - Feb 28 1900. No change: expresses no delusions: answers questions intelligently - attends chapel + amusements: health good. Feb 28 Visited by friend: Feb 28 Wt. 116#.

Mar. to June 1901 Mar. 1st. to 13 troubled with infected finger which was lanced and dressed, healed without any particular trouble, May 30 Wt. 123#.

June to Sept. General health good, very melancholy, says little to those about her, objects to taking out door exercise, neat in habits and appearance, sleeps well at night. Aug. 27 Wt. 135#. Sept. to Dec. general health good, takes exercise, works regularly in Center, Nov. 27 Wt. 140#.

Personal and Medical History of

Dec. to Feb. 1903. No change. Wt. 126# Aug. 1902 Visited by brother.

Personal and Medical History of Mrs. Ella J. Bean.

Whole No. 5323
Residence, New Prague Minn.
Date Admission, May 30' 1899
Admitted by Dr. P. M. Phelps. hour, 10 A.M.
How Sent, N. Meyer Jr. Scott Co.
Sex, Female Age, 47
Civil Condition, Married
Children, 5.
Age Youngest Child, sixteen years.
Occupation, Housewife.
Degree Education, Common school.
Profession, Religion, Congregational.
Habits, Good.
~~Nativity~~ Nationality, Newyork (Parents Ireland)
Physicians Committing, C.W. Malchow + F.A. Smith
Correspondents, F.A. Bean, New Prague, Minn.

No. of Years, 216
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, Previous attacks
Form, Chronic Melancholia.
Accompanying Bodily Disorder, Nervous.
Suicidal or not, Not now - Was several years ago.
Date of this Attack, Has been nervous since childbirth.
Duration, ?
No. of Attack, 5th
No. of Admission, 3rd Hosp.
Age First Attack, 34 (about)
Time of Leaving, October 1st 1901.
Time in Hospital, 2 yrs 4 mo 1 D
Result, Improved: Dispd Sept 11-1901 By B of C.-

EXAMINATION ON ADMISSION BY DR. Strickler *Date of* May 31'99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick.
MEMORY, Past Events, Fair.
Recent Events, Good Special Subjects, Good.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert.
REASONING POWER, Ordinary Subjects, Normal.
Special Subjects, irrational
Own Mental State, Appreciates her condition
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Systematized
Says she sees angels + hears voices.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,
Did not sleep well - Bowels regular.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, —— PRESENT WEIGHT, —— USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, Skin moist + elastic.
TONGUE, Coatings or Promptness of Movement, Moist + red.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Size normal. Response fair.
SIGHT, Good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, Fair Legs, Fair Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None.
PATELLAR REFLEX, Normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,, distinct.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Normal.
HEART, No Murmurs, Strength, Sounds, Strong Size,
Apex Beat, Regularity,
Size + Apex beat normal. Regular.
ARTERIES,
No apparent change.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
No signs of disease.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Exam. persistently refused. Ovariotomy 4 yrs. ago. (probably cystic condition of ovaries)
MENSTRUATION, previous to operation, regular but profuse. Estab. at 12 yrs. Periods always quite free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, fairly good.
BOWELS, Present Condition, Regular

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Personal and Medical History of Ella J. Bean.

1899

This patient was brought here by her husband + sons, in fair physical condition, with the following history: No history of consanguinity, heredity nor intemperance in patient nor parents: This is the fifth attack of insanity + 3rd admission here: 1st From Oct. 12/91 to Sept. 22/94 - Vol 18. P. 7. No. 2841. 2nd from Aug. 24/95 to May 30/98 Vol. 28. Vol. 349 No. 4184. Patient has been nervous + irritable since leaving here; disease appears stationary: So variable with monthly rational intervals: Derangement now manifested by thinking that she is deprived of her rights: Thinks husband is insane: Uses violent + profane language: Has threatened her husband: No filthy nor destructive habits: No peculiarities previously manifested: No severe diseases nor injuries to head: Has received no treatment since leaving here: Ovaries were removed in April 1895. On personal examination is passionate, nervous, unreliable in statements, manifestations of grief etc. On admission put upon A2 W. Cotton Rpt. Complexion fair: eyes brown: hair red; Condition of skin normal: Sexual small scars on face: Is clean: Behavior quiet: Talks intelligently.

May 30 - June 13: Summ. of 14 da. record by Dr. Bebb. On admission quiet + agreeable: Remains in room most of time: Appetite good: bowels regular: sleeps well: converses intelligently but is very quiet. Rarely speaks unless addressed. but is pleasant + agreeable in manner. Takes out door exercise: + assists with work but spends most of time reading + working for herself: July 25 Complained of pain in back, remained in bed: Expresses no delusions in conversation but her mind dwells much on her ideas + in writing expresses them more freely. in one letter in particular expressed delusions in regard to her children + husband. These are recent as during former attacks she always felt very kindly disposed toward her family.

Sept 1 - Feb 28 1900. Mch. Remains in room a good deal tho at times assists with ward work: at times becomes excited: Takes out door exercise: Jan 19 117#. Mch 1. - Nov 30 1900. General health good: Pleasant + agreeable on ward. July 21 Visited by husband: Remained in city over night. July 17 Vaccinated: Work Went to city: Nov 16 Wt. 159# Dec 1. Feb 28 1901 General health good: Talks freely at times but is quiet + agreeable on ward. Feb 28 Wt. 156#

Mar. to June 1901 May 28 patient visited by husband, no change in general condition. Wt. 156½#. June to Sept. Patient remains the same in mental and physical condition Aug. 30 Wt. 158½# Sept. to Dec. Oct. 1st general health good, neat in habits and appearance, assists a little with work on ward, converses intelligently, is generally pleasant and agreeable on the ward although occasionally disturbed and irritable, bowels regular, sleeps well at night, Oct. 1st taken home by husband,

Personal and Medical History of

Personal and Medical History of Amelia Sears

Whole No. 5326

Residence, St. Paul, Minn

Date Admission, June 1st 1899.

Admitted by Dr R. M. Phelps hour, 5th P.M.

How Sent, E.W. Bazille Jof P. Ramsey Co.

Sex, Female Age, 46.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, None (Father a physician)

Degree Education, Common school.

Profession, Religion, Congregational.

Habits, Not intemperate.

~~Nativity~~ Nationality, Ohio (Parents born in United States)

Physicians Committing, Howard Lancaster + A.W. Dunning

Correspondents, Miss Sears, (Sister) 790 Sylvart St. St. Paul.

No. of Years, 2 1/2

Insane Relatives, Father's brother died insane.

Cause Exciting, Spinal meningitis

Cause Predisposing, With probable Heredity.

Form, Recurrent Melancholia

Accompanying Bodily Disorder, had meningitis four times

Suicidal or not, Not.

Date of this Attack, 3 mo. ago.

Duration, 3 mos.

No. of Attack, 2nd

No. of Admission, 1st/2nd Provo Hospital Utah.

Age First Attack, 42 yrs.

Time of Leaving, Feb 16, 1901

Time in Hospital, 1 yrs - 8 mths. 15 dys.

Result, Improved. Discharged July 29/1901.

EXAMINATION ON ADMISSION BY DR. Strickler *Date of* June 2 '99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, poor

Recent Events, fair Special Subjects, poor.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Illusive.

REASONING POWER, Ordinary Subjects, poor.

Special Subjects,

Own Mental State, appreciates her condition

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

Not apparent.

Melancholia without and apparent delusions.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother, Died - Cancer.

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Cerebro Spinal meningitis several years ago.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches, Vertigo

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Has not slept well the past week. Constipation.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3. PRESENT WEIGHT, 110 lbs USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Burn on right cheek and over right eye. Skin moist-elastic.

TONGUE, Coatings or Promptness of Movement, Tongue moist + red - readily protruded.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Rigs normal.

SIGHT, Impaired -

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Apparently no disturbance -

HEARING, Normal -

COORDINATION, Arms, Fair Legs, fair. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None -

PATELLAR REFLEX, Normal - Other Reflexes, not disturbed

ARTICULATION, Slurred, Hesitating, Slow, Distinct.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Apparently normal -

HEART, No Murmurs, Strength, Sounds, Size, Apex Beat, Regularity, Sounds fairly strong - Size not increased - Apex beat normal - Is regular.

ARTERIES,

No change can be detected -

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

No signs of disease.



CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Treated for 23 mos. for retroversion - Treatment beneficial. Subject to headache + backache at that time - These still continue - but not so severe - External genitals normal Some local tenderness especially on left side - slight retroversion - Leucorrhoea

MENSTRUATION, Irregular - treated

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Awake at night but quiet.

BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Has very quiet pleasant manner - Converses intelligently usually - Has a frank honest expression but has been found untruthful.

Personal and Medical History of Amelia Larson.

1899.

This patient was brought here by sheriffs deputy Ed. Storms attended by Miss Edith Payson in fair physical condition with the following history: No history of consanguinity, Father's brother died insane. First attack of insanity occurred four years ago & lasted three months - patient was during that time in hospital at North Provo, Utah. & improved temporarily. First symptoms of present attack manifested three months ago by melancholia with homicidal tendencies. Disease appears increasing. Is variable. Derangement now manifested by uncleanly & untidy habits with inability to apply her-self to her ordinary pursuits. Is homicidal. Habits untidy & uncleanly but neither filthy nor destructive. No peculiarities previously manifested. Patient had spinal meningitis, four attacks. Has been in hospital as above stated. On personal examination is depressed, suspicious, & constantly mutters to herself.

On admission put upon Infirmary (Gtn. Cpt. Complexion dark. Hair grayish black eyes gray. No marks, scars & bruises noted. Is clean. Behavior quiet. Speaks intelligently.)

June 1 - 15 June. 14 da. record by Dr. Bebb. On admission very quiet. slept well. Temp pulse & resp. about normal. (a slight rise at times). appetite fair. bowels rather constipated requiring enemata. Sleeps well. Complained of headache. After June 5 up on ward. Very quiet & pleasant. Conversation intelligent. assisted with dining room work. Had frequent headaches. June 21 Trans. to A2. June 29 - July 15 Monstr. Aug 17 No special change. continues quiet & agreeable. assists with work. Occasionally goes to bed with some slight illness. Is rather nervous & excitable. Has expressed no delusions.

Sept 1 - Feb 28 1900. Neat. Appetite fair. Very nervous & frequently has nervous headaches. Takes outdoor exercise. Quiet & agreeable on ward. Dec 5 Trans to B3. on account of kleptomaniac tendencies Jan 15 Wt. 116 lbs. Jan 22 Several teeth extracted. Mch 1 - Nov 30 1900. In good general health. Assists with work. Appetite good. Bowels inclined to be constipated. Sleeps well. Takes outdoor exercise. Somewhat depressed at times. Interests herself with reading & sewing. July 21 Vaccinated. Nov 9 Complained of not feeling well. put to bed. Quite nervous & somewhat depressed. Remained in bed two days. Was up again in bed a couple of days. Dec 1 - Feb 16 1901 General health good. Quiet & agreeable. converses intelligently. Feb 12-16 Visited by uncle & went home on trial with him.

Letter Apr 17 from uncle states that patient is doing nicely mentally. but still coughs.

Personal and Medical History of

Personal and Medical History of Alvina Powers.

Whole No. 5329

Residence, St. Paul, Minn.

Date Admission, June 2, 1899.

Admitted by Dr. A. F. Stricker. hour, 6:45 P.M.

How Sent, Ell. Bazille & J. of P. Ramsey Co.

Sex, Female Age, 38 yrs.

Civil Condition, married.

Children, 3 -

Age Youngest Child, — 7 yrs.

Occupation, Housewife. (Husband a laborer.)

Degree Education, ?

Profession, Religion, Catholic.

Habits, Not intemperate.

~~Nationality~~ Nativity, Germany (Parents also born there)

Physicians Committing, Haldor Brieve & F. P. Lamar Gregoire

Correspondents,

No. of Years, VVV

Insane Relatives, None.

Cause Exciting, —

Cause Predisposing, —

Form, ~~Acute~~ mania Ac. Melan - agitans.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Attempted by drowning.

Date of this Attack, ?

Duration, ?

No. of Attack, 1st

No. of Admission, 1 hos. (at C. & C. Hospital)

Age First Attack, ?

Time of Leaving, Sept. 12. 1900

Time in Hospital, 1 yr. 3 mo. 10 d

Result, Discharged Sept. 26. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Stricker Date of June 2 '99.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Poor

Recent Events, Fair Special Subjects, Confused.

PERCEPTIVITY, Alert or Dull, Correct or Illusive, Illusive

REASONING POWER, Ordinary Subjects, Confused.

Special Subjects, "

Own Mental State, "

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects, Transitory present. She is much disturbed, maniacal with delusions.

HALLUCINATIONS, Apparently present.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), 1 miscarriage 2 children

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Restless - Tendency to constipation.

Personal and Medical History of Alvina Powers

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 6 in. PRESENT WEIGHT, Wt. 113 # USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Skin dark & elasticity decreased

TONGUE, Coatings or Promptness of Movement, Tongue coated; - Fremulous.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Size moderately dilated. Response to light fair.

SIGHT, Fair

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Fair -

COORDINATION, Arms, fair Legs, fair. ~~Grasp~~, Cannot make special test on account of excitement

TREMORS, Hands, Tongue, Facial Muscles, General, of Tongue - fine fibrillary.

PATELLAR REFLEX, Exaggerated - Other Reflexes, Normal -

ARTICULATION, Slurred, Hesitating, Slow, distinct

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Apparently not disturbed not impaired

HEART, No Murmurs, Strength, Sounds, Size, 1

Apex Beat, Regularity, Size normal - apex beat normal Regular - rapid.

ARTERIES, No change detected.

LUNGS, Chest, Symmetry, Expansion, Expansion fair - B. Sounds - somewhat roughened over upper lobes.

Breath Sounds,

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

6/7/99 GYNECOLOGICAL EXAMINATION, External genitalia normal - except slight laceration of perineum uterus normal position. Erosion of os. slight leucorrhoeal discharge.

MENSTRUATION, has been irregular for some time. during menses. some pain over left ovarian region. Says menses regular previous to admission

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Awake at night & noisy.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She is probably a primary defector at present she is in poor general health, poorly nourished & exhausted from excited mental state & loss of sleep - Sub-acute mania.

Personal and Medical History of Alvinia Powers.

1899

This patient was brought here by sheriff's deputy Hanson, attended by Bro Magnus + J.A. Markut in fair physical condition: First symptoms of insanity manifested by extreme depression, disease appears increasing: Is variable: Derangement now manifested on subject of religion, also by depression, agitation, insomnia + refusal to eat. Thinks she ought to become a sister, Not disposed to injure anyone: No filthy nor destructive habits: No peculiarities previously noted: No severe diseases nor injuries to head: Has been in restraint 24 hours: Has received opium treatment: On personal examination is agitated, restless, incoherent. On admission put upon Infirmary (Gen'l Rpt. Complexion dark: hair brown: Eyes gray: Condition of skin hot + dry: No marks, scars nor bruises noted: Small open sore on right hand: Small bruise on legs + arms: Is dirty: Behavior maniacal: Has delusions.)

June 7 - 16 Summ. 14 day record by Dr Bess On admission very nervous + restless + out of bed often: first night slept very little Temp. 99-102°. June 3 Temp. 104°. Hot baths given. Pulse 90 - 118. Resp. normal. Appetite fair. Bowels rather constipated, given sedatives + other medicine, which she often refuses. Very careless in appearance: After June 4 dressed + up on ward: Sleep often disturbed: Expectorated some + slight cough noticed: Complained of pain in chest: Continued restless, talkative + at times noisy during first week: During second week quieter altho very much disturbed at times + inclined to be violent. July 16 Visited by husband

July 17 - Remained in bed Complained of pain in left side, coughed some: July 25 up + dressed. Aug 1 - Oct 10 Sick in bed, sick record kept. Coughed + expectorated a good deal, had pain in chest: general physical failure noted. Visited on Sept. 14 by husband. Nov. 30 There has been some improvement in condition since last note: She is up on ward: appetite good: bowels regular, sleeps quite well: Most of time extremely restless + depressed: wanders about hall, wringing hands + moaning: Thinks she has done some great wrong for which she is detained here: Is fairly neat in habits but indifferent to appearance: Assists a little with work: Has a slight rise of temp. daily.

Dec - Feb 5 1900. Jan. 5 Temp. 101 Jan 6. Very restless + at times excited + noisy: wanders about wringing hands + moaning: Is melancholy: Converses readily: habits clean but indifferent as to appearance: Appetite good: Requires laxatives: Jan 6 attempted to escape by jumping thro window where nurse was her room breaking bck: was brought back with difficulty: screamed + fought. Is kept in seclusion as she has tuberculosis + expectorates over everything: Mch 3 Restless + depressed + indifferent. Does no work. May 30 Taken out of doors: Aug 30. No change physically - Is growing a little

Personal and Medical History of

quieter mentally: Taken out of doors nearly every day: At times talks pleasantly + rationally. Sept. 5 Still in seclusion: Coughs + expectorates a great deal: Very weak: lies on bed a great deal: Talks sensibly + coherently: Appetite quite good: Sleeps well: Sept. 12 Visited by sister + taken home.

Discharged

Personal and Medical History of Catherine Thornton

Whole No. 5330

Residence, Lanesboro, Minn.

Date Admission, June 3rd 1899.

Admitted by Dr. P. M. Phelps hour, 8:30 AM.

How Sent, E. V. Farrington & A. P. Fillmore Co.

Sex, Female Age, 33 yrs.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Housework (Father a farmer)

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate.

~~Nationality~~ Nativity, Minn. (Parents born in Ireland)
Became a resident of Fillmore Co. 30 yrs ago.

Physicians Committing, H. W. Phillips & E. R. Thompson.

Correspondents, Dan Thompson (Bro) Lanesboro, Minn.

No. of Years, 22 3.

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing, Unknown.

Form, Defective - High grade intricate.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Attempted to burn herself.

Date of this Attack, Ten years ago.

Duration, About 10 years.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 23 years.

Time of Leaving, 10th September 1901.

Time in Hospital, 2 yrs 3 mos 7 Ds

Result, Recovered: Discharged Nov 30/901.

EXAMINATION ON ADMISSION BY DR. Strickler Date of June 3'99

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, poor.
Recent Events, fair. Special Subjects, poor.

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

REASONING POWER, Ordinary Subjects, fair.
Special Subjects, Below average.
Own Mental State, Has some appreciation of her condition

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,

She laughs without any apparent cause.

HALLUCINATIONS, apparently present.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,
Restless - Regular in habits.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. 3 in. PRESENT WEIGHT, 112 lbs. USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Large irregular scar on right side of trunk & arm old burn, Skin harsh & dry.

TONGUE, Coatings or Promptness of Movement, Fissured - protruded with difficulty.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal: response fair.

SIGHT, Fair.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Fair.

COORDINATION, Arms, fair Legs, fair. ~~Grasp,~~ Special tests are fairly well performed.

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Delayed. Other Reflexes, normal.

ARTICULATION, Slurred, Hesitating, Slow, Distinct

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Apparently not disturbed.

HEART, No Murmurs, Strength, Sounds, Size, Size not increased - Sounds
Apex Beat, Regularity,
normal - apex beat normal position
Regular.

ARTERIES,
No change detected.

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Right clavicle highly arched - Expansion fair.
B. Sounds - No signs of disease.

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

CRANIAL MEASUREMENTS,

Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

Prominent forehead - platocephalic.

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact. very close & firm. anterior lip of cervix prominent. uterus retroflexed & inclined toward left.

MENSTRUATION, Cannot obtain history.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Poor.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She appears in fair general health - well nourished. She is apparently an imbecile of high grade subject to attacks of excitement and at other times much depressed.

Personal and Medical History of Catherine Thornton.

1899. This patient was brought here by Sheriffs deputy Dan Thornton (brother), in fair physical condition with the following history:- No history of consanguinity, heredity nor intemperance in patient nor parents: First symptoms of attack manifested by hysterical fits ten years ago; thought she was going to die: Fourteen years ago became very despondent & melancholy: Disease appears increasing: Not variable: Has had rational intervals during the ten years but none in a year. Derangement now manifested by hiding articles; destroying furniture: Kills chickens, ducks &c, Cuts the ears off cats: Wants to change furniture. Not disposed to injure people: Attempted suicide by burning: No peculiarities previously manifested: No severe disease nor injuries to head: No confinement nor restraint employed: Has had several physicians & time taken to Labrosse for treatment, but without any good results. On personal examination she has all the appearance of chronic mania.

6/3/99 On admission put upon Infirmary (Gen'l Rpt.) Complexion fair: hair & eyes brown: skin rough: Large scar on right side on Arm & leg: A few small bruises on her lower limbs: Is rather dirty: Neck is rather thick & right clavicle is more prominent than left: Knees rather bowed. Behavior quiet: Does not talk much but answers questions fairly well: Laughs & talks to herself.

June 3 - 17th Insm. 14 da. record by Dr. Babb On admission was quiet in behavior & appeared rather stupid: untidy in habits: Pulse & resp. + temp. about normal: Appetite usually quite good, bowels constipated: sleeps well: Takes outdoor exercise: Most of time sits by herself & is very quiet: June 12 became much more disturbed, broke ornament on hall cutting her hand. From this time on was more excitable & several times broke dishes &c, June 16. Visited by sister. July 1st Trans. to C. Aug. 25 Menats. No apparent improvement in patient: Is very distructive & violent & is obstinate & irritable. Refuses to talk & is very quick in her movements & requires close attention: Rarely speaks & when she does usually talks incoherently to herself: never makes a sensible remark. Appetite is improving & she takes outdoor exercise

Sept 1- Feb 28 1900. Untidy: Destructive: Has many delusions: appetite fair: Sleeps well: Bowels regular. Visited by friends Nov 15 & on Dec 5 by Sister. Feb 28. Wt. 90# March 1- Nov 30 1900. Dirty & careless: Talks incoherently & does not voluntarily converse. Has mania for breaking things: At times very destructive: Is resistive: Eats & sleeps well: Takes out door exercise. July 16 Vaccinated 19 slight swelling & inflammation noted about vaccination. Patient vomited. Oct 18 wt 104# Dec 1- Feb 28 1901 No change - General health good.

Mar 1- June 1- 1901 General health continues poor: expectorates a great deal of the time: has a rising temperature and seems to be failing

Personal and Medical History of Catherine Thornton

physically. Mar. 13 refused food. Temperature in the afternoon was 103.7°, transferred to Infirmary & put to bed. From Mar. 13 to April 14 Tem. range was from 100 to 103.8: fever was continuous during this time. On an average of one degree difference between the afternoon and morning the highest range of pulse was 114° respiration 44: from this time on to May 18 Tem. was decreased until it was 99°. in the morning. Most of the time practically normal expectorations continued, symptoms seemed to be those of tuberculosis; dullness in the apexis of the lungs but no tubercular bacilli found, treatment was that of stimulants and tonics & creosote. Diet milk with eggnogs. Patient during time was extremely untidy and distructive. Mar 23 visited by brother; Apr. 12. visited by sister. May 30 Wt. 90 1/2#

June. Patient has been confined to bed: untidy in habits and appearance: appetite poor: bowels generally regular, requires cathartics at times; sleeps fairly well: answers questions intelligently but does not volunteer conversation: expectorates a great deal: Examination of sputum showed tubercular bacilli in large numbers. Sept. 10 was visited by sister and taken home.

Died in St. Paul Nov. 29, 1901

Died

Personal and Medical History of Christine Lattmann.

Whole No. 5331
Residence, Winona Co. Minn.
Date Admission, June 5th 1899.
Admitted by Dr R. M. Phelps hour, 4 P.M.
How Sent, H.L. Buck & of P. Winona Co.
Sex, Female Age, 43.
Civil Condition, Married
Children, 14
Age Youngest Child, 14 months.
Occupation, Housewife (husband a farm laborer)
Degree Education, Can read & write.
Profession, Religion, Lutheran.
Habits, Not intemperate.
~~Nationality~~ Nativity, Germany (Parents also born there)
Physicians Committing, F.R. Price & H.G. McGaughey.
Correspondents, Mr Lattmann

No. of Years, 22 +
Insane Relatives, None.
Cause Exciting, Change of life.
Cause Predisposing, —
Form, Acute Delirium
Accompanying Bodily Disorder, Nervousness.
Suicidal or not, Lacks of it.
Date of this Attack, 4 mos ago
Duration, 4 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 43 yrs.
Time of Leaving, Indy 8th 1899
Time in Hospital, 33 da.
Result, Died Diabetes Mellitus

EXAMINATION ON ADMISSION BY DR. Strickler *Date of* June 7 99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused.
MEMORY, Past Events, poor
Recent Events, " Special Subjects, poor.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Illusive.
REASONING POWER, Ordinary Subjects, So Confused to reason
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Regarding her children
She is suspicious & cannot concentrate her attention
HALLUCINATIONS, Apparently auditory & visual.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in. PRESENT WEIGHT, 134 lbs USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, Skin dry & inelastic.
TONGUE, Coatings or Promptness of Movement, Gray coating, protruded with difficulty.
PUPILS, Equality, Size, Response to Light, and Accommodation, Left pupil moderately dilated. Right normal response. Left does not react.
SIGHT, Impaired
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Apparently no disturbance of ocular muscles
HEARING, About normal.
COORDINATION, Arms, poor Legs, poor. Strial test ~~Grasp~~, Cannot be made on ac of her Confusion
TREMORS, Hands, Tongue, Facial Muscles, General, Occasional twitching of hands.
PATELLAR REFLEX, decreased & delayed Other Reflexes, decreased.
ARTICULATION, Slurred, Hesitating, Slow, Not apparently disturbed.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Apparently not disturbed
HEART, No Murmurs, Strength, Sounds, Size, indeterminate
Apex Beat, normal Regularity, Regular,
Sig not increased

ARTERIES,
No signs of disease.

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest Symmetrical
Expansion fair
No signs of disease

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Laceration of perineum. external genitals fluid otherwise normal Uterus - about 6 mos. pregnant. Cervix slightly dilated.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Awake at night.
BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). The patient appears much confused, feeble & somewhat delirious, picks at bed clothes & mutters to herself. Her general health is somewhat impaired. It is difficult to judge of her mental condition since she cannot be understood & no information could be obtained from her husband. She resembles a case of chronic melancholia, but also has some symptoms of a more definite brain lesion.

Personal and Medical History of Christine Lattmann.

1899.

This patient was brought here by Sheriff Fuhrmann attended by Mr Lattmann, in fair physical condition, with the following history: No history of consanguinity, heredity nor intemperance in patient nor her parents: First symptoms of insanity manifested four months ago by lapse of memory: Disease appears increasing: Not variable: Derangement now manifested by leaving home at night with lamp to look for children; thinks she has killed some of her children: Not disposed to injure anyone: No filthy nor destructive habits: No peculiarities previously manifested: No acute diseases nor injuries thead: No confinement nor restraint employed: No treatment pursued:

6/5/99 On personal examination "eye bad - indifferent - nervous"
On admission put upon Infirmary: complexion dark: hair brown: eyes brown: Skin in normal condition: Scar on right side of chin + + on left shoulder: A few small bruises on legs: Is clean: Pupils unequal: left much larger: Behavior quiet: Does not speak English.

Summary Notes by Dr. Stiller Patient admitted June 5'99. She was grim & back + feet in bed: seemed very quiet + depressed. During the first few weeks her temperature remained about normal but she was awake at night + restless + did not stay in bed. She seemed quite weak + was unable to help herself. All her movements were made in a jerky manner + local spasms were noted in groups of muscles. Patient was so stupid that it it was impossible to make out definitely what her mental state was but at times she brightened up + would answer simple questions. For the most part she muttered incoherently + complained of pain in back + abdomen + in her head. When admitted she was found to be about six months pregnant and the foetal movements could plainly be felt also the heartbeat. Os was much dilated. She remained in about the same condition for a month. Her appetite becoming poor + she frequently requiring laxatives. At times the right pupil would be widely dilated while left was contracted to a pin point. At other times conditions were reversed in the two eyes. Her pulse was very quick + feeble + heart signs were indistinct + distant + she gradually became weaker + more stupid + would not take her food. Her husband was notified of her condition + came to visit her. On July 4th she began to fail very, her temperature gradually became elevated so that on July 8 it was 103°. Pulse was very rapid + feeble, + she had some cough + difficulty in breathing. She died at 11:45 AM.

The body was sent to Bethany. Cause of death Diabetes Mellitus.

Died.

Personal and Medical History of

Personal and Medical History of Augusta Boelk.

Whole No. 5333

Residence, Waltham, Mower Co. Minn.

Date Admission, June 9' 1899

Admitted by Dr. R. A. Gibbs. hour, 6th P.M.

How Sent, St. Waltham & Ofk. Mower Co.

Sex, Female Age, 44.

Civil Condition, married

Children, Eleven.

Age Youngest Child, 17 mos.

Occupation, Housewife

Degree Education, Common school.

Profession, Religion, Lutheran.

Habits, Not intemperate.

Nationality, Germans (Parents also born there.) Became resident state 1870 in

Physicians Committing, R.W. Allen & H.H. Johnson.

Correspondents, Husband, Frank Boelk. Waltham.

No. of Years, 226

Insane Relatives, None known

Cause Exciting, Unknown

Cause Predisposing, "

Form, Paranoia.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, 4 years ago.

Duration, 4 years.

No. of Attack, 1st

No. of Admission. 2nd.

Age First Attack, 39 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. A.J. Stricker *Date of* 6/9/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Somewhat confused.

MEMORY, Past Events, fair

Recent Events, " Special Subjects, fair.

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

REASONING POWER, Ordinary Subjects, fair.

Special Subjects, poor.

Own Mental State, does not think she is sick.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed

DELUSIONS, Systematized, Transitory, Special Subjects, immoral
conduct husband -
Moral + ethical failure prominent.

HALLUCINATIONS, not apparent.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4 ins. PRESENT WEIGHT, 130½ lbs. USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Skin pallastic & dry.

TONGUE, Coatings or Promptness of Movement, heavy gray coat. protruded hesitatingly.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - moderately dilated - Response fair.

SIGHT, Not impaired

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, not impaired

HEARING, Not impaired

COORDINATION, Arms, fair Legs, fair - Grasp, special tests - below average.

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Normal - Other Reflexes, Not impaired -

ARTICULATION, Slurred, Hesitating, Slow, distinct.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, apparently not disturbed

HEART, No Murmurs, Strength, Sounds, normal Size, No

Apex Beat, do Regularity, regular



Jan. 1900.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

ARTERIES,
No signs of disease detected.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion fair.
No signs of disease

8/5/99 EXAMINATION URINE, Quantity, Sp. g. 1012 Reaction, Neutral Color and Appearance, yellow. cloudy ropy deposit.

Albumen, None Sugar, None.

Casts and Crystals, amor. urates - a few pus-corps. uric acid crystals + many overlapping epith. cells.

6/15/99 GYNECOLOGICAL EXAMINATION, Extensive laceration of perineum - cystocele - lateral laceration of cervix - uterus normal position.

MENSTRUATION, Cessation since last January.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Impaired.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Personal and Medical History of Augusta Boelk.

1899.

This patient was brought here by Sheriffs deputy Jno Padden attended by Mr Frank Boelk. in fair physical condition, with the following history: No information concerning heredity, consanguinity nor intemperance in patient nor parents. First symptoms of insanity manifested about four years ago, was at this Hospital from June 9'99 to Mch 26'98 (for further particulars see Vol. Fol. No.) was more quiet after she went home Now has strange ideas; claims to see & hear strange things: Disease appears increasing of late: has never been perfectly right since first attack: Derangement now manifested by thinking & saying that all of her friends are bad; lack virtue; that husband & daughter cohabit together etc: Patient is unkind to baby, punishes it in an unusual way & has tried to hit her daughter with a poker. No filthy nor destructive habits: Peculiarity noted that she always thought everyone was depraved. No severe diseases nor injuries to head. Has been under care of several physicians without any good results: On personal examination seems quiet, but talks incessantly upon her supposed troubles which we are satisfied are nearly all entirely imaginary. On admission put upon Infirmary [G.P.I. Rpt.] Complexion dark: hair & eyes brown: skin in normal condition: No marks, scars nor bruises noted. Is clean: Behavior quiet: Has delusions.)

June 9 - 23. Summ. 14 da. record by Dr Bell. On admission quiet & depressed: Talked freely & sensibly on ordinary subjects but expressed many delusions. Physical health quite good. Temp. pulse & resp. normal. Appetite good: bowels constipated: Sleeps well. Patient remained quietly on ward, rarely speaking to anyone unless addressed. Takes no apparent interest in anything: refuses to work & usually sits in one place & position from day to day. Is quiet & depressed June 14 Visited by A.S. July 13. & Aug 10. Menses. Rather timid & embarassed in manner Is never troublesome but becomes rather irritable if asked to do any work. Sept 1 - Feb 28 1900. Oct 21 Visited by sister & husband.

Nov 9. Neat usually quiet. Very disagreeable when spoken to. Appetite fair Sleeps well: Rarely goes out for exercise. Jan 19 Wt. 127 #.

Mch 1 - Nov 30 1900. Neat: Appetite good: bowels regular: Very quiet. Sometimes refuses out door exercise: Very irritable when disturbed in any way. June 11 Visited by friends: June 16 Struck another patient without cause. July 21. Visited by daughter & friend. July 17 Vaccinated unsuccessfully. Nov 16 Wt. 131 #.

Dec 1 - Feb 28 1901. General health good. no change Feb 28 Wt. 133 #

Mar to June 1901 Mar. 3 to 8 visited by friends, shows no change in mental or physical condition, May 30 Wt. 120 #. June to Sept. General condition remains unchanged, aug. 31 Wt. 133 #.

Personal and Medical History of Augusta Boelk.

Sept. to Dec. 1901 Patient in good general health, eats and sleeps well, takes out of door exercise, is unoccupied, cross and irritable, attempts to strike if interfered with, Trans. to No. 3. West. Nov. 19 patient taken home to Austin by Miss Ida Sonnenberg to attend mother's funeral was returned Nov. 20. Nov. 29 Wt. 118 #.

Dec. to Feb 1903 No change. Wt about 119 #, Nov. 11 - 02 Visited by a lady friend. Patient neat in habits & appearance: generally ~~un~~ cleanly sometimes untidy. Expectorates a great deal. Otherwise physical health good. Sleeps well: bowels regular: goes out for exercise but does no work. She is ordinarily quiet and dosent as a rule converse but at times answers questions. Sometimes scolds a great deal in German: occasionally violent: Dec 1st. Wt. 107½ #.

Personal and Medical History of Mrs. Kate Kunz.

Whole No. 5337

Residence, Freedom, Waseca Co, Minn.

Date Admission, June 14th 1899.

Admitted by Dr. A. J. Kilbourne hour,

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

Sex, Female Age, 37 yrs.

Civil Condition, Married.

Children, 2.

Age Youngest Child, 5 yrs.

Occupation, Housewife.

Degree Education, Common school.

Profession, Religion, Roman Catholic.

Habits, Not intemperate.

Nationality, Germany (Parents also born there.) Naturalized Became President of State of Iowa 56 - of Co. in Sept. 96.

Physicians Committing, D.P. McMahon & D.S. Cummings.

Correspondents, Henry Kunz (husband) Alma City 5 mi. S.E.

Telephone or Telegraph Frank Collins, Waseca, Minn.

No. of Years, 2 30

Insane Relatives, None.

Cause Exciting, Fright caused by attempted intimacy on part of a Henry (June 8/99) Tramp (soldier.

Cause Predisposing, —

Form, Acute Delirium

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, Not.

Date of this Attack, Sunday June 11 '99.

Duration, 3 days.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 37 yrs.

Time of Leaving, July 7 1899

Time in Hospital, 23 d.

Result, Died. Acute Nephritis

EXAMINATION ON ADMISSION BY DR. Stricker *Date of* June 14 '99

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Poor

Recent Events, " Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Rather dull & illusive.

REASONING POWER, Ordinary Subjects, Below average.

Special Subjects, Nil.

Own Mental State, Says she is not sick.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed.

DELUSIONS, Fairly Systematized, ~~Transitory,~~ Special Subjects,
On subject religion & on children.
Religious melancholia with delusions

HALLUCINATIONS, Not apparent

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, One week.

ONSET, Gradual or Sudden, Sudden.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, None.

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Lost Appetite, Lost and Bowels, Inclined to Constipation

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, — PRESENT WEIGHT, — USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, 3 large bruises noted, one Lower Extremities. One on inner surface of left leg about 3 in. in diam. Skin soft & elastic.

TONGUE, Coatings or Promptness of Movement, Grayish coating: promptly protruded.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal responses good.

SIGHT, Good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, No impairment of ocular muscles.

HEARING, Not disturbed.

COORDINATION, Arms, fair Legs, fair Grasp, Fingers feet, below average.

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Exaggerated Other Reflexes, present & normal.

ARTICULATION, Slurred, Hesitating, Slow; Distinct.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Tingling & cool sensations of limbs.

HEART, No Murmurs, Strength, Sounds, Size, Distinct

Apex Beat, No Regularity, Regular.

ARTERIES,
No change detected

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical.
Expansion good.
No sign of disease detected.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

6/29/99 GYNECOLOGICAL EXAMINATION, Exam. by Dr Mayo - Septic Endometritis - Lymphatics affected - advised non-interference by operation because condition too far advanced.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Patient appears in fairly good physical condition but is very flashy.

Personal and Medical History of Mrs Kate Kunz

1899

This patient was brought here by Sheriffs Deputy Frank Collins, attended by Henry Kunz in fair physical condition, with the following history:- No consanguinity, heredity nor intemperance in patient nor in parents: First symptoms of insanity manifested June 11th 1899. Disease appears increasing. Not variable: Derangement now manifested by continually talking in an irrelevant & incoherent manner on religious & emotional subjects since June 11th. No disposition shown to injure anyone. No filthy nor destructive habits: No peculiarities previously manifested: No severe diseases nor injuries to head. No confinement nor restraint employed: No treatment pursued: On personal examination patient is very much agitated mentally.

June 14 On admission put upon Infirmary List (G.H.M. Spt.) Complexion dark: hair & eyes brown: Skin quite rough: No marks, scars nor eruptions noted: A number of bruises on both limbs & arms. Pathen dirty: No. Teeth in upper jaw 11: on right side & one broken off: One out on left. Lower jaw 14 - two on left side broken off. Is quite disturbed: Talks somewhat incoherently.

Summary Notes by Dr. Strickler Admitted to the Hospital June 14'99: was bathed & put to bed. Patient was very ~~very~~ excited, noisy, untidy in habits & at times quite violent: Altho she apparently had no definite object in her violence, she would throw herself about on the floor, striking against the furniture & wall, so that she required a great deal of attention. Temp. was slightly elevated: appetite remained good: bowels were constipated: was awake at night & very restless & noisy. Remained in about the same condition until July 1st: She lost rapidly in flesh on account of her excitement & sleepless nights - Temp. became much elevated, reaching 104 & 105: sordes collected on the teeth, & she became delirious: Visited by her husband - also by her brother: Urine contained large quantities of albumen & granular casts & there was desquamation of epithelium. She gradually became weaker, fell into a Stupor and died July 7th at 3:30 ~~p.m.~~. Husband was present at her death & removed body to the Roman Catholic Cemetery in Rochester.

Died.

Personal and Medical History of

Personal and Medical History of Ingri Kallak.

Whole No. 5338

Residence, Faribault, Rice Co, Minn.

Date Admission, June 15th 1899.

Admitted by Dr. A. A. Bebb hour, 3 PM.

How Sent, James Hunter Sheriff Rice Co.

Sex, Female Age, 68

Civil Condition, Married.

Children, 7

Age Youngest Child, 28 yrs.

Occupation, — (Husband a laborer)

Degree Education, Common school.

Profession, Religion, Lutheran.

Habits, Not intemperate.

Nationality, Sweden - (Parents also born there)

Physicians Committing, H. H. Hubbard + 2nd. Rice.

Has been a resident of state since 68, of Co 2 years 6 mo.

Correspondents, Miss Millie Kallak (daughter) Box 227 Faribault.

Mr. & J. Swanson (Son-in-law) 1st Ave. So. Faribault. — Telephone 9 Laufenburger & Co.

No. of Years, 231

Insane Relatives, None known.

Cause Exciting, Religious enthusiasm.

Cause Predisposing, Chronic attacks.

Form, Recurrent Mania

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, 4 wks. ago

Duration, 4 Wks.

No. of Attack, 3rd

No. of Admission, 2nd

Age First Attack, 61 yrs.

Time of Leaving, Aug. 17. 1899

Time in Hospital, 2 mo. 2d.

Result, Disc. Apr. 17. 1900 Imp

EXAMINATION ON ADMISSION BY DR. Strickler Date of June 15 99

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, } Confused Special Subjects, &.
Recent Events, }

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert + illusive.

REASONING POWER, Ordinary Subjects, }
Special Subjects, } Confused.
Own Mental State, }

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, ~~Transitory,~~ Special Subjects, Religion.

She is exalted, confused + inattentive.

HALLUCINATIONS, Not apparent.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Good + Constipation.
Awake at night.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 10 PRESENT WEIGHT, 91 lbs. USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Slight bruise on left arm. Skin in normal condition.

TONGUE, Coatings or Promptness of Movement, Grayish coating: protruded readily: deviates to right.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal. Response to accom. fair to light right fair.

SIGHT, Impaired

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Left eye blind, lid inverted, cornea opague, purulent discharge eyeball soft. ophthalmia

HEARING, fair

COORDINATION, Arms, fair Legs, fair. Grasp, Special Test cannot be made.

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Normal Other Reflexes, Normal.

ARTICULATION, Slurred, Hesitating, Slow, distinct

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Apparently not disturbed

HEART, Murmurs, Strength, Sounds, Size, Pulse. Systolic Sound at mitral area - S Sounds somewhat accentuated.
Apex Beat, Regularity, Apex 5. 1 in. to left of nipple line.
Irregular + intermittent.

ARTERIES,
Roll under finger -
Pulse full, high tension, thready.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest narrow.
Expansion fair. Bulging in 2nd + 3d interspace with inspiration.
B Sounds roughened with occasional moist rales on right side.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

8/8/99 EXAMINATION URINE, Quantity, Sp. g. 1010 Reaction, acid Color and Appearance, Light yellow clear white flaky deposit.

Albumen, None Sugar, None.

Casts and Crystals, Amor. urates. Excessive amount pus corpo. a few epith. cells. + uric acid crystals

GYNECOLOGICAL EXAMINATION, Slight laceration of perineum - external genitals otherwise normal hyperaemia of cervix - laceration of cervix - atrophy of uterus.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Mentally this patient is exalted + confused, prays most constantly + is violent + noisy. Probably due to religious excitement - Presumptive chronic mania. She left heart is hypertrophied.

Personal and Medical History of Ingre Kallak.

1899

This patient was brought here by Mr. O.P. Swanson, as sheriff's deputy, attended by Miss Millie Kallak, in feeble physical condition, with the following history: First attack of insanity occurred in 1882 & patient was here from to for further particulars see Vol.3 Fol 135 No. 496. Patient had a second attack in 1898 lasting six weeks: First symptoms of present attack manifested about 4 weeks ago by excitement & restlessness: Disease appears increasing: not variable: Derangement now manifested by talking constantly on religious subjects: Not disposed to injure anyone: Tears her clothing occasionally: Has always been very religious & this seems to be the origin of her insanity. No acute diseases nor injuries to head. Has been watched since commencement of attack: Has received no treatment. On personal examination shows great excitement: Talks constantly. On admission put upon Infirmary Gen'l Ref. Complexion dark: eyes gray: hair grayish: left arm bruised.

June 15 to 29. Summ. of 14 da. record by Dr. Babb. On admission very much disturbed & excited. Struggled when bathed & took down bed in room: was quite noisy until given sleeping dose - after that slept quite well. Pulse & resp. about normal: Temp. slightly elevated. Appetite improved after first week: Bowels require laxatives. From 16th - 19th was very noisy & excited & continued so during greater part of night as well as day; Conversation rambling & incoherent. After first week slept a little better & became quieter tho still disturbed at times. Neat in habits: Takes outdoor exercise. June 28 Struck Mrs. Hanchman bruising her eye. July 1 - Aug 18 Gradually improved mentally, became much quieter, neater in habits & assisted with ward work but still noisy & disturbed at times. Aug 18 Mental improvement has continued, talks sensibly & seems free from delusions. Is very helpful & much interested in other patients. Aug 15 Visited by friend. Today (Aug 18) Taken home on trial.

Discharged

Personal and Medical History of

Personal and Medical History of Grace Decord.

Whole No. 5740

Residence, Houston Co, Minn.

Date Admission, June 17th 1899.

Admitted by Dr A. F. Strickler hour, 6th Pm.

How Sent, L. Budahl Sup't Houston Co.

Sex, female Age, 16 yrs.

Civil Condition, single

Children, -

Age Youngest Child, -

Occupation, Working at home (father's laborer)

Degree Education, Can read & write.

Profession, Religion, Can not say.

Habits, Not intemperate.

~~Nationality~~, Nativity, Minn. (Houston) (Parents nativity unknown)

Physicians Committing, D.C. Rhines & Ry. Ferguson.

Correspondents, M. S. Porter (Guardian) Brownsville, Minn

No. of Years, 233

Insane Relatives, Father supposed to have been insane.

Cause Exciting, Unknown.

Cause Predisposing, Probably heredity.

Form, Melancholia Ag. (Recurrent)

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, Not.

Date of this Attack, 3 days ago

Duration, 3 days.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 16 yrs.

Time of Leaving, Oct 26th 1900.

Time in Hospital, 1 yr. 4 mo. 7 da.

Result, Discha. Recovered. Feb. 5th 1901.

EXAMINATION ON ADMISSION BY DR. Strickler Date of June 19 99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Confused.

MEMORY, Past Events, } Poor

Recent Events, } Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Illusive

REASONING POWER, Ordinary Subjects, } Will not reason

Special Subjects, }

Own Mental State, Says she is troubled in her head.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Depressed

DELUSIONS, Fairly Systematized, Transitory, Special Subjects,

Fear of bodily injury -

Apparently much depressed & in constant fear

HALLUCINATIONS, Apparently auditory & visual.

ILLUSIONS, Concerning simplest events.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Mother is blind

Paternal Relatives, Unsatisfactory can be obtained from patient

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Fair Appetite, and Bowels,

Personal and Medical History of Grace Decord.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4 PRESENT WEIGHT, 93½ lbs USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Skin moist & dark

TONGUE, Coatings or Promptness of Movement, Gray coating - protruded promptly.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - moderate dilation responses fair

SIGHT, Fair

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Nothing abnormal noted.

HEARING, Fair.

COORDINATION, Arms, Fair Legs, Fair Grasp, Special tests below average.

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Increased. Other Reflexes, Present.

ARTICULATION, Slurred, Hesitating, Slow, Distinct.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Apparently not disturbed

HEART, Murmurs, Strength, Sounds, Size, No Feeble

Size not increased - apex beat normal

Apex Beat, Regularity,

Regular.

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest narrow.

Expansion fair.

No signs of disease.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

9/9/99 EXAMINATION URINE, Quantity, Sp. g. 1023 Reaction, Acid Color and Appearance, Pale yellow-clear Slight flaky deposit

Albumen, none Sugar, None.

Casts and Crystals, a few epith. cells. uric acid crystals & amor. urates.

6/13/99 GYNECOLOGICAL EXAMINATION, External genitals normal. hymen intact Uterus normal pos.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Restless at night.

BOWELS, Present Condition, Tendency to Constipation.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient is certainly below the average mental grade Her father was considered insane & her mother is "peculiar". She was brought up under many disadvantages, her parents were supported by the county for a long time. At present patient is depressed, constantly begging to be spared from punishment & walking about in a restless manner. She is poorly nourished but otherwise is apparently good general health.

Personal and Medical History of Grace Record.

1899

This patient was brought here by sheriff deputy Geo M. Blanchard attended by Mrs. Blanchard, in fair general health, with the following history:- No history concerning consanguinity: Father supposed to have been insane: First symptoms of insanity manifested three days ago by fear of punishment for crime: Disease appears stationary: Is variable: Derangement most manifested by fear of being hung. Not disposed to injure anyone: No filthy nor destructive habits. No previous peculiarities noted. Patient had pleurisy in Dec. 1898 & has not been well since. Has been watched at home for past three days. Has received no treatment. On personal examination noisy & in emotional excitement & in poor physical condition. On admission put upon Infirmary list. Complexion dark: Hair & eyes brown: Bites in normal condition: No marks, scars nor bruises: Is dirty: No bodily peculiarities noticed: 14 teeth in upper & 13 in lower jaw: Is disturbed: Has delusions (G.H.U. Rpt.)

June 7 - Daily Sum. 14 da. record by Dr. Bobb. Very much disturbed & quite noisy at times. Slept only 4 hours. Temp. about normal in morning, slight rise afternoons Pulse & resp. about normal. Appetite fair: bowels constipated. Sleep good after first four nights. Patient very melancholy & depressed, walks restlessly about about hall, expression agitated. Seems to be constantly fearing danger & is also quite resistive apparently on account of delusions

July 1st - 7 3. Became more quiet & neat in habits & appearance.

Aug 31. Appetite has improved. Is neat in habits & appearance: assists some with work but is still very restless & fears that she will be killed. She has improved gradually mentally during this month & is comparatively quiet & has lost (Aug 31) the anxious, depressed expression. Is very agreeable & assists with work. Aug. 1. Trans. to A2. Aug 10 - 21 did not appear quite so well physically complained of headache. Aug 21 Trans. to Infirmary Aug 30 Trans to A2. Apr 14 1900 Ref. Disturbed & noisy. Incoherent: Appetite fair: Laxatives given: Sleeps poorly Apr 18. No restraint. May 30 Still noisy & disturbed Trans. B1. General health good. July 13 More quiet assists with work. Trans. to C3. Sept 8. Neat. Appetite good: was vaccinated successfully July 17. Sept 1 Trans. A2. Sept 19. Sick with sore throat. Oct. 20 Visited by friends Oct 24 went home. Letter received from her Mother Jan 16 1901 - says she has entirely recovered & has worked out some.

Nov 20 1900 went home

Discharged.

Personal and Medical History of

Personal and Medical History of Anna Sechida

Whole No. 5345
Residence, St. Paul, Minn.
Date Admission, June 23, 1899.
Admitted by Dr. A. J. Stricker hour, 6 7½ PM
How Sent, By Gallick Nat. Com. Ramsey Co.
Sex, Female Age, 19 yrs.
Civil Condition, Single.
Children, ——
Age Youngest Child, ——
Occupation, Domestic.
Degree Education, Common school.
Profession, Religion, Catholic
Habits, Not intemperate.
Nationality, Hungary (Parents also born there) Nativity
Physicians Committing, Waldo Mayo + J. D. Brimhall. President of State Board 81 after June 83
Correspondents, Geo. Sechida (Father) 196 Edmund St. St. Paul, Minn.

No. of Years, 238
Insane Relatives, Sister here.
Cause Exciting, worry over sisters insanity.
Cause Predisposing, Unknown
Form, Hysteria with mild maniacal attacks.
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, May 1899.
Duration, About one month.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 19 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Stricker Date of June 23 '99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused.
MEMORY, Past Events, fair
Recent Events, Special Subjects, do
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert - illusive
REASONING POWER, Ordinary Subjects, below average
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted

DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any but talks incoherently
She appears hysterical
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Has had three previous attacks
Sleep, Appetite, and Bowels Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 4 in. PRESENT WEIGHT, 107 lb. USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, Deformity of left hip
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal normal responses fair
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good
COORDINATION, Arms, good Legs, good Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None
PATELLAR REFLEX, Not constant Other Reflexes, present
ARTICULATION, Slurred, Hesitating, Slow, Not impaired
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Hyperaesthetic
HEART, No Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Size not increased
ARTERIES,
No evidence of disease
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest flat.
Expansion fair
No signs of disease

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

8/3/99 EXAMINATION URINE, Quantity, Sp. g. 1026 Reaction, acid Color and Appearance, yellow-clear
Albumen, None Sugar, none.
Casts and Crystals, amor. urates a few epith. cells + triple phosphates.

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact but lax. Uterus normal position - slight hyperaemia of cervix. Slight leucorrhoea.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Restless at night
BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient is in good physical health. Mentally appears hysterical. Has probably always been below average + is supposed to have worried about her sister who is a patient in this Hospital

Personal and Medical History of Gina Ichida.

1899

This patient was brought here by Sheriffs deputy A. L. Phillips attended by Geo. Ichida, in fair physical condition, with the following history:- No history of consanguinity; Sister, Theresa Ichida here insane. No intemperance known in patient nor in parents. First symptoms of insanity manifested May '99 by unrest & agitation over sister in Rochester: Disease appears increasing, is variable, with irregular rational intervals: Derangement now manifested by imagining she has communications with Kings & Princes; muttering to herself. Not inclined to do injury to any one: No filthy nor destructive habits. Has brooded & worried over her sisters commitment for three or four years: No severe diseases nor injuries to head sustained. Has been receiving opium treatment for 2 weeks. On personal examination is preoccupied: Talks to herself, smiles vacuously.
On admission put upon Infirmary (5th Ward Ppt) Complexion fair: hair brown: eyes blue: Skin in normal condition: No marks scars moles: bruise on left arm: Is clean: Has some hip trouble; sways when walking
28 teeth - one out left lower 2 out right upper jaw. Behavior quiet: Talks quite sensibly.)

June 28 to July 6. Ann. 10 days record by Dr Bess. Slight rise of temp part of time: pulse & resp. about normal: appetite good: bowels regular: sleep good: usually very quiet. Physical condition quite good: Neat in habits: rather careless in appearance. Takes out door exercise: will not converse freely, usually being very quiet. Reads a great deal: Is very proud of her neck & arms & persists in showing them: is very silly in actions & very affected: Very obstinate & put in restraint for a day or two to break her of it. Much better afterward: Altho apparently indifferent to those about her she watches them furtively & poses &c. & every action seems done for effect. She is also very hysterical. June 28 Trans. to B3. Aug 31 A slight mental improvement noted,- Not so silly & appears more interested in surroundings than formerly. During Sept. & October mental improvement did not continue & she seemed more depressed. Was very affected, hysterical & expressed delusions more freely. When she first came here she showed considerable interest in sister but of late pays little attention to her. Calls out of windows to friends whom she imagines she sees outside.

Nov 1- Feb 28 1900. Patient untidy: appetite fair: bowels regular & menstruation regular: Takes outdoor exercise: Has many delusions: Incoherent & extremely obstinate: Feb 28 Somewhat better: Answers questions sensibly & reads some. March- Nov 30 1900. Sleeps & appetite poor. Expresses delusions thinks she is a queen: Takes outdoor exercise: Is noisy. July 21 Vaccinated. Becoming somewhat untidy: Trans to C3. Aug 30. Very mischievious: Requires constant attention untidy: appetite fair: Occasionally strikes nurses. Nov 21 97½ lbs.

Personal and Medical History of

1900

Dec 1- Feb 28 1901- Dec 17 Hair cut. Very dirty: lies about on floor: Fed on tray: requires constant attention. Given electrical treatments: Jan 28 Neater & brighter mentally.
Feb 28 Wt. 116½ lbs. More stupid & untidy again. Mar 1- June 1- 1901
Does no work: menstruates: no change in mental or physical condition. May 29 Wt 120½ lbs. June to Sept. Very indifferent, never converses, takes out door exercise Sept. 2 Wt 111½ lbs. Sept. to Dec. During next quarter observed to be failing physically, anaemic and losing in weight, now 22 Wt. 107½ lbs.
Dec to Feb 1903 No change. Wt about 80 lbs. Patient has a great deal of trouble with her stomach: vomits a great deal. Occasionally fed by tube. Patient is quiet & apathetic. Takes no interest in anything: does not converse or answer questions. Seems to understand when her name is spoken. Spends a great deal of time in bed. She expectorates almost continually. Saliva and mucus flows unheeded from her mouth: seems to have no control over herself in this respect. Bowels regular. Appetite fairly good. Sleeps well.

Personal and Medical History of Elizabeth Saaum.

Whole No. 5346
Residence, Marshall (?) Minn.
Date Admission, June 22' 1899.
Admitted by Dr. A. F. Stricker hour, 9.30 A.M.
How Sent, P. Moran Dep't Dakota Co. Minn.
Sex, Female Age, 26 yrs.
Civil Condition, married.
Children, one
Age Youngest Child, four months.
Occupation, Housewife (husband a farmer)
Degree Education, common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
~~Nationality~~ Nativity, Minnesota. (Parents born in Germany)
Physicians Committing, J. C. Fitch + Asst. Asst. M.D.
Correspondents, Charles Saaum (husband) Hastings, Dakota Co. Minn. (will be in St. Paul in a few days.)

No. of Years, 23
Insane Relatives, None.
Cause Exciting, Puerperal sepsis.
Cause Predisposing, Confinement.
Form, Puerperal mania.
Accompanying Bodily Disorder, Puerperal sepsis.
Suicidal or not, Not.
Date of this Attack, Mch 5th 99.
Duration, 3 mos.
No. of Attack, 2nd
No. of Admission, 1st
Age First Attack, 26 yrs.
Time of Leaving, Sept. 10. 1899
Time in Hospital, 2 m. 19 d.
Result, Disc. Apr. 17. 1900. Rec.

EXAMINATION ON ADMISSION BY DR. Stricker *Date of* June 22' 99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear
MEMORY, Past Events, Fair - Confused at times.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert
REASONING POWER, Ordinary Subjects, fair
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Not any apparent.
Apparently hysterical.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Since Feb. 99.
ONSET, Gradual or Sudden, Sudden.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Parents related.
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Puerperal sepsis
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Three maniacal attacks since Feb. 1899.
Sleep, Appetite, and Bowels, constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in. PRESENT WEIGHT, 130# USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin,
TONGUE, Coatings or Promptness of Movement, Swollen, coated - protruded promptly.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal. responses fair -
SIGHT, Good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, good Legs, good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None
PATELLAR REFLEX, Decreased. Other Reflexes, present.
ARTICULATION, Slurred, Hesitating, Slow, Not disturbed.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Not impaired.
HEART, No Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
size not increased
apex beat normal -
ARTERIES,
No signs of disease detected

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair
No signs of disease

7/9/99 EXAMINATION URINE, Quantity, Sp. g. 1012 Reaction, Neutral Color and Appearance, Yellow cloudy.
Albumen, None Sugar, None -
Casts and Crystals, a few uric acid crystals, oxalate of lime + epith. cells.

GYNECOLOGICAL EXAMINATION, Several examinations were made -
Lac. cer. and perineum - Ext. gen. mor. acicle from lac.
MENSTRUATION, Dysmenorrhea - mild in character - Some local tenderness -
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Nervy + awake at night.
BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient appears in fair general condition has suffered from puerperal sepsis. She seems irritable + excitement at times. The husband states that attack came on after falling into a passion

Personal and Medical History of Elizabeth Saam.

1899

This patient was brought here by sheriffs deputy John Wasel attended by Drs J.H. Hyland & Charles Saam (husband) in fair general health, with the following history: No history of consanguinity, heredity nor intemperance in patient nor in parents: First symptoms of insanity manifested by acute mania four days after birth of child (born Feb 28 99) Has had three attacks of insanity since: disease appears decreasing: In variable: Derangement now manifested on all subjects: During first attacks was disposed to injure others: No filthy nor destructive habits: No pleuriarties previously manifested: No severe diseases nor injuries to head: Has been confined at home three weeks: Has received ordinary sedative treatment. On personal examination is very excitable, constantly talking, at times coherent but changing rapidly from one subject to another. On admission put upon infirmary diet (S.H.M. Rjct) Complexion dark: eyes brown, hair red Skin rough & dry: No marks, scars nor bruises noted: Very dirty, vermin found: One tooth out on either side of lower jaw: Upper jaw 2 missing, 5 on plate - right left. Behavior very much disturbed: Has delusions, talks rather incoherently.)

June 22 - July 6. Dilute, 14 da. rec. by Dr. Bibb. Did not sleep any the first night & very little the second, after that rested quite well. Temp. pulse & resp. normal. Appetite good: Bowels usually regular: Is quite well physically: Very noisy most of time, quite careless about appearance and at times destructive. July 1 Attempted to elope while out walking July 2 Has improved a little & commenced to assist with work. Is very quiet: Takes out door exercise: July 3 again attempted to elope from lawn in evening: brought back from town. July 4 - Aug 6. Sept. 10. Menstr. Untidy, very noisy & destructive much of time. Necessary to keep her in restraint. Aug. 17 More quiet is up on ward. Aug 19 Is improving gradually: Talks much more sensibly & is not nearly so loud & boisterous in manners Assists with ward work: Nov. 4. Taken home on trial.

Discharged

Personal and Medical History of

Personal and Medical History of Ella Maud VanSlyke.

Whole No. 5348
Residence, Elmore, Minn.
Date Admission, June 28th 1899.
Admitted by Dr. A. J. Strickler hour, 8:30 AM.
How Sent, J. J. Winship Jof P. Faribault Co.
Sex, Female Age, 25
Civil Condition, married
Children, Two.
Age Youngest Child, about 18 mos.
Occupation, Housewife (Husband a Brakeman)
Degree Education, Common school.
Profession, Religion, Free Methodist.
Habits, not intemperate.
~~Nationality~~ Maternity, Missouri. (Father New York. Mother Illinois)
Became Inmate of State Pris Apr. 1899
Physicians Committing, J. E. Spurr & C. N. Burton
Correspondents, D. A. VanSlyke (Elmore) - Lake Crystal, Minn.
Mo. L. McArthur (Mother) Elmore, Minn.

No. of Years, 24?
Insane Relatives, None.
Cause Exciting, Nervous depression.
Cause Predisposing, Unknown.
Form, Melancholia - suicidal
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Attempted to poison herself in March '99.
Date of this Attack, March '99
Duration, About 3 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 25 years.
Time of Leaving, June 19. 1900
Time in Hospital, 11 mo. 21 da.
Result, Dis. Nov. 7. 1900
Unimproved

EXAMINATION ON ADMISSION BY DR. A. J. Strickler Date of June 28 '99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick
MEMORY, Past Events, Good
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert.
REASONING POWER, Ordinary Subjects, Fair
Special Subjects, Illusive
Own Mental State, Appreciates her condition to some extent
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Much depressed.
DELUSIONS, Systematized, Transitory, Special Subjects,
Suicidal
HALLUCINATIONS, Visual
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.
LENGTH INVASION, Several months
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
never well since a child: Measles at 3 never grew fast.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Poor Appetite, Poor and Bowels, Fruit & Constipation

Personal and Medical History of Ella Maud Van Slyke.

PHYSICAL CHARACTERISTICS.

HEIGHT
WOUNDS
TONGUE
PUPILS equal
SIGHT,
EYES,
HEARING,
COORDINATION,
TREMORS, Hands, Tongue,

Per Type Book Operator
Worked 5348 Put through Volume ~~43~~ 40
Pol
What we strive for is Gloria

Wilder, Id 83676
Jan 25-1981

State Mental Hospital
Medical Records
2110 Center St
Rochester, Minnesota 55901

D. Arthur VanSlyke
VAN SLYKE FARMS
ROUTE ONE
WILDER, IDAHO 83676

WILDER, ID JAN26 PM 1981 83676

State Mental Hospital
Medical Records
2110 Center St.
Rochester, Minnesota 55901

send copy left upper left quad

Whole No.
etc

Sent 2-9-81 D. Houston

also date of admission & discharge

7/15/09. EXA ... clear.

GYN ... ovary
preg. ... hea... body, after has only ... weeks
MEN ... stric... AT
OPH
BLO
SLE
BOW

Give condensed statement of present Mental and Physical Condition (the mental ... the degree of invasion, estimate of previous mental grade, and any physical impairment). She is not in good general health, having lost some in weight & physical state impaired some by depressed condition. Mental state represents suicidal melancholia sub-acute

Personal and Medical History of Ella Maud VanDyke.

Whole No. 5348 No. of Years, 241

Residen

Date Ac

Admitte

How Se

Sex,

Civil Co

Children

Age Yo

Occupati

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Keep ask for
Medical records
5348
Volume ~~43~~ 40
pol
Wilder, Id 83676
Jan 25-1981

State Mental Hospital
Medical Records
210 Center st
Rochester, Minnesota 55901
Dear Staff.
Please send me a copy of the
records for Maude Ella VanDyke,
admitted June 28, 1899 from Elmore,
Minnesota

Yours Truly
D Arthur VanDyke
(Grandson of patient)
Rt 1
Wilder, Id 83676

send as ~~d~~
upper left square

Sent
2-9-81
D. Houston

Whole No.
etc

plus date of admiss + discharge

'99.

R

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DELUS

HALLU

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Fair & Constipation.

Personal and Medical History of Ella Maud Van Dyke.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5 PRESENT WEIGHT, 97½ lbs USUAL WEIGHT, NUTRITION, Impaired.

WOUNDS, Abnormalities and condition of Skin, None - Skin dry + irritable by rubbing.

TONGUE, Coatings or Promptness of Movement, normal.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Normal responses fair.

SIGHT, fair

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, fair.

COORDINATION, Arms, fair. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Intensional

PATELLAR REFLEX, Increased - Other Reflexes, Normal

ARTICULATION, Slurred, Hesitating, Slow; Hesitating.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Hyperasthetic.

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Normal.

ARTERIES,

Normal.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

7/15/99 EXAMINATION URINE, Quantity, Sp. g. 1015 Reaction, acid Color and Appearance, yellow-clear.

Albumen, None Sugar, None.

Casts and Crystals, Amor. + amon. urates. a few uric acid crystals + epith. cells.

irreg. GYNECOLOGICAL EXAMINATION, Examined by Dr. Mayo. Uterus large + soft - cystic right ovary laceration cervix + perineum - advises future operation. Endometritis - leucorrhoea profuse - yellowish discharge, uterus adherent to left + retroverted - tenderness over ovary + body of uterus

MENSTRUATION, Always irregular - sometimes 4-5 times a month at others 6 wks apart - has only menstruated a few times this summer - dysmenorrhoea usually absent six weeks after confinement.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Awake at times.

BOWELS, Present Condition, Trad to constipation.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). She is not in good general health, having lost some in weight + physical state impaired some by depressed condition. Mental state represents suicidal melancholia sub-acute

Personal and Medical History of Ella Maud Van Slyke.

1899

This patient was brought here by her husband, D.A. VanSlyke, attended by her Mother Mrs. L. McArthur, in fair general health, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor parents: First symptoms of attack manifested in March 1899 when she attempted suicide by taking poison: Disease appears increasing: Is variable & attacks are provoked by slight or no provocation: Derangement now manifested generally, on no one subject: Patient is disposed to injure others: Not suicidal at present: No filthy nor destructive habits: In childhood was of a very impulsive nature: No severe diseases nor injuries to head: No confinement nor restraint employed: Has received no medical treatment. On personal examination is very emotional. On admission put upon Infirmary Mest Gen'l. Rpt. Complexion dark: hair & eyes brown: Skin in Normal condition: No Marks, scars: ~~Old~~ bruises noted on left arm. Several small scratches on right hand: Is clean: 3 teeth out lower jaw & 2 out upper - — 7s left.

June 28 - July 1st. Insan. 14 da. record by Dr. Bett. When admitted was very quiet & depressed: Talked quite sensibly: Temp. pulse & resp. normal: First mess appetite quite good: bowels constipated: medicine given t.i.d. Sleep good: Took out door exercise: Neat in habits. Quite restless & wanders about hall or sits in room: At times quite disturbed: rarely converses with other patients: Is very nervous in movements & picks fingers with pins until quite sore: Lies down a good deal & is very obstinate: Second mess appetite not so good: refused part of meals & medicine to room most of time. July 8 Left fingers much swollen on account of picking them with pins. Patient continues very much depressed & is more actively suicidal. July 17 Attempted to choke herself with neck tie. & on same day tried to get out of bus when driving over bridge: Had asked several times to be allowed to go down to look at river. Visited by Mother & taken home. Oct. 5 Rel'd by husband: Complained of pain in back caused by jumping from car window. No special injury apparent.

Nov. 30 Very much depressed: Wandered about ward wringing hands & moaning: Neat in habits but indifferent in appearance. Answers readily when addressed: is often irritable. Dec 26-27 Visited by Mother & sister.

Dec. 30 Is quieter but more depressed: a decided mental failure apparent. Is much confused & very incoherent. At times has periods of excitement when very noisy, cries loudly for "help" & seems to be apprehending some immediate danger: Has become untidy in habits & has failed very much physically. Appetite is poor: bowels constipated. Formerly asked continually to be allowed to go home & worried about her mental condition, now she is too dazed & confused to realize her condition & does not seem to remember anything about her relatives. Jan 5. 1900. Wt. 88 3/4. Given electrical treat-

Personal and Medical History of

1900

ments. General faradism & massage 3 x wk. Jan 29 Seems weaker physically, has a slight rise of temp. Appetite usually poor: is kept in bed. Today Visited by husband & sister & taken home.

Discharged

Personal and Medical History of Katherine Prosser.

Whole No. 5349
Residence, St. Paul, Minn.
Date Admission, July 5th 1899.
Admitted by Dr. A. J. Stricker hour, 1:30 Pm.
How Sent, E.W. Boyille Dept of P. Ramsey Co.
Sex, Female Age, 27 yrs.
Civil Condition, Single.
Children, ——
Age Youngest Child, ——
Occupation, School Teacher.
Degree Education, Common school.
Profession, Religion, Presbyterian.
Habits, Not intemperate.
~~Nationality~~ Nativity,
Physicians Committing, L. E. Riggs & E. L. Eshelby.
Correspondents, Ga Prosser (bro.) 653 Laurel Ave, St. Paul. Minn.

No. of Years, 242
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, —
Form, Melancholia with mild hysterical element
Accompanying Bodily Disorder, Mastoid disease.
Suicidal or not, Suicidal.
Date of this Attack, 6 mos. ago
Duration, 6 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 27 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. A. J. Stricker. *Date of* July 6 '99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Fairly clear.
MEMORY, Past Events, } good
Recent Events, } Special Subjects, Ago.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert & correct.
REASONING POWER, Ordinary Subjects, Average
Special Subjects,
Own Mental State, draws irrational conclusions.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Somewhat depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
No evidence of delusions observed.

HALLUCINATIONS, None apparent.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Healthy
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, fair Appetite, variable and Bowels, Tend to constipation.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 9½ in PRESENT WEIGHT, 116½ lbs USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin,
TONGUE, Coatings or Promptness of Movement, Clean & protruded readily.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - responses good.
SIGHT, Not impaired
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, Good Legs, Good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight intensional
PATELLAR REFLEX, Normal- Other Reflexes, Normal
ARTICULATION, Slurred, Hesitating, Slow, Not impaired
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Normal Complains of numbness of left arm
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal.
ARTERIES,
Normal.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical -
Expansion 3 c.m.
No evidence of disease

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

7/29/99 EXAMINATION URINE, Quantity, ℥ XXXIV Sp. g. 1015 Reaction, acid Color and Appearance, yellow - clear white flaky deposit.
Albumen, None Sugar, None -
Casts and Crystals, Amor. urates - a few epith cells & oxalate of lime crystals.

GYNECOLOGICAL EXAMINATION, Uterus normal position: hymen intact. Complains of pain over left ovary - not associated with menstruation.
MENSTRUATION, Regular & quite free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Restless - disturbed by other patients
BOWELS, Present Condition, Tend to Constipation

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient is in good general health. She presents many signs of having suffered from acute suicidal maniacal attacks with a probable hysterical element. She appears refined & of a fair degree of intelligence.

Personal and Medical History of Katherine Risser.

1899

This patient was brought here by Sheriffs deputy A. L. Phillips attended by brother G.A. Risser, in fair general health with the following history:- No history of consanguinity, heredity nor intemperance in parents nor in patient: First attack of insanity (present one) came on about six months ago: by depression with delusions: disease appears increasing not variable. Derangements manifested with suicidal tendencies: Not disposed to injure anyone: Has attempted suicide three times, took morphine the last time: No filthy nor destructive habits: No previous peculiarities manifested: Has had a mortoid diarrhoea: No confinement nor restraint employed: No treatment pursued: No further facts learned on personal examination. On admission put upon Infirmary (G.H.K.Pt. Complexion light - hair light: eyes blue: skin in normal condition Several small scars on back: Is clean: No bodily peculiarities manifested: Teeth not counted: Behavior quiet: Talks sensibly.

July 5 - 19th Insm. 14 da: record by Dr Babb. Temp. pulse & resp. normal: Appetite good: bowels usually regular: sleeps well: receives medicine, tonics & electrical treatment: Is very neat in appearance: usually very quiet & pleasant in manner: Talks quite sensibly: reads much of time: Is quite depressed, nervous & irritable Nov 3. Appears quite intelligent: converses freely & is not quite so depressed: Sept 14 Visited by brother & sister-in-law. Aug 1 & Oct 5 Menstr.

Nov 3 Visited by brother & his wife & taken out on trial.

Mch 9. Returned. Mch 30. Usually quiet: Does not talk a great deal: likes to be alone. Does no work: Bowels somewhat constipated. Apr 23. Visited by brother:

May 30 Frequently asks to go home: June 15. While out on lawn climbed in a wagon & attempted to leave grounds: June 29. Very languid & indolent Has to be forced to get up mornings. Expresses some delusions. Takes out-door exercise: Trans to B 3. Oct 15 Attacked nurses: In seclusion.

Nov 16. Not so well as usual: expresses delusions freely: Says she is the wife of a minister. Talks a great deal about him: Is at times noisy. Frequently asks to be sent home: Dec 1 - Feb 28 1901 General health good. Expresses many delusions: Very disagreeable & irritable on ward. Feb 25 Wt. 140#. Annoys other patients

Mar to June 1901 No change in mental or physical condition May 28 Wt. 145#.

June to Sept. June 3 Trans. A. 3, general condition remains unchanged. Aug. 27 Wt. 143#.

Sept. to Dec. Neat in habits and appearance, general health good, takes out door exercise, reads a great deal, assists with work in ward diningroom, regularly, menstruates regularly, patient is full of delusions of persecution and expresses them freely,

Oct. 4 & Nov. 10 menstruated, Nov. 28 Wt. 141#.

Mar. 1st '02 to Feb. '03 No change. Wt. 137# May 17th '02 Visited by mother.

Personal and Medical History of

Personal and Medical History of Rose Licha

Whole No. 5353

Residence, St. Paul, Minnesota.

Date Admission, July 7th 1899.

Admitted by Dr. A. J. Strickler hour, 7th Am.

How Sent, E.W. Bazille & of P. Ramsey Co, Minn.

Sex, female Age, 18 yrs.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Domestic (Father a laborer

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate (Father intemperate)

~~Nationality~~ Nativity, Wis. (Father Switzerland. Mother Wis.)

Physicians Committing, Waldon Auen & O.R. Archibald

Correspondents, Miss Licha (sister) Jackson St. near 5th St Paul, Minn.

Seth L. Ishaun (brother-law) c/o Shaffer & Rossum or 470 Martin St. St. Paul.

Tel. c/o Central police station.

No. of Years, 24

Insane Relatives, None,

Cause Exciting, Fright - Coming home at night broke down in

Cause Predisposing, unknown - Hebephrenia

Form, Defective with hysterical element Adolescent Insanity

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, Not.

Date of this Attack, 2 weeks ago.

Duration, 3 years. (since first manifested

No. of Attack, Several.

No. of Admission, 1st hrs - At City Hospital St. Paul.

Age First Attack, 15 yrs.

Time of Leaving, July 28 - 1900

Time in Hospital, 1 year & 21 Ds.

Result, Discharged July 28/1901. Recovered.

EXAMINATION ON ADMISSION BY DR. A. J. Strickler *Date of* July 7-99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Confused.

MEMORY, Past Events, Does not answer rationally.

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Illusive.

REASONING POWER, Ordinary Subjects, Apparently without reason.

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Exalted. Depressed at times.

DELUSIONS, Fairly Systematized, Transitory, Special Subjects, parents.

HALLUCINATIONS, Not apparent.

ILLUSIONS, present.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

Silly + childish.

HISTORICAL.

LENGTH INVASION, Few days.

ONSET, Gradual or Sudden, Sudden.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, School girl.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

edical History of

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 121 USUAL WEIGHT, NUTRITION, Good

and condition of Skin, Normal condition.

mptness of Movement, Normal

sponse to Light, and Accommodation, Equal - size normal - Responses good.

Patient much distressed

EMENTS,

ance,

ference to left

able cause, the

neural health.

for her mamma

CRAZED BY FRIGHT.

An Eighteen-Year-Old Girl Sent to the Insane Hospital.

Rosa Licha was examined in the probate court yesterday and committed to the insane hospital at Rochester. She is eighteen years old and her insanity is traced to a fright three years ago. One night the family went to a party and left Rosa alone in the house. While they were gone she received a severe fright, what it was no one knows. When the family returned home they found the house locked up and were forced to obtain admittance through a cellar window. As they went in Rose rushed out, crazed with fright. Ever since she has been gradually growing worse, until her friends finally decided to send her to the hospital.

Pioneer 7/19/99

Took Her Home.

S.L. Ishan left this morning for St. Paul with his sister-in-law, Miss Rose Licha, who was committed to the State hospital a week ago, during his absence from the city. Mr. Ishan is somewhat annoyed at the manner of the commitment. The young lady had been living with his wife, her sister. She had suffered somewhat from hysteria, but her case was not considered a dangerous one, and she had practically recovered six weeks ago and asked to be allowed to get work as a domestic. Her protectors objected to this but at length permitted her to enter a good family in St. Paul, fearing to oppose her wishes. Something more than a week ago she was found roaming the streets of the capitol city with her mind a perfect blank. She was sent to a city hospital, and there, as the easiest means of disposing of her, she was committed to the State hospital of this city. When Mr. Ishan arrived home and found what had been done, he was naturally angered. The people who had her sent here said they did not know that she had any one to take care of her and thought they were doing her a kindness. Mr. Ishan came to Rochester last evening and found no difficulty in securing her release, being supplied with the proper papers. The girl is about 16 years of age, bright appearing and does not seem to be insane. Her case is a peculiar one, and she is only affected at times with temporary mental aberratio

Schaffer & Rossum
JOBBERS OF
SADDLERY HARDWARE, LEATHER, SHOE FINDINGS
AND SHOE STORE SUPPLIES.
MANUFACTURERS OF HARNESS, HORSE COLLARS, FLY NETS AND BOOT & SHOE UPPERS
20-22-24 CHICAGO AVE. EAST.

ANSWERED
JUL 22 1899

St. Paul July 14 1899

Asst Hospital. Rochester Minn.

safely with my patient. Rose Licha
[illegible] and I thank God that I brought her,
she is now beyond doubt perfectly sane, her reason
returned as suddenly as it departed. She had a fearful
headache for 2 hrs when she sank into a deep
and natural sleep, snoring very loudly, when she
opened her eyes, the light of reason was in them.
The past few weeks are a blank to her. she says it
seems as though she had been dead.
She is thin and weak and her bowels in bad order,
but I have an experienced physician attending her who
assures me that the worst is now over, and that with proper
treatment, she will in a very few days be fully restored
in both mind and body. Thanking you for your kindly
care of her and your very considerate treatment of me while
there, and with kindest regards to Miss Gleason. I remain

Yours. Truly. Seth L Ishaun
393 Aurora Av. City

Personal and Medical History of Rose Licha

Whole No. 5353

Residence, St. Paul, Minnesota.

Date Admission, July 7th 1899.

Admitted by Dr. A. J. Strickler hour, 7th Cor.

How Sent, E.W. Bazille C. of P. Ramsey Co, Minn.

Sex, female Age, 18 yrs.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Domestic (Father a laborer

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate (Father intemperate)

~~Nationality~~ Nativity, Wis. (Father Switzerland. Mother Wis.)

Physicians Committing, Waldon Smith + Dr. Archibald

Correspondents, Miss Licha (Sister) Jackson St. near 5th St Paul, Minn.

Seth L. Scham (Brother-in-law) c/o Scheffer + Rossum — or 470 Martin St. St. Paul.
Tel. c/o Central police station.

No. of Years, 2 yrs

Insane Relatives, None.

Cause Exciting, Fright - Coming home at night

Cause Predisposing, Influenza - Hysteria

Form, Defective with Hysterical Puberescent Enhancement

Accompanying Bodily Disorder, None

Suicidal or not, Not.

Date of this Attack, ?

Duration, 3 years. (since first attack)

No. of Attack, Several.

No. of Admission, 1st here -

Age First Attack, 15 yrs.

Time of Leaving,

Time in Hospital, 1

Result, Discharged

EXAMINATION ON ADMISSION BY DR. A. J. Strickler July 7 '99.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Recent Events, } Does not answer rationally. Special Subjects,

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

REASONING POWER, Ordinary Subjects, Special Subjects, Own Mental State, } Apparently without reason.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted. Depressed at times.

DELUSIONS, Fixed, Systematized, Transitory, Special Subjects, Parents.

HALLUCINATIONS, Not apparent

ILLUSIONS, present.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,
Silly + childish.

HISTORICAL.

LENGTH INVASION, Few days.

ONSET, Gradual or Sudden, Sudden.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

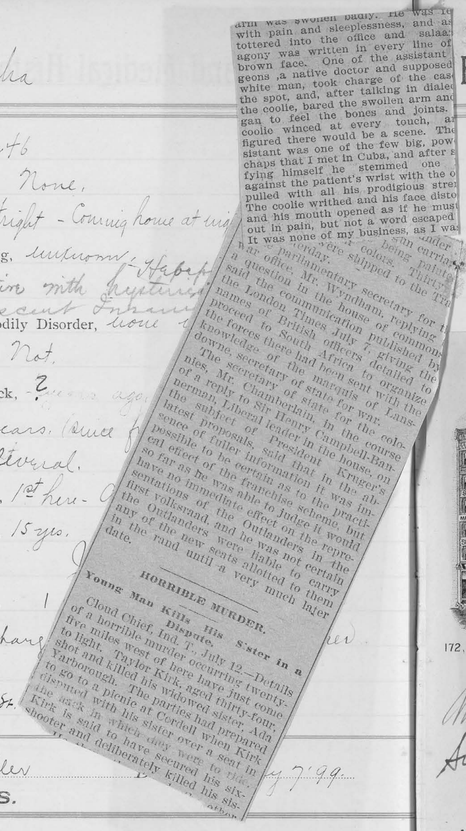
HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, School girl.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,


arm was swollen badly. He was
with pain and sleeplessness, and a
tottered into the office and salaa
agony was written in every line of
brown face. One of the assistant
geons a native doctor and supposed
white man, took charge of the cas
the spot, and, after talking in dialec
the coolie, bared the swollen arm and
gan to feel the bones and joints.
coolie winced at every touch, a
figured there would be a scene. Th
sistant was one of the few big, pow
chaps that I met in Cuba, and after
fying himself he stemmed one
against the patient's wrist with the o
pulled with all his prodigious stre
The coolie writhed and his face disto
and his mouth opened as if he must
out in pain, but not a word escaped
It was none of my business, as I wa
parliamentary secretary for
a question in the house of common
said the communication published by
the London Times July 7, stating the
proceed to South Africa to organize
the forces there had been sent with the
knowledge of the marquis of Lans
downe, secretary of state for the colo
nies. Mr. Chamberlain in the house on
a reply to Sir Henry Campbell-Banner
man, Liberal leader in the house, on
subject of the proposals, said that if the
latest proposals, said that if the
cence of offer information it was im
possible to be certain as to the practi
cal effect of the certificate scheme but
so far as he was able to judge it would
have no immediate effect on the repre
sentations of the Outlanders in the
first Volksraad, and he was not certain
the Outlanders were liable to carry
out the new seats allotted to them
until a very much later
date.

HORRIBLE MURDER.

Young Man Kills His Sister in a

Dispute.

Cloud Chief, Ind. T. July 12.—Details
of a horrible murder occurring twenty-
five miles west of here have just come
to light. Taylor Kirk, aged thirty-four,
shot and killed his widowed sister, Ada
Yarborough. The parties had prepared
to go to a picnic at Cordell when Kirk
insisted with his sister over a seat in
the hack in which they were to ride.
Kirk is said to have secured his six-
shooter and deliberately killed his sis-

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6 PRESENT WEIGHT, 121 USUAL WEIGHT, NUTRITION, Good

WOUNDS, Abnormalities and condition of Skin, Normal condition.

TONGUE, Coatings or Promptness of Movement, Normal

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - Responses good.

SIGHT, Good

Patient much distressed



ANSWERED JUL 22 1899

St. Paul July 14 1899

Mr F. A. Kellogg Asst Hospital. Rochester Minn.

Sir

I arrived here safely with my patient. Rose Licha in due time, and I thank God that I brought her, she is now beyond doubt perfectly sane, her reason returned as suddenly as it departed. She had a fearful headache for 2 hrs when she sank into a deep and natural sleep, snoring very loudly, when she opened her eyes, the light of reason was in them. The past few weeks, are a blank to her. She says it seems as though she had been dead.

She is thin and weak and her bowels in bad order, but I have an experienced physician attending her who assures me that the worst is now over, and that with proper treatment, she will in a very few days be fully restored in both mind and body. Thanking you for your kindly care of her and your very considerate treatment of me while there, and with kindest regards to Miss Gleason. I remain

Yours. Truly. Seth L Scham
393 Aurora Ave. City

ance,

ferent to left

able cause, the

rmal health.

for her mamma

EMENTS,

Personal and Medical His

Whole No. 5353

Residence, St. Paul

Date Admission, July

Admitted by Dr. A. J

How Sent, E.W. Bax

Sex, Female

Civil Condition

Children,

Age Yr

Occ

99

nity, Consanguinity, Epil-

PERCEP teria, Inebriety, Consumption),

REASONING POWE

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indiffe ives,

Exalted. depressed at times. nd Sisters,

DELUSIONS, Fairly Systematized, Transitory, Special Subjects, f DISEASES (especially Typhoid Fever, Sunstroke,

ead Injuries, and Surgical Operations),

ABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

HALLUCINATIONS, Not apparent.

ILLUSIONS, present.

OCCUPATION, Healthy or not, School girl.

Detail Date, Duration, and Character of Previous Attack, if any,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

Silly + childish.

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6 PRESENT WEIGHT, 121 USUAL WEIGHT, NUTRITION, Good

WOUNDS, Abnormalities and condition of Skin, Normal condition.

TONGUE, Coatings or Promptness of Movement, Normal

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - Responses good.

HT, Good

S, Nystagmus, Squint, Arcus Senilis, or other troubles,

EARING, Good

COORDINATION, Arms, Fairly good as far Legs, as tests could be ~~Grasp,~~ made - Patient much distressed

TREMORS, Hands, Tongue, Facial Muscles, General, None

PATELLAR REFLEX, None Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, hyperesthetic.

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

No evidence of disease.

ARTERIES,

Normal.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Exp. J.C.M.

No evidences of disease.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, external genitals normal. uterus adherent to left otherwise normal position.

MENSTRUATION, history not reliable - says regular + free from pain.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, sleeps fairly well

BOWELS, Present Condition, Inclined to ~~Constipation~~.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient in good general health. She acts like a "spoiled child". hovers her face with her hands + cares for her mamma. The hysterical element of her disorder appears very prominent. After 2nd admission appeared quite a typical case of Hebephrenia.

Personal and Medical History of Nora Licha.

1899

This patient was brought here by Sheriffs deputy H. Hanson, attended by Mrs J. Primo in fair general health, with the following history:- No consanguinity. Hereditary Father intemperate: First symptoms of insanity manifested three years ago: Has had two temporary recoveries: has been in City Hospital, St. Paul. Disease appears increasing: Is variable: Derangement now manifested by excitement, fear of bodily injury: Tried to take off her clothes in Court: Not disposed to injure anyone: No filthy nor destructive habits known: Before accession of disease was very religious & intense in likes & dislikes: Has received hospital care & treatment as above stated. On personal examination keeps hands to eyes; tries to undress herself: Will not converse rationally: On admission put upon Infirmary (Gen. Ward. Complexion fair: hair light: eyes blue: Skin in normal condition. 3 moles on chest. Small bruise on left arm: Is clean: One molar out left + 2 out right lower jaw: Behavior quiet: Talks very little, occasionally will answer questions (from Miss M. Gleason.)

Summary Nurses Notes by Dr. A. F. Strickler: Admitted July 7'99: Bathed & put to bed: Apparently in good general condition: Slept well at night & had a good appetite: seemed very childish - called for her "mamma and "papa" & would not talk rationally on any subject nor answer questions. Bowels were constipated: She remained on the ward, exhibiting no change in her mental condition, until July 12th '99 when she was visited by her brother-in-law and taken to his home.

Cont. by Dr Bass. Oct. 7. Returned: Slight mental improvement, not so foolish in manner & conversation but is rather disturbed & quite noisy. Nov 19 Complained of pain in abdomen. Temp. 97 4. P. 100. Was very restless & moaned until until 12 PM. Slept rest of night. Nov. 20 Slight rise of temp. Quite comfortable during day. Complained of pain in evening over ovaries: Turpentine stupes applied: seemed to suffer greatly. Hypo. given: Temp. after this remained about normal: Appetite fair: Bowels constipated, repeated enemata given. Pain continued until Nov. 24. up on 25th. Nov 30. Bowels regular: appetite fair: sleeps quite well: Neat in habits & appearance: Is very changeable at times quiet & depressed, at others noisy & restless: Does no work: Converses readily. Jan 15 1900 Wt. 130 Temp. 98.9. Fairly quiet on ward: cries at times: Conversation sensible: Appetite rather poor: Takes outdoor exercise. Menstruation regular: Became disturbed this this morning, threw herself on floor & was very hysterical 11 6 PM. Cheerful & mischievious at times depressed.

Mch 2 July 25 1900. Rather uncertain in behavior: at times noisy but usually quiet: Appetite good: Bowels somewhat constipated: Sleeps well: Quiet & agreeable. Temp. 4 to 8 3 July 1 Sick in bed for several days. Pain in side & back.

July 11 Vaccinated. July 25 Sent home.

Discharged

Letter from Mr. Isham. Nov 7. States patient has entirely recovered.

Personal and Medical History of

Personal and Medical History of Eliza Murphy.

Whole No. 5356
Residence, St. Paul, Minn.
Date Admission, July 11th 1899.
Admitted by Dr. A. J. Stricker hour, 7:30 P.M.
How Sent, Ex. Bazille Dep't. Ramsey Co.
Sex, Female Age, 70 yrs.
Civil Condition, widowed.
Children, Four.
Age Youngest Child, 27 yrs.
Occupation, Housekeeper
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
~~Nativity~~ Nationality, Ireland (Parents born there)
Physicians Committing, J. Leavitt F. K. Omdahl.
Correspondents, Mrs P. J. McQuillan 575 Dyckhart St. St. Paul
Miss Kath. Murphy 576 Carroll St. % Barnes. Telephone Dale 308.

No. of Years, 24?
Insane Relatives, None.
Cause Exciting, Age.
Cause Predisposing, —
Form, Senile Dem.
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Not,
Date of this Attack, 3 yrs ago.
Duration, 3 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 70 yrs.
Time of Leaving, Sept. 14. 1900
Time in Hospital, 1 yr. 2 m. 3 d.
Result, Died Demintia

EXAMINATION ON ADMISSION BY DR. A. J. Stricker *Date of* July 11 '99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused & sluggish.
MEMORY, Past Events, Poor.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
dull, illusive.
REASONING POWER, Ordinary Subjects, Much below normal.
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent.
DELUSIONS, Systematized, Transitory, Special Subjects,
Not definite
HALLUCINATIONS, Auditory.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Nothing prominent
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,
Awake at night. Appetite poor

Personal and Medical History of

Court Notes.
Eliza Murphy was examined in the probate court yesterday, and being found to be suffering from senile dementia, she was committed to the insane hospital at Rochester.

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft. PRESENT WEIGHT, 90 lbs. USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, Abdominal hernia Skin in normal condition.
TONGUE, Coatings or Promptness of Movement, Slight coat protrudes readily.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Rie normal. Responses fair.
SIGHT, fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, fair
COORDINATION, Arms, fair considering age. Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Intensional tremors of hands & tongue.
PATELLAR REFLEX, Normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Somewhat slow & slurred.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, fair
HEART, Murmurs, Strength, Sounds, Size, Feeble n.
Apex Beat, n. Regularity,
Somewhat irregular.
ARTERIES,
Sclerosed.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
No evidence of disease.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

7/28/99 EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, acid Color and Appearance, reddish yellow cloudy with ropy deposit
Albumen, Present by all tests Sugar, none -
Casts and Crystals, Amor. urates. Excessive amt. pus & epith. cells. Several uric acid crystals & a few granular casts (?)
GYNECOLOGICAL EXAMINATION, Laceration of perineum also extensive laceration of cervix. Erosion of cervix. uterus retroflexed - Atrophy of cervix & uterus - Considerable local tenderness. Has Haemorrhoids -
MENSTRUATION, No history obtained - menopause past.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Awake at night
BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient is in a feeble condition: is irritable & childish. Her mental condition resembles senile dementia. Was probably of average intelligence

Personal and Medical History of Eliza Murphy.

1899

This patient was brought here by Sheriff's deputy Hanson attended by Miss Murphy in a feeble physical condition, with the following history: No consanguinity, heredity nor intemperance in patient nor parents known: First symptoms of insanity manifested three years ago, by failing mind: Disease appears increasing: Not Suicidal: Derangement now manifested by senile dementia. Not disposed to injure anyone: Habits filthy & destructive: No peculiarities previously manifested: No severe diseases nor injuries to head sustained: None restraint has been employed: No treatment pursued:
On personal examination is a case of senile dementia.
July 11 On admission put upon Infirmary Ward G.H.N. Rpt. Complexion fair: hair & eyes gray: Skin dry: Has an umbilical hernia: Is clean: Has only six teeth: Has small growth on upper part of right leg: Behavior quiet: Talks incoherently.
July 11 - vs Summ. nurses 14 da. Record by Dr. Bess. On admission quite stupid & talked to herself. Is very old & feeble: usually quiet. Temp. pulse & resp. about normal- record mark slight rise of temp - pulse 62-88. usually slow. Appetite fair: is fed by nurse: Bowels require frequent laxatives & enemata: Sleep fairly good. tho at times very restless & out of bed often: Complains of pain in abdomen. July 24 Did not sleep any, moaned all night: Aug. 8 Visited by Father Riordan
Aug 15 up on ward & takes out on lawn: Continues quiet: wanders about aimlessly, usually muttering to herself: seldom answers questions & is very indifferent to surroundings: Is careless in habits & appearance: Sleeps very poorly: Sept 1 - Feb 28, 1900 - Quiet: wanders aimlessly about ward: incoherent: Mutters to herself: Very untidy in habits: Demented: Appetite fair: Bowels constipated: Sleeps poorly. Dec 11 Struck by Mrs Thuett. cut on head - no bad results: Jan 5 Wt 90 3/4 lbs. Feb 4 Requires considerable attention: Fell out of bed during night slightly bruising left eye.
Feb 5. Knocked down & hair pulled by E Klock. Trans. to Infirmary
March 1 - Sept 11 1900 Very restless: wanders about ward: mutters to herself: Is demented & incoherent: untidy in habits: appetite fair: Bowels constipated: Sleeps fairly well. Aug 19 In bed: very weak: Failing:
Aug 28 & 29 Visited by daughter: Aug 30 Remained in bed. Sept 4 Very weak & helpless: Does not converse: Seems indifferent to surroundings: Appetite poor: fed by nurse: Bowels constipated: given high enema frequently. Sept 10 Growing progressively weaker: failed rapidly & died Sept. 14 at 5:30. P.M.

Died.

Personal and Medical History of

Personal and Medical History of Maggie Faulhaver, (or Faulhaber)

Whole No. 5359
Residence, Wabasha Co, Minn.
Date Admission, July 14th 1899.
Admitted by Dr. R.A. Bebb —— hour, 4 Pm.
How Sent, M. Kennedy J. of P. Wabasha Co.
Sex, female Age, 33 yrs.
Civil Condition, married.
Children, 4
Age Youngest Child, four months.
Occupation, housewife (husband a farmer)
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
~~Nativity~~ Nationality, Minn. (Parents born in Ireland)
Physicians Committing, W. J. Milligan W.K. Lincoln.
Correspondents, Mr. John Faulhaver (or Faulhaber) husband. Kellogg, Wabasha Co, Minn.

No. of Years, 25 yr.
Insane Relatives, None
Cause Exciting, Masturbation.
Cause Predisposing, Previous attacks.
Form, Chr. Mania (acute)
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, May 1899.
Duration, about 2 mos.
No. of Attack, 2nd
No. of Admission, 2nd
Age First Attack, 27 yrs.
Time of Leaving, Apr. 3rd. 1900
Time in Hospital, 8 m. 19 d.
Result, Dism. Nov. 7. 1900 Improved

EXAMINATION ON ADMISSION BY DR. Strickler *Date of* July 14' 99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Fairly clear.
MEMORY, Past Events, } Fair
Recent Events, } Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert but illusive.
REASONING POWER, Ordinary Subjects, Fair
Special Subjects, } below average.
Own Mental State, }
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed, exalted at times.

DELUSIONS, Systematized, Transitory, Special Subjects,
Not systematized or fixed.
HALLUCINATIONS, Auditory & visual.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,
Mania with delusions.

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3½ PRESENT WEIGHT, 173# USUAL WEIGHT, NUTRITION, Fair.
WOUNDS, Abnormalities and condition of Skin, Skin normal.
TONGUE, Coatings or Promptness of Movement, Slight coating - protruded readily.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Size Normal - responses good.
SIGHT, Good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, Fair Legs, Fair. ~~Grasp~~, Accurate tests could not be made because of disturbed condition of patient.
TREMORS, Hands, Tongue, Facial Muscles, General, None
PATELLAR REFLEX, Increased. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Normal
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
No evidences of disease.
ARTERIES,
Normal


Jan. 1900.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
No evidence of disease
7/25/99 EXAMINATION URINE, Quantity, ʒ XXIV Sp. g. 1020 Reaction, acid Color and Appearance, yellow clear.
Albumen, None Sugar, None.
Casts and Crystals, Amor. urates + a few epith. cells.

GYNECOLOGICAL EXAMINATION, Laceration of perineum: external genitals otherwise normal - extensive irregular laceration of cervix: uterus slightly retroflexed & adherent to right. leucorrhoeal discharge - yellowish - profuse.
MENSTRUATION, Regular - except after 3rd child - absent 9 mos - subject to headache - not painful since marriage formerly had severe pains in ovarian region.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Restless.
BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Fair general health - Acute mania with delusions. Breasts are full of milk.

Personal and Medical History of Maggie Faulkavrs. (Nee Maggie Berry)

1899

This patient was brought here by Sheriffs deputy G.G. Dickman, attended by Mr John Faulkavrs (husband) in good physical condition with the following history: No consanguinity nor heredity known. First attack of insanity occurred in 1893 & patient was here from June 2 to Sept 28: 93. (Re Maggie Berry Vol. 24 Fol. 13. No. 3359.) First symptoms of present attack manifested in May 1899. by melancholia. Disease appears stationary. Is tidy & variable: Is disposed to injure others: No filthy nor destructive habits: No previous peculiarities noted. No severe diseases nor injuries to head. Was in hospital in '93 as above stated. has received no further treatment. No further facts noted on personal examination. On admission put upon Infirmary Med/ Gen Pat Complexion dark: hair light brown: eyes hazel: Skin in normal condition: Large bruise on left arm & a few small ones on right arm. Is dirty: Is stubborn, could not count teeth but some are missing. Father disturbed while being taken to ward & bathed. Says she is not insane but husband wishes to get her away from home so he will be free:)

July 14 - 29 Dress. 14 do. record by Dr. Bibb Temp: Pulse & resp. about normal. Appetite good: Bowels constipated: Was at first very restless & had considerable milk in breasts: slept only one hour: Very resistive: removed bandage from breasts: After second night slept quite well. Very untidy, incoherent & expressed many delusions: Gradually improved mentally during next three months: Was visited on Aug 9-10 by husband: Oct 1- Jan 1, 1900 No special change is quieter & takes more interest in surroundings assists with work: Inclined to be melancholy & cross at times. Takes outdoor exercise: Bowels rather constipated: Not sometimes disturbed: Is careless in appearance & very much disturbed at times: Often resists & attacks nurses Frequently quarrelsome: Sept 7 Complained of pain in side & remained in bed: Sept 8 Menses. Sept. 27. Attended Mr. Moody, complains occasionally of feeling ill & goes to bed for a day or two. Visited Oct. 18 by friend. Generally refuses to go out doors. Has habit of expectorating on floor & has to be watched. Dec 22-23. Visited by husband & taken home for a short visit. Jan 1/1900 Returned. Jan 3 Very disagreeable & untidy. Takes outdoor exercise: Trans. to A3. Jan 14 Wt. 119½ lbs. Jan 19. Menstruated. Feb 28. Untidy disagreeable & annoying in manner. Takes outdoor exercise Apr. 14. Improved somewhat. Allowed to go home today

Discharged

Personal and Medical History of

Personal and Medical History of Miss Lizzie Casey

Whole No. 5367

Residence, Price Co, Minn.

Date Admission, July 18' 1899.

Admitted by Dr. E.J. Watrous, hour, 3 P.M.

How Sent, James Hunter Supt. Price Co.

Sex, Female Age, 57.

Civil Condition, Single

Children, -

Age Youngest Child, -

Occupation, Dressmaker (Father a farmer)

Degree Education, Common school.

Profession, Religion, Catholic

Habits, Not intemperate.

Nationality, (Price Co, Minn - (Parents born in Iceland)

Physicians Committing, P.N. Jackson & M.L. Mayland

Correspondents, Jane Casey, Faribault Minn.

No. of Years, 255

Insane Relatives, None,

Cause Exciting, La Grippe in '91.

Cause Predisposing, Unknown

Form, Paranoia

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Not,

Date of this Attack, 1891.

Duration, 8 yrs.

No. of Attack, 1st Continuous.

No. of Admission, 2nd Rec. St. Peter '91 - Trans. to Fergus F. in '95

Age First Attack, 29 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. R.A. Babb. Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick - somewhat confused.

MEMORY, Past Events, Fair

Recent Events, - Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert - not correct.

REASONING POWER, Ordinary Subjects, Fair

Special Subjects, Poor.

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Usually indifferent - shows some feeling when she recites her wrongs.

DELUSIONS, Systematized, Transitory, Special Subjects,
Delusions of persecution. probably transitory

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, died Consumption

Paternal Relatives,

Mother, died Pneumonia

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None.

HABITS, Drinking and Smoking, None.

HEADACHES, VERTIGO, OR CONVULSIONS, Occasional headache

OCCUPATION, Healthy or not, says "nurse"

Detail Date, Duration, and Character of Previous Attack, if any,
See Vol XXIV p. 369.

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. 7 in PRESENT WEIGHT, 155# USUAL WEIGHT, NUTRITION, good.

WOUNDS, Abnormalities and condition of Skin, Scar on abdomen from operation. Skin dry & rough.

TONGUE, Coatings or Promptness of Movement, Prompt - light coat.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Rig normal - responses normal.

SIGHT, Good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, No trouble

HEARING, do.

COORDINATION, Arms, good Legs, good Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Fine of hands & tongue.

PATELLAR REFLEX, Normal. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Normal

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal.

ARTERIES,
Normal - regular.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

8/3/99 EXAMINATION URINE, Quantity, 3j XLV 111/1y Sp. g. 1012 Reaction, acid Color and Appearance, pale yellow - clear.

Albumen, None Sugar, None.

Casts and Crystals, Amor. urates. & a few epith. cells.

GYNECOLOGICAL EXAMINATION, Ext. gen. nor. Hymen lac. Uter. nor. pos.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps well.

BOWELS, Present Condition, Inclined to constipation

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Of fair intelligence. Delusions of persecution are prominent. Paranoia. Chronic case of some years duration. Physical condition very good.

Personal and Medical History of Lizzie Casey.

1899.

This patient was brought here by Sheriff's deputy J. B. Thompson, attended by Theresa Casey, with the following history:- No consanguinity nor heridity known: Has borne in St. Peter Rochester + Fergus Hospitals - + has never fully recovered since first symptoms were manifested in 1891. Is abusive, [illegible] Delusions & Hyppa. logiacious + charges men with attempted immorality with her. Thinks she owns property + says her name is Sheehan. Disease appears stationary Not variable. Is disposed to injure others. Is neither filthy nor destructive Has received hospital treatment as above stated. On personal examination is very abusive; claims to be a graduate in medicine in employ of associated charities: Being imposed upon in every way etc.
On admission put upon Infirmary Mat (Gen. Rpt. Complexion dark: Hair black: eyes blue: skin in normal condition: Long scar on abdomen from abdominal operation. Is dirty: Has upper incisor out. Has 15 upper + 16 lower teeth. Is quiet: Assisted some while being bathed. Talks intelligently.)
Summary notes - by Dr. Weygandt. Patient neat in habits + appearance: Rather quiet: Reads most of time: Takes out door exercise: Appetite good: Bowels constipated requiring frequent laxatives. July 26 Wass. to 63. — Aug 15 Wass to 85. Attends amusements: Converses readily + often argues on religious subjects also prays a good deal. Sept 6. Visited by Rishus Nov 30. Does not seem as well: is becoming very careless in appearance; is rather silly + laughs a great deal: Complains + is easily irritated + quarrelsome. Jan 27 148# Feb 19 Fed. Mch 1 - Nov 30 1900 Not in Habits but sometimes careless: Has religious delusions: Talks quite sensibly: usually quiet on ward: Prays a great deal: Appetite fair: bowels constipated: Sleeps well: Takes outdoor exercise:
July 25. Vaccinated. Nov 21. Does no work: Obstinate at times.
Nov 30 Wt 125#. Dec 1 - Feb 28 1901 Appetite good: Bowels regular: sleeps well: attends amusements: Works in laundry: Converses readily.
Mar 1 - June 1 - 1901 Does no work: no change in mental or physical condition
May 30 Wt. 147#. June to Sept. Attends chapel and amusements, takes exercise, does no work. Sept. 1 Wt. 156#. Sept. to Dec. Nov. 30 Wt 153. no change.
Dec to Feb. 1903 Gen'l health very good; sleeps well: appetite good: takes exercise. attends amusements in Chapel but does no work. Is quite delusional but ordinarily converses and answers questions readily and intelligently. Habits & appearance neat. Is at times disagreeable occasionally quarrels with the other patients. Dec. 1st Wt 168#.

Personal and Medical History of

Personal and Medical History of Mrs. Anna Johnson #3

Whole No. 5363

Residence, Aurora, Steele Co. Minn.

Date Admission, July 18th 1899.

Admitted by Dr. P. A. Bebb hour, 7:25 P.M.

How Sent, U.A. Eggleston Dept. Steele Co.

Sex, female Age, 22

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Housework (husband a farmer)

Degree Education, Com. school.

Profession, Religion, Not a ch

Habits, not intemperate.

~~Nationality~~ Nativity, Stark Co. Minn. (Father Denmark Mother Norway)

Physicians Committing, B.M.P. Coulon & W.C. Eustis.

Correspondents, Martin Johnson (Father) Bixby, Minn.

No. of Years, 256

Insane Relatives, None.

Cause Exciting, Uterine trouble.

Cause Predisposing, Previous attacks.

Form, Melancholia.

Accompanying Bodily Disorder, Uterine trouble.

Suicidal or not, Not.

Date of this Attack, About 3 wks. ago.

Duration, 3 wks.

No. of Attack, Several

No. of Admission, 1st

Age First Attack, About 21 years

Time of Leaving, Dec 25. 1899

Time in Hospital, 5 mo. 7 da

Result, Discharged Aug 8. 1900 Improved

EXAMINATION ON ADMISSION BY DR. Bebb. Date of Aug. 99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Sluggish - Quite clear.

MEMORY, Past Events, Appears good -

Recent Events, Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Rather dull but not incorrect.

REASONING POWER, Ordinary Subjects, Quite good -

Special Subjects, do

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Indifferent or rather depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

Expresses none.

HALLUCINATIONS, Probably none.

ILLUSIONS, do.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, a year (?)

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Living, well - about 50.

Paternal Relatives, Says no nervous trouble.

Mother, Living - not well for years - nervous

Maternal Relatives, Says no nervous trouble

Brothers and Sisters, 3 all well -

Children - none.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Measles & La Grippe about 13 yrs ago.

HABITS, Drinking and Smoking, Drank some cider - never smoked

HEADACHES, VERTIGO, OR CONVULSIONS, Subject to headaches recently

OCCUPATION, Healthy or not, Housework.

Detail Date, Duration, and Character of Previous Attack, if any,

Says none.

Sleep, Appetite, and Bowels,

Appetite rather poor. Bowels constipated. Sleeps quite well.

Personal and Medical History of Anna Johnson #3

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3. PRESENT WEIGHT, 116 USUAL WEIGHT, NUTRITION, Fair

WOUNDS, Abnormalities and condition of Skin, none. Skin in normal condition.

TONGUE, Coatings or Promptness of Movement, Clear - prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, dilated - response good.

SIGHT, Quite good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good.

COORDINATION, Arms, Good Legs, Good - ~~Grasp~~, Special tests good.

TREMORS, Hands, Tongue, Facial Muscles, General, None

PATELLAR REFLEX, Right normal - left diminished Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Not very distinct - hesitating & slow - Depressed tone.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Normal - Regular

ARTERIES, P. 74

Regular - Normal -

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical

Expansion fair -

R. lung rather shallow especially upper

Resonance normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

7/19/99 EXAMINATION URINE, Quantity, 3 XX 4½ fs Sp. g. 1022 Reaction, neutral Color and Appearance, Reddish-yellow. Cloudy. White flaky deposit.

Albumen, none Sugar, none.

Casts and Crystals, a few pus corpuscles & epith. cells. oxalate of lime crystals, amor. urates & few uric acid crystals.

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact. Uterus normal position.

MENSTRUATION, regular with one exception (2 yrs. ago ceased for 3 ~~years~~ mos.) until admission - Dysmenorrhoea - pain over pubic region & in back.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Laughs in rather a silly way. Patient very well until about a year ago last fall. Thought she took cold - Trouble commenced with headaches & painful menstruation. Went to school until 12 or 13. In 4th grade then. Hard to learn.

Personal and Medical History of Anna Johnson #3

1899

This patient was brought hre by Sheriff's deputy Schuyler J. Johnson attended by Mrs. Julia Thimson, in fair physical condition, with the following history: No history of consanguinity, heredity nor intemperance in patient nor her parents. First symptoms of insanity manifested about two years ago, has had several attacks of short duration. First symptoms of present attack manifested about three weeks ago by violent fits of passion + melancholy. Disease appears increasing. Is variable. Derangement manifested on no particular subject. is cross + abusive to parents + threatens to kill them + poison herself. Is filthy + destructive in habits. No peculiarities previously manifested. No severe diseases nor injuries to head. No confinement nor restraint employed. No information concerning treatment.

9/18/99 On personal examination Temp. 100, pulse 120. Resp. normal. At present + Examination rational. On admission put upon Infirmary list (Ward N. Ept. Complexion fair: hair light, eyes blue: Skin in normal condition: No marks, scars nor bruises noted: Is clean. Has thirty teeth 2 molars out upper left jaw. Behavior quiet: Talks intelligently)

July 18 to Aug 1. Summ. of 14 da. record by Dr. Bibb. Temp., pulse + resp. about normal: Appetite impaired: Bowels require occasional laxative: sleep good: Is very quiet + rarely speaks: but answers questions quite sensibly: Remains unoccupied: Takes out door exercise: Is untidy in appearance + takes little interest in surroundings.

Sept 1 - Dec 5/1899. Quiet: sleeps well. Appetite good: bowels regular: Takes out-door exercise: Assists with ward work. Sept. 19 Visited by father.

Dec 25/1899. Patient has improved. Allowed to go home today.

Discharged.

Letter from father July 19/1900. states that patient has improved a little but is still for from well.

Personal and Medical History of

Personal and Medical History of Johanna Flynn.

Whole No. 5366

Residence, Houston Co. Minn.

Date Admission, July 7th 1899.

Admitted by Dr R. A. Babs hour, 4 P.M.

How Sent, L. Budahl J. of P. Houston Co.

Sex, Female Age, about 34 yrs.

Civil Condition, single

Children, none

Age Youngest Child, —

Occupation, Housework (Father a farmer)

Degree Education, Public school education

Profession, Religion, Roman Catholic.

Habits, Not intemperate.

~~Nationality~~ Nativity, Penn. (Parents born in Ireland.)

Because resident of State 7 yrs. 7½ yrs.

Physicians Committing, C. J. Ferguson & D. C. Rhines.

Correspondents, Mr. John Flynn, bro. Mrs. Kate Hennessy (sister)
Caledonia, Minn.

No. of Years, 759

Insane Relatives, Maternal cousin

Cause Exciting, Perhaps overwork & care of sick mother.

Cause Predisposing, Unknown.

Form, Paranoia

Accompanying Bodily Disorder, poorly nourished

Suicidal or not, not suicidal

Date of this Attack, July 5' 1899.

Duration, 19 days.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, about 34 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. ..... Date of .....

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,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, PRESENT WEIGHT, USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin,

TONGUE, Coatings or Promptness of Movement,

PUPILS, Equality, Size, Response to Light, and Accommodation,

SIGHT,

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING,

COORDINATION, Arms, Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,



Jan. 1900.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

8/24/99 EXAMINATION URINE, Quantity, ℥ XXXV 11/14 Sp. g. 1020 Reaction, acid Color and Appearance, Yellow-clear-White flaky deposit.

Albumen, None Sugar, None

Casts and Crystals, Amor. urates. a few epith. cells & pus corpuscles.

GYNECOLOGICAL EXAMINATION, External genitals normal- Local tenderness. leucorrhoea, a moderate amount. Uterus antiflexed.

MENSTRUATION, Says regular & free from pain.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Personal and Medical History of Johanna Flynn.

1899

This patient was brought here by Sheriff Geo. N. Bharrud attended by Mrs. K. Hennessy (sister) in fair physical condition, with the following history: No history of consanguinity one cousin on mother's side insane. First symptoms of insanity manifested Jan. 5 '99. Has been gradually growing worse since then: Disease appears increasing: Is variable: patient seems rational at times: Has shown no homicidal nor suicidal tendencies: No filthy nor destructive habits: Has always been considered odd, perhaps on account of poor hearing: No severe diseases nor injuries to head sustained: Has been confined in jail for 24 hours. No treatment pursued. On personal examination is poorly nourished & has trouble with both ears. On admission put upon Infirmary G.S.N. Apt.-Complexion dark: hair black: eyes brown: skin in normal condition No marks scars nor bruises noted. Is dirty. Has 9 upper & 13 lower teeth: behavior quiet. Has delusions)

July 24 to Aug 7. Trans. 14 da, rec. by Dr Bebb. On admission quiet. Talked quite sensibly: slept well: Temp. pulse & resp. continued about normal: Bowels usually regular: Appetite good: Physical condition quite good: expressed some delusions but talked very little: Takes out door exercise: Aug 7 Trans. to A[3]. Sept. 1 Neat in habits & appearance: sleeps well: Assists with ward work: Is very quiet & depressed rarely speaking except to ask to go home: She gradually ceased to express delusions & conversation became more coherent. Nov. 5 Complained of toothache, face swollen.

Sept 1- Feb 28 1900. Jan. 14 Wt. 123#. Feb 26 Visited by brother: Neat & tidy: quiet: Takes out door exercise: Is pleasant & agreeable: works on ward. Has many delusions. Mch 1- Nov 30 1900 Quiet. Appetite fair: Bowels regular. Works in center dining room: Very deaf: Thinks she has much money. July 15, Hand & arm swollen to elbow. Trans. to Infirmary. Swelling went down after 4 days treatment. July 16 Trans. to A[3]. July 17 Vaccinated successfully: Aug 16 2 teeth extracted. Nov 16 Wt. 136¼#. Nov. 27 Right hand & wrist swollen: Came underroom. No abrasion of skin. Dec 1- Feb 28 1901. General health good: Feb 28 Wt 136½#. Expresses delusion that people have stolen her money & property.

Mar. to June 1901 No change in either mental or physical condition, May 29 Wt. 126#.

June to Sept. Patient is unoccupied, shows no change in general condition Aug. 31 Wt. 117#.

Sept. to Dec. Sept. 2 visited by friends, Sept. 28 patient became very obstinate and excited during the day Trans. B. 2, General health fair, patient is very deaf, expresses many delusions, thinks she sees friends and relatives about the institution who have come to take her home, is at times very obstinate in manner. Nov. 8 Wt. 114¼#.

Up to Feb. 1, 1903 No change- Wt. about 115# Patient is cleanly in habits and tidy in appearance: is quite deaf: therefore conversation is held with extreme difficulty. She talks to herself in whispers: does no work:

Personal and Medical History of

attends no amusements but takes exercise. Is not at all robust in health although she has no special ailment apparently. She is inclined to run away when out of doors and makes numerous attempts from the ward. She is quite troublesome in this way on the ward. Dec. 1st. Wt. 116½#.

Personal and Medical History of Sarah McGonigle.

Whole No. 5368

Residence, St. Paul, Minn.

Date Admission, July 28th 1899.

Admitted by Dr R. A. Webb hour, 7 PM.

How Sent, Ecu, Bazille & Co's Ramsey Co.

Sex, female Age, 35 yrs.

Civil Condition, ~~single~~? Divorced.

Children, - 2

Age Youngest Child, - 5 years.

Occupation, housekeeper.

Degree Education, Common school.

Profession, Religion, Not a church member.

Habits, Temperate.

Nativity, Nationality, St Paul, Minn. (Parents born in Ireland)
Residence of state 16 yrs. 35 yrs.

Physicians Committing, L. M. Brupe & H. R. Wenrich.

Correspondents, Relatives at 483 Charles St. St. Paul, Minn.
For information address
Mr Frank L. Hudson N.Y. Life Bldg. St. Paul, Minn.

No. of Years, 261

Insane Relatives, One cousin died at St. Peter.

Cause Exciting, Unknown

Cause Predisposing,

Form, ~~Acute~~ Chron, Mania

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, 3 yrs ago.

Duration, 3 yrs.

No. of Attack, 1st

No. of Admission, 1st at Fergus Falls one year.

Age First Attack, 32 yrs.

Time of Leaving, July 4. 1900

Time in Hospital, 11 mo. 6 da.

Result, Disc. Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Strickler Date of Aug 2 99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick but confused.

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

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

REASONING POWER, Ordinary Subjects, }
Special Subjects, } Fair.
Own Mental State, }

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS, Not apparent

ILLUSIONS,
Sub acute mania

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
2 children 1 miscarriage.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite and Bowels, Good & constipation

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2½ PRESENT WEIGHT, 103 lb USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, None. Skin normal.

TONGUE, Coatings or Promptness of Movement, Normal

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal. Responses good.

SIGHT, Good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Pterigium of left eye.

HEARING, Good

COORDINATION, Arms, below average Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None

PATELLAR REFLEX, Increased. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Rather slow.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Average

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

No evidence of disease

ARTERIES,

No evidence of disease

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

do.



Jan. 1900.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

8/8/99 EXAMINATION URINE, Quantity, ℥ XL Sp. g. 1030 Reaction, acid Color and Appearance, Yellow- cloudy.

Albumen, None Sugar, None.

Casts and Crystals, Amor. urates. epith. cells of all kinds. many overlapping - a few pus corpuscles + oxalate of lime crystals.

GYNECOLOGICAL EXAMINATION, Laceration of perineum - external genitals otherwise normal - extensive lateral laceration of cervix - endometritis with profuse purulent discharge. Extensive erosion of cervix.

MENSTRUATION, Every three weeks since birth of last child regular previous & that. On first day has neuralgic pain over left ovarian region, also in back.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Restless.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment).

Fair general health. Sub-acute mania.

Personal and Medical History of Sarah McGonigle.

1899.

This patient was brought here by sheriffs deputy H. Hanson attended by Drs. Willard in fair physical condition, with the following history:- No consanguinity, nor heredity known: Parents were intemperate in early days: First symptoms of insanity manifested three years ago - patient was in Fergus Falls Hospital about one year:- present trouble is a continuation of former attacks: Disease appears increasing: Is not variable: Derangement now manifested by talking in a rambling manner: Is a monomaniac on subject of poisoning: believes she has been a victim: Not disposed to injure anyone: No filthy nor destructive habits: No previous peculiarities known: No information concerning severe diseases nor injuries to head. Has been confined for two days in county jail. No treatment pursued since leaving Hospital. On personal examination talks in a vulgar & profane manner. On admission put upon Infirmary. (G.H.N. Supt) Complexion dark: hair dark brown: eyes brown: condition of skin normal: A few small scars on left arm & leg: Has vermin: Is dirty: 13 teeth above & 15 below: behavior quiet: Has delusions says her brother-in-law: tried to poison her for her money.)

July 28 - Aug 1st. Summary 14 days rec. By Dr Bell. Temp. 99° - 101° Pulse & resp. about normal: Aug 1st Pulse 100 - 104. Appetite fair: Bowels rather constipated. On admission was quite disturbed & slept only 4 hours: During first week very noisy, some nights also destructive & untidy. & was at times in restraint: uses profane language. Aug 16 Trans. to C2. Aug 30 but slight improvement noted: appetite continues poor: Is quite noisy at times: Takes out door exercise: is neat in habits: bowels constipated Oct. 16 Appetite has improved: sleeps better: Complains of pain around heart at times, refuses medicine: Commenced today (Oct 16) to assist with ward work: Trans to B3. Nov 10 Memo. Talks much more sensibly: & is agreeable on ward: assists with work: takes out door exercise: Dec 1 - Dec 31 1900 Jan 1st Wt. 171# Quiet & agreeable: Converses pleasantly: Neat: Works some on ward: Eats & sleeps well: Menstruates regularly. March 1 - Works in laundry: June 30 no change. July 4 Went home.

Discharged.

Sister Writes Oct 18 1900 That patient is very well & working:

Personal and Medical History of

Personal and Medical History of Emma Schumacher.

Whole No. 5369
Residence, Winona Co. Minn.
Date Admission, July 31 1899
Admitted by Dr. A. J. Kilbourne hour,
How Sent, H.L. Buck & opp. Winona Co.
Sex, female Age, 51 yrs.
Civil Condition, single.
Children, —
Age Youngest Child, —
Occupation, Housework. (Father a farmer.
Degree Education, Common school.
Profession, Religion, not a church member.
Habits, not intemperate.
~~Nativity~~ Nationality, Minn. (Parents born in Switzerland)
Physicians Committing, P.B. Blair & Hans Lichtenstein.
Correspondents, John Schumacher
Oak Ridge, Winona Co. Minn.

No. of Years, Ner
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, Unknown.
Form, Melancholia.
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Talks of it,
Date of this Attack, 2 wks ago.
Duration, About 2 wks.
No. of Attack, 3rd
No. of Admission, 1st. (St Hospital at La Crosse Wis.)
Age First Attack, 26 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. F. A. Babb. *Date of* 8/30/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused & sluggish.
MEMORY, Past Events, poor
Recent Events, " Special Subjects, do.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Not dull but illusive.
REASONING POWER, Ordinary Subjects, Poor
Special Subjects,
Own Mental State, incoherent & unreliable.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed

DELUSIONS, Systematized, Transitory, Special Subjects, on fighting & religion.
Power of attention impaired. Slow. Melancholia with delusions.
HALLUCINATIONS, apparently
ILLUSIONS, "
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Says dead
Paternal Relatives,
Mother, says dead
Maternal Relatives,
Brothers and Sisters, one brother.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Statements not reliable.
HABITS, Drinking and Smoking.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, does not sleep well. Appetite fair Inclined to be constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 in. PRESENT WEIGHT, 118# USUAL WEIGHT, NUTRITION, rather poor.
WOUNDS, Abnormalities and condition of Skin, Has lost little finger R. hand. Scars on left forearm - skin normal.
TONGUE, Coatings or Promptness of Movement, Clear - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal - Response to light fair - to accom. good.
SIGHT, Apparently quite good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Apparently quite good.
COORDINATION, Arms, Fair Legs, Fair. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Of hands & slight of tongue.
PATELLAR REFLEX, About normal Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Can talk distinctly - often hesitates & at times speaks low & indistinctly
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal & regular.
ARTERIES,
Pulse regular.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical.
Expansion fair.
B. sounds normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

9/5/99 EXAMINATION URINE, Quantity, ⅔ X V ℥ Sp. g. 1025 Reaction, acid Color and Appearance, Reddish yellow - cloudy - flaky deposit
Albumen, Trace by Heat & Tannic. Sugar, None.
Casts and Crystals, Amor. urates. Excessive amount of pus & oxalate of lime crystals. Several mucous bands & epith. cells.
GYNECOLOGICAL EXAMINATION, Lateral laceration of cervix ⅓ to extension & deep erosion. Uterus retroflexed. External genitals normal except slight laceration of perineum.
MENSTRUATION, No history obtainable.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Apparently understands quite well. Often does what is asked but is at times obstinate.

Personal and Medical History of Emma Schumacher.

1899

This patient was brought here by Sheriff Geo. Fehrmann attended by Anna Fehrmann, in fair physical condition, with the following history:- First attack occurred about 5 years ago & lasted about one year - was in hospital at La Moure, N.D. First symptoms of present attack manifested about 2 weeks ago by refusal to eat or talk & inclination to wander. Disease appears increasing & is variable. Derangement now manifested by thinking her brother & herself in danger of being killed. She wanders from home. Carries butcher knife to protect herself. Not disposed to injure anyone. No previous peculiarities known. No severe diseases nor injuries to head sustained. No confinement nor restraint since leaving Dakota hospital. No treatment pursued. On personal examination is very nervous & morose. Pays no attention & will not speak. Constantly picking with fingers.

On admission put upon Infirmary Most (Left Wing) Rpt. Complexion dark. Hair & eyes brown. Skin in normal condition. Scars on left arm & wrist. No toes on left foot. little finger right hand gone & next finger crooked. So very dirty. No upper teeth. 14 below. So quiet. refuses to talk.)

July 31 - Aug 14. Summary 14 da record by Dr Bebb. On admission very quiet. said very little. After first day brightened up. Temp slightly elevated. Pulse & resp. about normal. Appetite much impaired, some days refuses nourishment. Bowels usually regular. Sleep fair. Careless in appearance & inclined to be destructive. usually quiet in behavior. Expresses many delusions & talks incoherently. At times is very disagreeable. Takes out door exercise. Aug. 7 attempted to elope. Aug 10. Much disturbed. cried & was very noisy & restless.

Aug 15 to Sept 1. No special change noted. Most of time restless, destructive & inclined to be mischievious & is very unreliable. On Aug. 30 took knife from dining room. searched but knife not found until following day when she dropped it while standing on hall.

Sept 1 - Feb 28 1900. Sept 1 Visited by brother. untidy & very destructive. Fed by nurse, appetite poor. Secluded part of each day. Does nothing. Eats anything she can find - tooth picks - rags, buttons &c. & pulls out her hair & eats it. Frequently complains of pain in right side. Feb. 25. 91°. Mch 1 - Nov. 30 1900. Clean. Has delusions. Occasionally violent & destructive during may - quieter than usual. Appetite good. usually sleeps well. Bowels constipated. Takes outdoor exercise. July 17 Vaccinated. Always refuses to go to dining room. Very resistive. Oct 29 No change. Trans. to 2nd. Nov 30. Wt. 105 #. Dec 1 - Feb 28 1901 General health good. Feb 28 Visited by friend. Wt. 109 #.

Mar. to June 1901 Patient is troublesome and very melancholy, at times expresses desire to kill herself, has hallucinations of hearing, occasionally strikes at other patients, does not converse,

Personal and Medical History of

Mar to June 1901 has to be dressed and undressed, general health good, appetite fair, sleeps well, takes out door exercise, neat in habits, kept in bed. May 15 Wt. 110 #.

June to Dec. Patient remains in same mental and physical condition. Nov. 30 Wt. 108 #.

Dec to Feb 1, 1903 No change in condition. Wt. about 113 #.

Personal and Medical History of Jane Segar (or Seagar)

Whole No. 5370
Residence, Albert Lea, Minn.
Date Admission, July 31 1899.
Admitted by Dr. E.J. Ivanous hour, 7 P.M.
How Sent, H Blackmer Jof P. Freeborn Co.
Sex, Female Age, 30.
Civil Condition, married.
Children, 4
Age Youngest Child, 11 mos.
Occupation, Housewife (Husband a painter.)
Degree Education, Fair.
Profession, Religion, Not a Ch. member,
Habits, Temperate.
~~Nationality~~ Nativity, Minn. (Father Canada, Mother New York.)
Physicians Committing, G.W. Barck & D.A. Blackmer
Correspondents, Mr. Homer Segar. Albert Lea, Minn.

No. of Years, 263
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, —
Form, Melancholia with delusions.
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not
Date of this Attack, January 1899.
Duration, 7 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 30 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Bebb *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Mind quite clear & quick
MEMORY, Past Events, Quite good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert.
REASONING POWER, Ordinary Subjects, Quite good.
Special Subjects, "
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
About normal - Rather indifferent
DELUSIONS, Systematized, Transitory, Special Subjects,
About husband.
Power of attention impaired.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Long.
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, thinks he is living
Paternal Relatives,
Mother, Died 3 yrs. ago. (So he old. not at all nervous. Cause of death) had haemorrhoids.
Maternal Relatives,
Brothers and Sisters, living & well.
4 children all living & well.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had severe attack of "Grippe" about 8 yrs. ago & throat has troubled her at times ever since.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, Says has continuous headaches on vertex also has faint weak spells.
OCCUPATION, Healthy or not, Housekeeper.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Not Appetite, Fair and Bowels, Constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, PRESENT WEIGHT, USUAL WEIGHT, NUTRITION, Fairly good.
WOUNDS, Abnormalities and condition of Skin, Skin cool & dry - hands & feet cool.
TONGUE, Coatings or Promptness of Movement, White coating. protruded promptly.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - slightly dilated. responses normal.
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, Quite good Legs, Quite good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands & tongue.
PATELLAR REFLEX, diminished Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, Normal.
HEART, Murmurs, Strength, Sounds, Size, Sounds at base weak
Apex Beat, Regularity, Regular
Says she has palpitation of heart.
ARTERIES, Normal
Pulse weak - regular.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

8/5/99 EXAMINATION URINE, Quantity, 3x 11 p Sp. g. 1007 Reaction, acid Color and Appearance, Yellow - clear.
Albumen, None Sugar, None
Casts and Crystals, Amor. urates & a few Epith. cells.

GYNECOLOGICAL EXAMINATION. Has extensive laceration of perineum. Uterus normal position & movable. laceration & slight erosion of cervix - Local tenderness.
MENSTRUATION, Usually regular, Has pain & flow profuse at time of admission Menstrual period delayed two weeks. This is the only irregularity she mentions. Frequently complains of headache
OPHTHALMOSCOPIC EXAMINATION, Not. exam. at this yrs.
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Poor.
BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Says husband applied for divorce 4 yrs. ago & she has never been the same since: that her mind constantly reverts to this trouble & she worries over it Says she is ashamed of her actions. & that she has always been irritable.

Personal and Medical History of Jane Degar.

1899.

This patient was brought here by Sheriff W.C. Mitchell attended by Mrs J.S. Butler in good physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor parents: First symptoms of insanity manifested about Jan.1st 1899. by imagining that people would injure her. Disease is variable, with irregular rational intervals: Derangement now manifested by thinking that neighbors are troubling her & threatens to kill them: Is destructive in habits: No peculiarities previously manifested. No severe diseases nor head injuries sustained: No confinement nor restraint employed: No treatment pursued. On personal examination appears excited and threatens others. On admission put upon Infirmary (Ward Rpt. Complexion dark: hair brown: eyes gray: Skin in normal condition: Several small scars on arms & back. Is clean: Has 15 upper & 14 lower teeth: Behavior quiet: Has delusions.

July 31 Summary 14 Days record by Dr Bebb. On admission very quiet & said little: very restless for part of night, quiet during the following day: considerable milk in breasts: temp. slightly elevated part of time: pulse & respiration normal: appetite fair: bowels constipated: Sleep much disturbed during first week: Somewhat better after that: ointment applied to breasts: bandaged daily: Very quiet in behavior: Sometimes irritable: frequently asks to go home: Is up on ward & takes out door exercise: Aug 8: Complained of feeling weak: Aug. 15: 16: Visited by husband: Aug 16 Taken out riding: Aug. 18 Out riding with brother: Aug. 30: No change: Sept. 11 Remains quiet: is decidedly disagreeable & fault finding at times: also complains frequently of various aches & pains: thinks people are talking about her. Went home to-day on trial.

Feb 20 Returned. Quiet & depressed: Very irritable & fault finding Fairly neat: Converses readily: Appetite good: Bowels constipated: Sleeps poorly. Is inactive: Does not like to work: Is hypochondriacal: Frequently complains of being sick. Mch 1- Nov 30/1900 Is profane: Expresses many delusions: Says people talk about her & attempt to keep her from her husband. Appetite good: Sleeps well: Bowels constipated: June 16 Visited by husband. June 22. Visited by sister & taken home. Returned a few days later. as they could not take care of her. Sept 23 Attempted to strike nurse. Nov 24 Appetite & general health good: at times quite disagreeable & occasionally violent: Has delusions Thinks she hears people talking about her & that she is to be killed Wt. 108#. July 4. July 21 Vaccinated. Dec 1- Feb 28/1901 General health good. Assists some with work: Has delusions: Feb 12 Improved: Works -more: Gives electrical treatments: Seems somewhat benefitted. Wt 123#.

Mar. to June 1901 Patient shows no change in mental or physical condition, May 28 Wt. 112#

Personal and Medical History of Jane Degar

June to Sept. Is unoccupied, takes out door exercise, general health fair, menstruates regularly, June 27 visited by husband and taken home by him.

Sept. to Dec. Oct. 14 Patient received on infirmary West, Oct. 17 Trans. to A.3, remains in same general condition Nov. 23 Wt. 113#.

Dec. to Feb. 1903 No change Wt about 111# Aug. 13, 1902 Visited by husband and son. Went out riding: returned next morning.

Personal and Medical History of Hattie Valois.

Whole No. 5377

Residence, St. Paul, Minn.

Date Admission, August 3rd 1899.

Admitted by Dr. E. Z. Wamous hour, 7 PM.

How Sent, E.W. Bazelle Asst. Ramsey Co.

Sex, Female Age, 21 yrs.

Civil Condition, single.

Children, —

Age Youngest Child, —

Occupation, Seamstress (Father a farmer)

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate.

~~Nationality~~ Nativity, Mother Parents born in Canada

Present at Ramsey Co. 4 yrs.

Physicians Committing, F. C. Bates & C. C. Miller.

Correspondents, Mary & Louis Valois, Centerville, Anoka Co. Parents

Mary Valois 571 Jackson St. St. Paul - (sister)

No. of Years, 1

Insane Relatives, None.

Cause Exciting, Acute meningitis.

Cause Predisposing, Unknown.

Form, Religious Melancholia

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, Feb. 20 '99.

Duration, 5 mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 21 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Strickler Date of Aug 3 '99.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Obstinate - will not answer questions
Recent Events, as coherent. Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Cannot test.

REASONING POWER, Ordinary Subjects, Cannot test.
Special Subjects,
Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Apparently depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
On religion.

HALLUCINATIONS, Not apparent.
ILLUSIONS,
Melancholia with religious delusions.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, None.

OCCUPATION, Healthy or not, Healthy.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, regular
Slept well before this attack.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in PRESENT WEIGHT, 98½ # USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, N.

TONGUE, Coatings or Promptness of Movement, Normal.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal - good.

SIGHT, Good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good.

COORDINATION, Arms, Good Legs, do Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None

PATELLAR REFLEX, normal Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Will not speak

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, Hyperasthetic

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal.

ARTERIES,
No evidence of disease

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
No evidence of disease

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

8/7/99 EXAMINATION URINE, Quantity, ℥ XLV 111/14 Sp. g. 1008 Reaction, Neutral Color and Appearance, light yellow - clear

Albumen, None Sugar, None

Casts and Crystals, Amor. urates. epith. cells of all kinds - many over lapping - excessin amt. pus corpuscles. & uric acid crystals.

8/15/99 GYNECOLOGICAL EXAMINATION, External genitals normal. Uterus normal position. Leucorrhoea.

MENSTRUATION, Always irregular. Cessation from two to three months at a time. Says some pain in back & abdomen during menstruation.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, fairly well.

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient in good general health - Reads her Bible all day, prays - is depressed - Probably suffers from religious melancholia.

Personal and Medical History of Hattie Valois.

1899

This patient was brought here by sheriffs deputy Kanson, attended by Mrs Mary Valois, in fair physical condition, with the following history: No history of consanguinity, heredity nor intemperance in parents nor in patient. First symptoms of attack manifested Feb. 20 1899 by attack of acute meningitis. Disease appears increasing. Is variable. Derangement manifested on subject of religion. Patient not disposed to injure anyone. No filthy nor destructive habits: No peculiarities previously manifested. No severe disease nor injuries to head. No confinement nor restraint employed, usual treatment for acute meningitis pursued. No further facts noted, on personal examination.

Aug 3 On admission put upon Infirmary (Gen. Rpt. Complexion dark. hair brown: eyes gray. Skin in normal condition: No marks, scars nor bruises: Is clean. Has 16 upper + 16 lower: behavior quiet. Refuses to talk.)

Summary 14 days record by Dr Bibb. On admission very quiet + depressed. sleeps well: Temp. pulse + resp. normal. Appetite poor the first week, improved slightly the second. Bowels require laxatives. Is reticent in manner + does not care to talk but in conversation is sensible. Is much depressed + cries a good deal. Spends most of time in room reading her prayer book. Takes out door exercise. At times is quite obstinate + resistive.

Aug 17 to Dec 1. – Menstr. augrs. + Sept. 17. Nov. 30 Very little change noted. Patient is indifferent to appearance; sometimes laughs to herself. Remains unoccupied. Nov. 30 Loss to 83.

Sept. - Feb 28 1900. Fairly quiet but very obstinate + destructive: Disagreeable in manner. Expresses delusions freely. Frequently attacks nurses + often fights when bathed. Takes out door exercise.

March - Nov 30. Quiet + agreeable. Works. General health good. ~~Approx. Visited by Brother~~ Eats + sleeps well. Habits occasionally dirty. Takes exercise. Bowels regular. Does not converse but answers when spoken to. Nov. 23 97#. Dec 1 - Feb 28 1901 General health good. Assists with work. Feb 15 Wt. 103#. At times violent + destructive. Mar to June 1901 No change in mental or physical condition. May 29 Wt. 95#. June to Sept. July 4 visited by sister and friend, shows no change in mental or physical condition. Aug 31 Wt. 92#.

Sept. to Dec. General health fair, takes out door exercise, is unoccupied, at times is violent and destructive, menstruates regularly. Nov. 24 Wt. 95#.

~~Dec to Dec 02~~ No change. Wt about 96#. July 24, 1902 visited by a friend.

Feb. 8, 1903 Patient failing very rapidly. Feb. 10th visited by sister and taken home.

Personal and Medical History of

Personal and Medical History of Ida A. Moody.

Whole No. 5375
Residence, St. Paul, Minn.
Date Admission, August 8th 1899.
Admitted by Dr. R. A. Bebb hour, 7 PM.
How Sent, E. W. Bazille B. of P. Ramsey Co.
Sex, Female Age, 32 yrs.
Civil Condition, married.
Children, none
Age Youngest Child, -
Occupation, Milliner (Husband a civil engineer)
Degree Education, Common school.
Profession, Religion, Lutheran.
Habits, Patient intemperate.
~~Nationality~~ Nativity, Sweden (Parents also born there)
Residence 4 years 17 yrs. Occ. 15 yrs
Physicians Committing, Dr. Dahlberg - C. N. Whitney
Correspondents, I. A. Holmen (bro) 415 Mt. Airy St. St. Paul.

No. of Years, 5.
Insane Relatives, None.
Cause Exciting, Unknown
Cause Predisposing, "
Form, General Paresis
Accompanying Bodily Disorder, Very nervous.
Suicidal or not, Yes. (used a razor.)
Date of this Attack, About one year ago.
Duration, One year
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 32 yrs.
Time of Leaving, Apr. 25. 1900
Time in Hospital, 8 m. 17 d.
Result, Discharged. Nov. 7. 1900
Improved

EXAMINATION ON ADMISSION BY DR. R. A. Bebb. *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick - confused.
MEMORY, Past Events, Impaired
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert. illusive.
REASONING POWER, Ordinary Subjects, Impaired
Special Subjects, "
Own Mental State, "
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.
DELUSIONS, Not Systematized, Transitory, Special Subjects,
Has many delusions of self-importance + grandeur.
HALLUCINATIONS, Talks often as though addressing
ILLUSIONS, friends.
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,
Power of attention impaired - silly - often unmoral.

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, says living Statements not accurate.
Paternal Relatives, —
Mother, says living
Maternal Relatives, —
Brothers and Sisters, —
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says she had scarlet fever when a child - Surgical operation (?)
HABITS, Drinking and Smoking, Says drank liquor.
HEADACHES, VERTIGO, OR CONVULSIONS,
Often severe headaches. Has vertigo frequently.
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, inclined to be constipated

Personal and Medical History of

Copy of Notice of Hearing petition of John A. Holman for appointment of guardian for Ida A. Moody - served Nov. 21. 1899 & filed with commitment papers.

MENTAL CHARACTERISTICS.

HEIGHT, NUTRITION, Good.
Scar on abdomen (?) Skin normal
normal - reporves fair
apparent,
Grasp,
tongue.
PATELLAR REFLEX, Exaggerated. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Somewhat slurred - quite prompt.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY, normal.
HEART, No Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal - regular.
ARTERIES,
Normal - regular.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion good -
B. Sounds more obscure on right apex
Slightly harsh on expiration -
Percussion note normal.



CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

8/9/99 EXAMINATION URINE, Quantity, ℥ XL Sp. g. 1022 Reaction, Neutral Color and Appearance, Yellow - cloudy - flaky deposit.
Albumen, None Sugar, None.
Casts and Crystals, Excessive amt. amor. urates. a few epith cells - pus corpuscles + fat globules.
GYNECOLOGICAL EXAMINATION, Two miscarriages. Slight laceration of perineum - external genitals otherwise normal - Extreme tenderness of fundus of uterus. Uterus retroflexed + adherent to left. Local tenderness + small tumor in left labia.
MENSTRUATION, Not painful. Always regular except one year ago - cessation for seven months -
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Usually good
BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). General physical condition good. Delusions of grandeur prominent. Manner is usually light, gay, elated. But if she cannot have her way is inclined to be obstinate + even violent. Is destructive + untidy at times. General appearance resembles general paresis strongly.

Personal and Medical History of Ida L.

Whole No. 5375

Residence, St. Paul, Minn.

Date Admission, August 8th 1899.

Admitted by Dr. R. A. Bebb hour, 7 P.M.

How Sent, E. W. Bazille Sh. of P. Ramsey Co.

Sex, Female Age, 32 yrs.

Civil Condition, married.

Children, none

Age Youngest Child, -

Occupation, Milliner (Husband a civil engineer)

Degree Education, Common school.

Profession, Religion, Lutheran.

Habits, Patient intemperate.

~~Nationality~~ Nativity, Sweden (Parents also born there)

Physicians Committing, Dr. Schlberg + C. N. Whitney

Correspondents, J. A. Holmes (Bro) 415 Mt. Airy St. St. Paul.

No. of Years, 5.

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing, "

Form, Simple Paresis

Accompanying Bodily Disorder, Very nervous

Suicidal or not, Yes. (used a razor.)

Date of this Attack, About one year ago.

Duration, one year

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 32 yrs.

Time of Leaving, Apr. 25. 1900

Time in Hospital, 8 m. 17 d.

Result, Died. Nov. 7. 1900

Improved

EXAMINATION ON ADMISSION BY DR. R. A. Bebb. Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quick - confused.

MEMORY, Past Events, Impaired

Recent Events, " Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Alert. illusive.

REASONING POWER, Ordinary Subjects, Impaired

Special Subjects, "

Own Mental State, "

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Exalted.

DELUSIONS, Not Systematized, Transitory, Special Subjects,

Has many delusions of self-importance + grandeur.

HALLUCINATIONS, Talks often as though addressing

ILLUSIONS, friends.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

Power of attention impaired - silly - often maniacal

HISTORICAL.

LENGTH INVASION,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Says living Statements not accurate.

Paternal Relatives, —

Mother, Says living

Maternal Relatives, —

Brothers and Sisters, —

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Says she had scarlet fever when a child - Surgical operation (?)

HABITS, Drinking and Smoking, Says drank liquor.

HEADACHES, VERTIGO, OR CONVULSIONS, Often severe headaches. Has vertigo frequently.

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, inclined to be constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 7½ PRESENT WEIGHT, 155# USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, Scars on back of neck Scar on abdomen (?) Skin normal

TONGUE, Coatings or Promptness of Movement, prompt - light coat.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - response fair

SIGHT, Says good but wore glasses.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, No trouble apparent.

HEARING, Good

COORDINATION, Arms, Good Legs, Good Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Fine of hands + tongue.

PATELLAR REFLEX, Exaggerated. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Somewhat slurred - quite prompt.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY, normal.

HEART, Murmurs, Strength, Sounds, Size, Apex Beat, Regularity,

Normal - regular.

ARTERIES,

Normal - regular.

LUNGS, Chest, Symmetry, Expansion, Breath Sounds,

Chest symmetrical

Expansion good -

B. Sounds more obscure over right apex Slightly harsh on expiration -

Percussion note normal.



CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

8/9/99 EXAMINATION URINE, Quantity, ½ XL Sp. g. 1022 Reaction, Neutral Color and Appearance, Yellow - cloudy - flaky deposit.

Albumen, None Sugar, None.

Casts and Crystals, Excessive ant. amor. urates. a few epith cells - pus corpuscles + fat globules.

GYNECOLOGICAL EXAMINATION, No miscarriages. Slight laceration of perineum - external genitals otherwise normal - Extreme tenderness of fundus of uterus. Uterus retroflexed + adherent to left. Local tenderness + - small tumor in left labia.

MENSTRUATION, not painful. Always regular except one year ago - cessation for seven months -

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, usually good

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). General physical condition good. Delusions of grandeur prominent. Manner is usually light, gay, elated. but if she cannot have her way is inclined to be obstinate + even violent. Is destructive + untidy at times. General appearance resembles general paresis strongly.

Personal and Medical History of Ida D. Moody

1899

This patient was brought here by Sheriff's deputy D.A. Holmes (bro) attended by Mrs Salmon in fair physical condition with the following history:- No consanguinity, No Lunacy known: Patient has been intemperate: First symptoms of insanity manifested about a year ago, by irritability: Disease appears increasing: Not variable: Derangement manifested by hallucinations of greatness & untrue statements: Is disposed to injure others: Attempted suicide with a razor: No filthy nor destructive habits: No previous peculiarities manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued: On personal examination has a sallow complexion; is very nervous, Lately has practiced masturbation.

Aug 8 On admission put upon M primary (G.R.N.Ky). Complexion dark: hair brown: eyes gray: Skin in normal condition: Small scars on upper right leg & back of neck: Is clean: Has 14 upper & 16 lower teeth: Is quiet: Talks intelligently but has rather exalted ideas.

Summary 14 da. record by Dr Bibb. Slight rise of temp. pulse & resp. normal: Appetite good: Bowels usually regular: Sleep good: Quite well physically: Is rather silly but talks quite sensibly on ordinary subjects: Is quiet & agreeable: expresses many delusions: Takes outdoor exercise. Very untidy in habits & at times very much disturbed Aug 13 Struck one of patients: Is inclined to be loud & boisterous, Aug 14. Trans. to B3. Aug 16. Went to dance; did not act properly & was brought home: Threatened to commit suicide. Is at times destructive & uses profane language: Aug 26 Trans. to C2. Aug 27 Very noisy & violent. Put in restraint & quite noisy for a few hours: emesis.

Sept 1- Fr 28 1900. Appetite poor: Quite noisy day & night: Very destructive Bowels constipated: Violent at times: Expresses many delusions Sept 24 Becoming more quiet: Sept 30 & Oct 1 & Visited by father. Oct 16 Still very destructive Dec 30. More troublesome Neat: works on ward: Expresses delusions: Takes outdoor exercise: Trans. to A3, Jan 17 - Wt 146½#; Quiet & well behaved: works, sleeps & eats well, Mch 1. No change. Apr 20 Visited by brother. Apr 25 Went home.

Discharged.

Letter received from Ida Holmes July 4 1900. States that patient is doing well- Tho prefers to be by herself & is forgetful & rather childish - physically quite well except for headaches.

Personal and Medical History of

Personal and Medical History of Emily Savage.

Whole No. 5377
Residence, Jamesville, Minn.
Date Admission, August 14th 1899.
Admitted by Dr. O.C. Heyerdale hour, 4 P.M.
How Sent, G.A. Wilson J. of P. Waseca Co.
Sex, female Age, 29.
Civil Condition, single
Children, none
Age Youngest Child, -
Occupation, none.
Degree Education, Common school.
Profession, Religion, Episcopal.
Habits, Not intemperate.
~~Nativity~~ ~~Nationality~~, Minn. (Parents born in England)
Because a resident of Waseca Co. see p 370.
Physicians Committing, M. J. Taylor + D.J. Mc Mahon
Correspondents, Mother Mrs. Christina Savage. Jamesville Minn
Sister. Miss Nellie Savage Jamesville Minn (?)

No. of Years, 7
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, "
Form, Recurrent mania Acc.
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, not.
Date of this Attack, 4 weeks ago.
Duration, 4 weeks.
No. of Attack, 3rd
No. of Admission, 3rd
Age First Attack, 20 yrs.
Time of Leaving, Feb. 3. 1900
Time in Hospital, 5 mo. 20 d
Result, Discharged Sept. 22. 1900
Recovered

EXAMINATION ON ADMISSION BY DR. Bess Date of Aug. 14 '99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Sluggish - confused.
MEMORY, Past Events, poor
Recent Events, " Special Subjects, do
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Not dull - illusive
REASONING POWER, Ordinary Subjects, Poor
Special Subjects, "
Own Mental State, "
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Slightly exalted.
DELUSIONS, Systematized, Transitory, Special Subjects,
Cannot determine
HALLUCINATIONS, Thinks she sees + hears children out-
ILLUSIONS, doors playing.
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, 9 yrs.
ONSET, Gradual or Sudden, Probably gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, Was insane - (Parents first cousins)
Father died from sunstroke.
Paternal Relatives,
Mother, Living - 68 yrs. old she thinks
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Supposed head injury.
Thinks she had typhoid fever.
HABITS, Drinking and Smoking, Says yrs,
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches
OCCUPATION, Healthy or not, Housework.
Detail Date, Duration, and Character of Previous Attack, if any,
See previous history Vols. 13 + 30. Has had numerous attacks
Sleep, Appetite, and Bowels, regular. She says
Sleeps fairly well - appetite good - must be fed.

Personal and Medical History of Emily Savage.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2" PRESENT WEIGHT, 115# USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, Skin in normal condition
TONGUE, Coatings or Promptness of Movement, Slight coating - fairly prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal. responses good.
SIGHT, Apparently good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Apparently good.
COORDINATION, Arms, normal Legs, normal - Grasp, Special tests fair
TREMORS, Hands, Tongue, Facial Muscles, General, None
PATELLAR REFLEX, Diminished Other Reflexes, do
ARTICULATION, Slurred, Hesitating, Slow, Hesitating but after she commences to talk quite good.
Conversation often wandering + incoherent.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
~~Conversation often sensible~~
SENSIBILITY, Normal
HEART, Murmurs, Strength, Sounds, Size, Normal
Apex Beat, Normal Regularity, Regular
ARTERIES,
Pulse weak - Intermittent.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair,
B. Sounds normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. 1020 Reaction, acid. Color and Appearance, yellow. Clear
Albumen, None Sugar, None
Casts and Crystals, a few epith. cells

8/15/99 GYNECOLOGICAL EXAMINATION, External genitals normal - except hypertrophy of labia - hymen intact - uterus retroflexed - slightly adherent to left. lat. mucky discharge.
MENSTRUATION, History of menstruation not reliable.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Does not sleep very well.
BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Physically she is quite well. Heredity probable cause - Previous mental grade low - This is a mild attack of chronic mania: Patient laughs foolishly without cause - Whistles - disarranges clothing + is at times extremely untidy + destructive. Many of her statements are incoherent + inaccurate.

Personal and Medical History of Emily Savage.

1899

This patient was brought here by Sheriffs deputy Frank A. Collins attended by Miss Nellie Savage in fair physical condition, with the following history: Parents were second cousins; No history of heredity nor intemperance in patient nor parents: First attack of insanity occurred in Jan. 1890 & Second in Feb 96. This is third admission 1st Jan 4 '89 to Apr 9 '90. (Vol 13 Fol. 92 No. 2252) 2nd From Feb. 1 '96 to June 4 '96 (Vol. 30 Fol. 85 No. 4316) First symptoms of present attack manifested about four weeks ago, by melancholia: Disease appears stationary. Not variable: Is very restless, Whistles: Not disposed to injure anyone: Habits filthy & destructive: No peculiarities previously manifested No severe diseases nor injuries to head sustained: Has received Hospital Treatment, as above stated: No further facts noted on personal examination.

8/14/99 On admission put upon Infirmary West (Sth. Rpt) Complexion dark eyes gray hair brown: skin hot & dry: small scar on lower part of back & in left groin. Is dirty: Has 10 upper & 11 lower teeth. Behavior quiet: Is incoherent.)

Summary of da record by Dr Bibb. On admission was untidy, disturbed & expressed many delusions: Temp. 100 8. Pulse & resp about normal. Appetite fair, bowels required laxatives: During first two nights slept disturbed & given mild sedative: Is not noisy but very nervous & restless: picking at clothing &c. constantly.

Aug. 30 Trans. to B. Rept as untidy. Eats & sleeps well. Bowels regular.

Nov 27. Has teeth extracted: Dre & roots extracted. Jan 18. Talks & acts very sensibly: Attends chapel & amusements: Works on ward. Reads a good deal: Lot 116 Tr. Feb 3 Went home on trial,

Discharged.

Personal and Medical History of

Personal and Medical History of Estella Curry.

Whole No. 5378
Residence, St. Paul, Minn.
Date Admission, August 14th 1899.
Admitted by Dr. A. J. Kilbourne hour, P.M.
How Sent, E.W. Bazille Dep. of P. Ramsey Co.
Sex, female Age, 41 yrs.
Civil Condition, married
Children, one
Age Youngest Child,
Occupation, Housewife (husband a railroad man)
Degree Education, Common school.
Profession, Religion, not a church member.
Habits, Has for years used crude opium.
~~Nationality~~ Nativity, Ohio. (Parents born in New York.)
Physicians Committing, Resident of State 20 yrs. M.D. 16 yrs. W.J. Hammill + J.T. Cavanaugh.
Correspondents, Mrs. Emma Burnett Mother
514 Hopkins St. St. Paul, Minn.

No. of Years, 8
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing,
Form, Paranoia (Ch. Mellus) with some depression
Accompanying Bodily Disorder,
Suicidal or not, Propensity active.
Date of this Attack, 6 yrs. ago
Duration, 6 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 35
Time of Leaving, November 17-1902
Time in Hospital, 3 yrs 3 mo 3 ds
Result, Improved. Dispt Nov 22/02
Boy Boff C.

EXAMINATION ON ADMISSION BY DR. Bibb *Date of* 8/14/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Below - quick.
MEMORY, Past Events, Appears quite good. but friends say statements are unreliable.
Recent Events, do. Special Subjects, do.
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert
REASONING POWER, Ordinary Subjects, Quite good.
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed.
DELUSIONS, Systematized, Transitory, Special Subjects,
Permanent delusions of persecution.
HALLUCINATIONS, Expresses none
ILLUSIONS, do.
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,
Nervous + irritable - Loss of will power - Ethical failure - Delusions.

HISTORICAL.

LENGTH INVASION, Six years.
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
No consanguinity nor heredity known.
Father, Living - 67 - well.
Paternal Relatives,
Mother, Living well.
Maternal Relatives,
Brothers and Sisters,
1 child 19 yrs.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
none.
HABITS, Drinking and Smoking, Has acquired opium habit. Taking crude opium - less than 3 gr per wks.
HEADACHES, ~~VERTIGO~~, OR ~~CONVULSIONS~~,
OCCUPATION, Healthy or not, Housework.
Detail Date, Duration, and Character of Previous Attack, if any,
1st Attack - of 6 yrs duration.
Sleep, Appetite, Bowels, usually good Does not sleep well.
Says she has chronic diarrhoea.

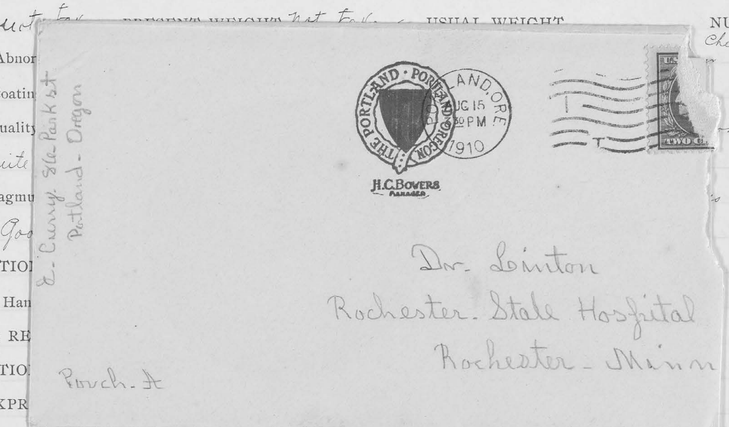
Personal and Medical History of Estella Curry

PHYSICAL CHARACTERISTICS.

HEIGHT, not t... USUAL WEIGHT
WOUNDS, Abnor...
TONGUE, Coatin...
PUPILS, Equality...
SIGHT, Quite...
EYES, Nystagmu...
HEARING, Goo...
COORDINATIO...
TREMORS, Han...
PATELLAR RE...
ARTICULATIO...
FACIAL EXPR...
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, Size, R...
Apex Beat, Regularity, Regular.
Sounds - full at apex - weak at base.
ARTERIES,
Somewhat sclerot...
Pulse slow, full, regular...
LUNGS, Chest, Symmetry, Expan...
Breath Sounds,
Chest not symmetric...
Exp. fair - Resp. vesic...
on right side increased...
Bounds - ; left flanks - short...
EXAMINATION URINE, Quant...
Albumen, Trace...
Casts and Crystals, ...
8/15/99 GYNECOLOGICAL EXAMINA...
a few adhesions arou...
injurition rather pa...
MENSTRUATION, Regular...
OPHTHALMOSCOPIC EXAMI...
BLOOD, Corpuscles, Hæmoglobi...
SLEEP, Present Amount and Char...
BOWELS, Present Condition, Diarrhoea.

NUTRITION, Fair.
Chest barrel shaped.
+ chest + arms.
...aces normal.
...s sometimes for close work.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
...ar Arc,
...meter,
...iameter,
Diameter,
...h,
Breadth Index,
...ities in Shape,
Color and Appearance, Yellow.
...ocele - Few of fat globules.
+ laceration of cervix + perineum
... leucorrhoea.
- Free from pain.





Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Father always intemperate + habits unusually bad shortly before her birth. Her insanity probably degenerative in origin. She was always cross + irritable - gradually becoming more + more unreliable - The claim mental trouble is due to use of opium - habit acquired 6 yrs ago. When taking medicine for diarrhoea - At present complains of diarrhoea + general discomfort Headache etc. Is nervous but general health fairly good - Appears to be a case of paranoia with some depression due to long continued use of opium.

Personal and



Mrs. Estella Curry, 86 Park St. Portland - Oregon

Whole No. 5378

Residence, St. C

Date Admission, Aug

Admitted by Dr. A.

How Sent, E.W. Bag

Sex, female

Civil Condition, ma

Children, one

Age Youngest Child, -

Occupation, Housew

Degree Education, Co

Profession, Religion, No

Habits, Has for y

Nativity

~~Nationality~~, Ohio.

President of State 20 yrs.

Physicians Committing, M

Correspondents, Mrs. Es

514 Ba

depression

Duration, 6 yrs.

17-1902

p 3 05

Nov 22/02

Boy Bof 6.

THE PORTLAND · PORTLAND OREGON

Portland Ore. Aug-14-
86 Park St

Dr Linton

Dear Madam - When I left the Hospital - you asked me to write and let you know what I thought of the west - I think the Country and climate are fine - I am what they call in the west a Floater in the Summer time I live in Oregon - in the Winter my home is in Los Angles - California -

I will send you one of my cards you can see that I have growed some I weigh two hundred lbs - will you tell Dr Killborn that I Received his letter and I thank him for his advice

Mrs Estella Curry

EXAMINATION of 8/14/99

MENTAL ACTIVITY, C

below - qu

MEMORY, Past Events,

say statements are

Recent Events,

PERCEPTIVITY, Alert

Alert

REASONING POWER,

Special Subjects,

Own Mental State,

EMOTIONAL STATE,

Depress

DELUSIONS, Systematiz

Permanent delus

HALLUCINATIONS,

ILLUSIONS,

The gross signs ab

of Attention, Moral and E

Loss of Will Power, Slig

Nervous + irritable - Loss of will power - Ethical failure - Delusions

y, Consanguinity, Epil-

Inebriety, Consumption),

phoid Fever, Sunstroke,

ons),

ried opium Habit. Taking crude - less than ½ gr per wks.

SIONS,

rescwork.

revious Attack, if any,

ife will.

iarhoea.

Personal and Medical History of Estella Curry

PHYSICAL CHARACTERISTICS.

HEIGHT, not Taken PRESENT WEIGHT, Not Taken USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, Pronounce at puncture of 5th rib with cartilage. Chest barrel shaped. right side more prominent. Eruptions on chest + arms.

TONGUE, Coatings or Promptness of Movement, Clean - hesitating + tremulous.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size dilated - responses normal.

SIGHT, Quite good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Commencing arcus senilis - uses glasses sometimes for close work.

HEARING, Good.

COORDINATION, Arms, Good Legs, good. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands + tongue.

PATELLAR REFLEX, much diminished. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, distinct + prompt.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, N-

Apex Beat, Regularity, Regular.

Sounds full at apex - weak at base.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

ARTERIES,

Somewhat sclerotic.

Pulse slow, full, regular 50.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest not symmetrical.

Exp. fair - Resp. rapid 32.

B. Sounds - on right side increased fremitus, left Rales - shortened expiration.

EXAMINATION URINE, Quantity, Sp. g. 1022 Reaction, acid Color and Appearance, Yellow-

Albumen, Trace by heat + Tanneto Sugar, Absent.

Casts and Crystals, Amor. urates + Epith. cells - + Pus corpuscles - Fecal fat globules.

8/15/99

GYNECOLOGICAL EXAMINATION, Uterus normal position - Slight laceration of cervix + perineum a few adhesions around body of uterus. Slight local tenderness. Leucorrhoea.

MENSTRUATION, Regular until four years ago - irregular since - Free from pain. menstruation rather painful

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Restless at times.

BOWELS, Present Condition, Diarrhoea,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Father always intemperate + habits unusually bad shortly before her birth. Her insanity probably degenerative in origin. She was always cross + irritable - gradually becoming more + more unreliable. She claims mental trouble is due to use of opium - habit acquired 6 yrs. ago. When taking medicine for diarrhoea - At present complains of diarrhoea + general discomfort Headache etc. In nervous but general health fairly good - Appears to be a case of paranoia with some depression due to long continued use of opium.

Personal and Medical History of Estella Curry.

1899

This patient was brought here by sheriffs deputy H. Hanson, attended by Mrs Burnett mother in fair physical condition, with the following history:- No consanguinity nor heredity known. Patient has used crude opium for years. First symptoms of insanity manifested six years ago, by delusions. Disease appears stationary, is variable but with no rational intervals. Derangement now manifested by permanent delusions of persecution. Not disposed to injure anyone, has never attempted suicide, but propensity thought to be active. No filthy nor destructive habits. No peculiarities previously noted. No severe diseases nor injuries to head sustained. No confinement nor restraint employed. No treatment pursued. On personal examination has usual appearance of a chronic morphine user. On admission put upon Infirmary Diet

8/14/99 G.N.R. Pat. Complexion dark. hair partly gray. eyes gray. Eruptions on chest & arms. Is clean. Has seven lower teeth & entire upper plate. Behavior quiet. Talks intelligently. Temp. of 14 day record by Dr Babb. Temp. & resp. about normal. Pulse slow at times & irregular 44-90. Appetite poor. Takes outdoor exercise part of time only. Aug 15 Complained of pain in abdomen & emesis. At times very restless & irritable. Aug 21 Visited by sister. So untidy in appearance. Lies in bed much of time. Sept 15 & Oct 15 Visited by husband & son Sept 15 & Dec 1. by sister. Oct 30 Trans. to B3. So becoming more obstinate & resistive often refuses to go out doors & to take meals & medicine Nov 29. Visited by sister; had shown no delusions here but talked freely about them to her sister & told her she was here to be killed & that all the women were here to witness the murder.

Nov 30 - Dec 28 1900 Dec Visited by sister; refuses medicine & nourishment. Very resistive at times. Dec 28 Visited by husband. Jan 5 Wt. 104½ lbs. 95 Quiet & sullen. Has many delusions. Seldom speaks. Always lounges about. Appetite poor. Frequently attacks nurses. Destructive to clothing. Mch 1- Nov 30 1900 Careless; usually very destructive; violent will not eat unless coaxed by nurses; occasionally combative. Sometimes profane & very aggressive. Appetite poor. Bowels regular. Quite restless at night, sleeps on floor most of time. Takes outdoor exercise. Has made many attempts to commit suicide often bars door at night. Mch 1st. Quite disturbed. Frequently fought nurses during March. Mch 27 Rolled up blankets to make nurses think she was in bed & hid behind bench in bay. Apr 23. Visited by friends. May 12 by sister. July 17 Vaccinated. Always refuses to go to dining room & occasionally refuses meals. Sleeps fairly well. Bowels regular. Expresses many delusions thinks people are to kill her. Sept 28. Attempted to hang herself during night. Nov 23. Wt. 119½ lbs. Nov 27 Attempted suicide by hanging. Mar. to June 1901 Patient is very active and extremely troublesome, very jealous, extremely violent at times, strikes herself and pieces great.

Personal and Medical History of Estelle Curry.

Mar. to June 1901 sores on her face, expresses many delusions, thinks that she is to be killed. May 31 Wt. 111 lbs. June to Sept. No change in either mental or physical condition, Aug. 31 Wt. 111 lbs. Sept. to Dec. Teases constantly for baths, shows no change in mental or physical condition Nov. 24 Wt. 103 lbs.

Dec. to Nov. 1902 Patient during this period has shown a very great improvement mentally and physically. Assists regularly with the work on the ward: is pleasant and agreeable though somewhat delusional. November 17th Patient visited by by her father and taken home. Wt. about 109 lbs.

Personal and Medical History of Nellie Krotcher.

Whole No. 5386

Residence, "rear"

Date Admission, August 26th 1899.

Admitted by Dr. R. A. Bebb hour, 10 a.m.

How Sent, H. Blackmer & of Pt. Freeborn Co.

Sex, Female Age, 30

Civil Condition, married (husband left her 2 yrs. ago.

Children, none.

Age Youngest Child,

Occupation, Domestic (husband a laborer)

Degree Education, Partial

Profession, Religion, Catholic.

Habits, unknown

~~Nationality~~ Nativity, Ireland (Parents also born there)

Physicians Committing, F. A. Blackmer & H. Nissen

Correspondents, Has only been at Wasca a short time. None

There appears to know anything about her-
Has a trunk at Lake House Wasca where she was working

No. of Years, 16

Insane Relatives, None known

Cause Exciting, Unknown

Cause Predisposing,

Form, Chr. Mel - (mixed with religious delusions & halus.)

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, 2 yrs ago

Duration, 2 yrs.

No. of Attack, 1

No. of Admission, 1

Age First Attack, 29 yrs

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Bebb. *Date of* 8/26/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Usually quite clear - Confused at times - Sluggish

MEMORY, Past Events, Fair

Recent Events, do. Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull - Fairly Correct on General subjects.

REASONING POWER, Ordinary Subjects, Fair.

Special Subjects,

Own Mental State, Sluggish - occasionally incorrect.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Mild depression.

DELUSIONS, Systematized, Transitory, Special Subjects, Religious.

HALLUCINATIONS, Hears priest talking with her often.

ILLUSIONS, None.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,
Power of attention impaired - slow - dull. Melancholy - worries over sins & for fear she will not tell the truth etc.

HISTORICAL.

LENGTH INVASION, Days several years

ONSET, Gradual or Sudden, Probably gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Says absent.

Father, Died 75 yrs ago - Don't know cause

Paternal Relatives,

Mother, Died 7 yrs ago - Don't know cause

Maternal Relatives,

Brothers and Sisters, One died of typhoid & other died of a Chicken - has had two miscarriages

PROMINENT DISEASES (Especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Typhoid fever when 10 yrs. old. Ovariotomy 2 yrs. ago, Several injuries to head but none proved serious - fell down cellar - also fell on stairs

HABITS, Drinking and Smoking, Drinks some but not to excess.

HEADACHES, VERTIGO, OR CONVULSIONS, Occasional headaches and vertigo.

OCCUPATION, Healthy or not, Domestic.

Detail Date, Duration, and Character of Previous Attack, if any,
Frequent former attacks. much the same as present one.

Sleep, Appetite, and Bowels, Has not slept any last few nights. Appetite poor - bowels constipated.

Personal and Medical History of Nellie Krotcher.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ PRESENT WEIGHT, 127 lb USUAL WEIGHT, NUTRITION, Ground nutrition good.

WOUNDS, Abnormalities and condition of Skin, Scar on abdomen. Stigmata of degeneration - 1st and 2nd phalanges of left hand are adherent about half way to extremity - radially syndactyl - Pupils react normally - Face flat Dymmetrical - left side more pronounced Skin warm - oily - offensive odor.

TONGUE, Coatings or Promptness of Movement, Heavy grayish coating - breath offensive - prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Size normal -

SIGHT, Fair. Some dimness recently. Increased at times.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Outward deviation of left eyeball -

HEARING, Fair.

COORDINATION, Arms, Fair - finger to nose - poor. Legs, Fair - Standing position fair. Grasp, Gait wavering & uncertain -

TREMORS, Hands, Tongue, Facial Muscles, General, Hands feel stiff - face nearly expressionless -

PATELLAR REFLEX, Diminished & unequal - especially lt. Other Reflexes, Diminished

ARTICULATION, Slurred, Hesitating, Slow, Indistinct - Hesitating - slow -

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,



HEART, Murmurs, Strength, Sounds, Size,
Rough systolic murmur at apex.

Apex Beat, Regularity,
Apex beat normal position - Visible on impulse & palpation
Sounds forcible at apex - normal at base.
Regular.

ARTERIES,
Full - regular.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical. Exp. fair - Resp. superficial. B. Sounds faint over right apex - More harsh & bronchial left side - Increased inspiration.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

8/27/99 EXAMINATION URINE, Quantity, ~~3 j~~ ~~xxv~~ j Sp. g. 1030 Reaction, acid Color and Appearance, reddish-yellow clear.

Albumen, none Sugar, none.

Casts and Crystals, Excessive amt. oxalate of lime crystals - few corpuscles & Epith. cells.

GYNECOLOGICAL EXAMINATION, Labia minora hypertrophied - extensive laceration of cervix & perineum. Extreme local tenderness - uterus anteflexed - extensive ulceration of cervix - bleeds on touch. Leucorrhoea profuse - yellowish tenacious & offensive - inflammation of vag & lips of os uteri.

MENSTRUATION, Usually regular - sometimes pain in pelvic region previous & menstruation also headache

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Poor.

BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patient has no friends about history obtained from her. Mental condition has probably always been below average. Claims she learned easily until 13 yrs. old. When she left school General health somewhat impaired. Also has varicose veins of both limbs. Case is apparently one of mild chronic melancholia - with delusions & hallucinations religious in character.

Personal and Medical History of Nellie Krotcher (or Katie)

1899

This patient was brought here by Sheriff E.S. Ellickson, attended by Mrs Ellickson in fair physical condition, with the following history:- No information concerning consanguinity: No history of heredity: First symptoms of insanity manifested two years ago by hallucinations: Disease appears increasing: Is variable: Derangement now manifested by religious hallucinations: Has threatened injury to others: No filthy nor destructive habits: Perverse peculiarities, "strange actions" No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued: On personal examination talks rationally except has hallucinations. On admission put upon Infirmary West. G.S.N.Pat. Complexion dark: eyes gray: hair brown: Skin in good condition: No marks, scars nor bruises noted: Has vermin: Is rather dirty: No finger nail on first finger of left hand: 14 upper + 14 lower teeth. Behavior quiet: Talks intelligently but is rather stupid.)

Aug 16 99. Summary 14 da. record by Dr. Bebb. Temp. + resp. about normal. Sept 3. Temp. 97+. Pulse usually about normal: Appetite fair: bowels constipated: Sleeps well: Able to be up on hall: Acts quietly unoccupied: Takes outdoor exercise: Usually quite pleasant but disturbed + cross at times: Talks quite rationally. Sept 7 Commenced to assist on hall: Writes a good deal: Subs. cont. Sept. 14 Visited by friend. Sept. 16 + Oct 9. + Nov. 12. Menstr. Nov. 30 At times irritable + noisy, careless in appearance. Answers questions readily when addressed: Appetite improved: Bowels regular: Sleeps well. Dec 1. - Feb 28 1900 Very neat: Depressed: Irritable + noisy at times: Assists with work: Eats + sleeps well: Bowels regular: Menstruates regularly: Feb 28 Wt 129# Mch 1 - Nov. 30 1900 Usually quiet + agreeable: Frequently depressed + at times irritable + scolds: Thinks she hears voices talking to her at night - Assists with ward work. As a rule sleeps well. Frequently cries + scolds because not allowed to go home. Aug 30 Menstruates regularly. Sept 20. Had dysentary. In bed several days.

Dec 1 - Feb 28 1901 General health good: Assists daily with ward work. Wt 103#.

Mar. to June 1901 No change in mental or physical condition May 30 Wt. 129 1/4 #.

June to Sept. Patient remains in same general condition Aug. 31 Wt. 128 1/2 #

Sept. to Dec. Sept. 7 patient taken out camping returned Sept. 17. Sept. 29 has many delusions and hallucinations of hearing, is quite noisy and disagreeable, Oct. 8. Trans. to C. 3. frequently assists some with ward work, at times is quite agreeable, Nov. 25 Wt. 131#.

Dec. to Feb. 1903 No change mentally. Wt 126# to 142# during this period.

Personal and Medical History of

Personal and Medical History of Gertrude Hallen.

Whole No. 5395

Residence, St. Paul, Minn.

Date Admission, Sept. 11th 1899.

Admitted by E.J. Watson M.D. hour, 7 PM.

How Sent, Ch. Bayliss Dept. Ramsey Co.

Sex, Female Age, 34.

Civil Condition, married

Children, Four

Age Youngest Child, 4 yrs.

Occupation, Domestic.

Degree Education, Common school.

Profession, Religion, Not a church member.

Habits, Not intemperate.

~~Nativity~~ Nationality, Norway. (Parents also born there)

Physicians Committing, L.A. Quinn & D.C. Jones.

Correspondents, Mrs Chas Halvorson Esdale Wis. (Near Bay City)

No. of Years, 7?

Insane Relatives, Mother & maternal uncle insane

Cause Exciting, Unknown.

Cause Predisposing, Heredity

Form, Paranoia & Mania

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Not.

Date of this Attack, 10 days ago.

Duration, 10 days.

No. of Attack, 2nd

No. of Admission, 2nd Rec. Has been at Brendota. Mo.

Age First Attack, 31 yrs.

Time of Leaving, Mar. 2 1900

Time in Hospital, 5 mo 19 d.

Result, Discharged Sept. 22, 1900 Recovered

EXAMINATION ON ADMISSION BY DR. A.A. Bibb *Date of* 9/12/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quick & quite clear.

MEMORY, Past Events, Quite clear on most subjects.

Recent Events, Fair Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,

Alert - illusive.

REASONING POWER, Ordinary Subjects, fair

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,

Says that people are jealous of her & wish to harm her.

HALLUCINATIONS, Expresses none

ILLUSIONS, none noticed.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, Several years. of this attack 10 days.

ONSET, Gradual or Sudden, Probably gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

States that insanity is only hereditary disease

Father, Living 60-70 drinks some.

Paternal Relatives,

Mother, D. 16 yrs. ago. miscarriage - was insane. One of mothers brothers foolish for years.

Maternal Relatives, a brother not bright.

2 Brothers and 2 Sisters well. 2 Brothers use intoxicates.

4 Children. Thinks she had one miscarriage.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

None.

HABITS, Drinking and Smoking, Drinks moderately.

HEADACHES, VERTIGO, OR CONVULSIONS, fainted once.

OCCUPATION, Healthy or not, Servant.

Detail Date, Duration, and Character of Previous Attack, if any,

2½ yrs ago - for 6 mos. at Brendota hospital.

Sleep, Appetite, and Bowels, Regular.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in. PRESENT WEIGHT, 128# USUAL WEIGHT, NUTRITION, Good

WOUNDS, Abnormalities and condition of Skin, Left side of body weaker. Skin normal.

TONGUE, Coatings or Promptness of Movement, Slight coating - prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size dilated - respond readily.

SIGHT, good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, ~~Quite good~~ No trouble since a child.

HEARING, Good.

COORDINATION, Arms, Quite good Legs, Rather uncertain Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands

PATELLAR REFLEX, Much diminished - Equal Other Reflexes, diminished.

ARTICULATION, Slurred, Hesitating, Slow, distinct. Hesitating

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

S. Sounds - normal at base. Faint beat.

Apex Beat, Regularity, at 4th spc.

Apex beat normal position.

Regular but rapid.

ARTERIES,

Normal - regular - Pulse 86

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical

Expansion good.

B. Sounds normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

9/13/99 EXAMINATION URINE, Quantity, ℥ XXXV Sp. g. 1012 Reaction, Acid Color and Appearance, Yellow - White flaky dep.

Albumen, None Sugar, None.

Casts and Crystals, Amor. urates - a few uric acid crystals & a few epith. cells.

GYNECOLOGICAL EXAMINATION, Laceration of perineum - external genitals otherwise normal - uterus retroflexed. Lateral laceration of cervix - erosion of os - endometritis with profuse purulent discharge. Gonorrhoea 5 to 6 yrs.

MENSTRUATION, Usually menstruates every 5-6 wks. Considerable pain in right shoulder & arm during menses subject to headache cervical & frontal.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Slight enlargement of thyroid. Physical condition in general quite good. Mental impairment probably chronic in character. Apparently always weak minded. Has fair degree of intelligence stile & memory appears quite good. but is inclined to be silly of manner & has delusions of persecution.

Personal and Medical History of Gertrude Hallen.

1899

This patient was brought here by Sheriffs deputy H. Hanson attended by Mrs. L. Kelly, with the following history: No information concerning consanguinity: Mother & maternal uncle some insane: First symptoms of insanity manifested two and a half years ago & patient was at Mercer hospital for six months: First symptoms of present attack manifested five days ago, by delusions: Disease appears increasing: Is variable. Derangement now manifested by by delusions that various persons are attempting to poison her: No filthy nor destructive habits noted: No previous peculiarities known: No severe disease nor injuries to head sustained: Patient has been confined in County jail four days: No treatment pursued so far as known. On personal examination is apparently feeble-minded. On admission put upon Inf. W. (G.H.H. Rpt Complexion dark: hair brown: eyes blue: Skin in normal condition: No marks, scars nor bruises noted: Is clean: Has nine upper & eight lower teeth: Behavior quiet: Talks intelligently.)

Sept 11 99 Summary 14 day record by Dr. Bibb. Patient received on ward. Temp. pulse & resp. continued about normal: Appetite fair: Bowels usually regular but given occasional laxative: Sleep good. Up & about ward: quiet & agreeable, & usually talks quite sensibly: Has hallucinations: Takes outdoor exercise: Remains unoccupied. Sept 20 Attempted to elope while out walking & became quite disturbed, was irritable the following day.

Sept 1 - Feb 28 1900. Sept 20. Attempted to elope while out walking: Neat: bowels regular: expresses many delusions thinks people talk about her very stubborn at times. Frequently attacks nurses: Oct 22. Attacked physician & nurses. Jan 15. 137½# Feb 10 Very agreeable: Assists with ward work: Enjoys games & reads. Converses readily.

March 10. Went home on trial

Discharged.

Personal and Medical History of

Personal and Medical History of Mrs. Rose A. Major.

Whole No. 2396
Residence, Wascca, Minn.
Date Admission, September 1st 1899
Admitted by Dr. O. C. Herjerdale hour, 3 PM
How Sent, G.A. Wilson J. of P. Wascca Co.
Sex, female Age, 27 yrs.
Civil Condition, married
Children, 2
Age Youngest Child, 5 yrs.
Occupation, housewife (Husband Ry clerk.)
Degree Education, common school,
Profession, Religion, Roman catholic.
Habits, Temperate.
Nativity
Nationality, Minnesota (Father, Ireland. Mother U.S.
Became resident of state in 1890 of Co 1890
Physicians Committing, D. J. McMahon + D. L. Cummings
Correspondents, Ernest Major Wascca, (Husband)

No. of Years, 26
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing,
Form, Paranoia
Accompanying Bodily Disorder, None mentioned
Suicidal or not, not.
Date of this Attack, Six months ago
Duration, Several months.
No. of Attack, 2nd or third.
No. of Admission, 2nd here (also at St. Peter)
Age First Attack, 25 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Rose A. Bebb. *Date of* Sept 13'99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick - not clear.
MEMORY, Past Events, Quite good.
Recent Events, do Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert illusive
REASONING POWER, Ordinary Subjects, fair
Special Subjects, impaired
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Variable - usually melancholy.
DELUSIONS, Systematized, Transitory, Special Subjects,
Of persecution. probably transitory.
HALLUCINATIONS, Expresses none.
ILLUSIONS,
Power of attention not impaired. very sarcastic + irritable. Silly at times. Many delusions.
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness,
Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, About 2 yrs. 9 mos.
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, living - Quite well.
Paternal Relatives, Says no nervous nor mental trouble
Mother, d. Inflammatory Rheumatism with cardiac Dilation
Maternal Relatives,
3 half brothers 1 half sister
4 Brothers and 3 Sisters, 1 sister died consumption,
2 Children 7 and 5 years of age.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Pneumonia
HABITS, Drinking and Smoking, yes.
HEADACHES, VERTIGO, OR CONVULSIONS? (vapurous, after) No convulsions
OCCUPATION, Healthy or not, Housekeeper
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Regular
Says sleeps well about every other night.

Personal and Medical History of

40/389
M Rose A. Major
Copy of Order for Hearing Petition of Thomas P. McCarty
at August 5/1901, at Wascca, Minn for appointment of
a guardian for
Rose A. Major insane; served and
service admitted 10th July 1901 (on original by DKJ)
(Papers filed with commitment papers.)

MENTAL CHARACTERISTICS.

UAL WEIGHT, NUTRITION, Impaired
left side of forehead. Skin - cool + moist - anaemic
- Coated.
Moderately dilated - responses slow.

good Legs, Good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Fine of tongue
PATELLAR REFLEX, Unequal. R. exaggerated. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, distinct
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal - regular.
ARTERIES,
Pulse rather weak.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair
B. Sounds normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

9/13/99 EXAMINATION URINE, Quantity, Sp. g. 1010 Reaction, Acid Color and Appearance, Yellow- clear.
Albumen, None Sugar, None
Casts and Crystals, A few epith. cells - amor. urates + oxalate of lime crystals.

GYNECOLOGICAL EXAMINATION, Laceration of cervix + perineum - slight erosion of cervix: moderate amt of leucorrhoeal discharge.
MENSTRUATION, No history obtainable - too irritable.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Variable - usually quite good.
BOWELS, Present Condition, Regular

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Formerly apparently a woman of average talents + education. Resembles paranoia - Delusions of persecution being most prominent. Emotions + memory only defective at times. Thinks neighbors are insane + rude. Constantly doing things to annoy + harm her. Is trying to defraud her of her rights. Says she is not sick. "There is no sickness" - That all ill feeling is due to electricity or something else. General nutrition somewhat impaired - Is anaemic. Looks tired - Says she has always worked pretty hard, but husband is very good to her. Says she has soreness over both sides when she coughs or laughs.

Personal and Medical History of Mrs. Rose A. Major.

Whole No. 2396
Residence, Wascca, Minn.
Date Admission, September 12' 1[illegible]
Admitted by Dr. O. b. Heyerdale
How Sent, G.A. Wilson J. of P. Wa[illegible]
Sex, female Age, 27 yrs
Civil Condition, married
Children, 2
Age Youngest Child, 5 yrs.
Occupation, housewife (husband Ry clerk.)
Degree Education, common schools,
Profession, Religion, Roman catholic.
Habits, Temperate.
Nationality, Nativity Minnesota (Father Ireland - Mother U.S. Became resident of state in 1890 of 29 yrs 1890
Physicians Committing D.F. McMahon + D.L. Cummings
Correspondents, Ernest Major Wascca, (Husband)

No. of Attack, 2nd or third.
No. of Admission, 2nd Here (also at Rochester)
Age First Attack, 25 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Rose A. Bebb. *Date of* Sept 13'99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick - not clear.
MEMORY, Past Events, Quite good.
Recent Events, do Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert illusive.
REASONING POWER, Ordinary Subjects, fair
Special Subjects, impaired
Own Mental State, "
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Variable - usually melancholy.
DELUSIONS, Systematized, Transitory, Special Subjects,
Of persecution. probably transitory.
HALLUCINATIONS, Expresses none.
ILLUSIONS,
Power of attention not impaired. very sarcastic + irritable. Silly at times. many delusions
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness,
Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, About 2 yrs. 9 mos.
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),
Father, living - Quite well.
Paternal Relatives, Says no nervous nor mental trouble
Mother, d. Inflammatory rheumatism with cardiac Dilation
Maternal Relatives,
3 half Brothers 1 Half sister
4 Brothers and 1 Sisters, 1 sister died Consumption,
2 children 7 and 5 years of age.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Pneumonia
HABITS, Drinking and Smoking, yes.
HEADACHES, VERTIGO, OR CONVULSIONS? No convulsions
OCCUPATION, Healthy or not, Housekeeper
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Regular
Says sleeps well about every other night.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ PRESENT WEIGHT, 106½ USUAL WEIGHT, NUTRITION, Impaired.
WOUNDS, Abnormalities and condition of Skin, Linear scar across left side of forehead. Skin - cool + moist - anaemic
TONGUE, Coatings or Promptness of Movement, Fairly prompts - Coated.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal: Moderately dilated - responses slow.
SIGHT, Quite good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, good Legs, Good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Fine of tongue
PATELLAR REFLEX, Unequal. R. exaggerated. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, distinct.
FACIAL EXPRESSION, Paretic, Sad, Etc.,
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal - regular.
ARTERIES,
Pulse rather weak.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair
B. Sounds normal.

CRANIAL MEASUREMENTS,
Circumference Horizontal,
Circumference Verto-Mental,
Naso-Occipital Arc,
Binauricular Arc,
Ant-Post Diameter,
Transverse Diameter,
Binauricular Diameter,
Facial Length,
Length-Breadth Index,
Volume,
Peculiarities in Shape,

9/13/99 EXAMINATION URINE, Quantity, Sp. g. 1010 Reaction, Acid Color and Appearance, Yellow - clear.
Albumen, None Sugar, None
Casts and Crystals, A few epith. cells - amor. urates + oxalate of lime crystals.

GYNECOLOGICAL EXAMINATION, Laceration of cervix + perineum - slight erosion of cervix: moderate amt of leucorrhoeal discharge.
MENSTRUATION, No history obtainable - too irritable.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Variable - usually quite good.
BOWELS, Present Condition, Regular

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Formerly apparently a woman of average talents + education. Resembles paranoia - Delusions of persecution being most prominent. Emotions + memory only defective at times. Thinks neighbors are insane + rude - Constantly doing things to annoy + harm her. + trying to defraud her of her rights. Says she is not sick. "there is no sickness" - That all ill feeling is due to electricity or something else. General nutrition somewhat impaired - Is anaemic. Looks tired - Says she has always worked pretty hard, but husband is very good to her. Says she has soreness over both sides when she coughs or laughs.

Personal and Medical History of Rose A. Major.

1899

This patient was brought here by Sheriff Frank Collins attended by Miss Fassender, in fair physical condition, with the following history:- No history of consanguinity nor lunedity: First attack of insanity occurred in 1897. Patient was in this Rochester Hospital from to . See Vol. Fol. No. She was afterward at St Peter. Present attack has come on during Summer for several months past she has been actively insane during her menstrual periods: Disease appears increasing: Is variable with rational intervals between menstrual periods: Derangement now manifested by various delusions; imagines neighbors are trying to burn her home & injure her in various ways: Is disposed to harm others: No filthy nor destructive habits noted: No previous peculiarities manifested: No severe diseases nor injuries to head: No confinement nor restraint employed since leaving Hospital. On personal examination she was found in a wildly excited condition & required services of two attendants to control her. On admission put upon Infirmary Diet (Lft N. Rpt. Complexion dark: eyes gray: hair brown: Skin in normal condition: No marks, scars nor bruises noted: is clean: Has 15 upper & 16 lower teeth Behavior quiet: Has delusions.)

9/17/1899 to 9/16/1899 Summary 14 da. record. by Dr. Bibb. Patient very quiet on admission & put to bed. did not sleep any, first night. Temp. pulse & resp. normal. Appetite fair: bowels regular: Takes out door exercise: After 2nd night slept well. up ward after first day. Quiet & agreeable: Talks quite sensibly at times but Expresses many delusions: Sept 27 began to be more irritable & disturbed. Refused to go walking. Oct 6 Fraus to B3 -- Oct 25 Menstruating. Nov. 31 Sleeps well: bowels regular: Takes out door exercise: usually quiet in behavior but scolds & talks to herself at times. Thinks everyone must be slightly insane in order to live. Sept 1- Feb 28 1900 Extremely noisy & destructive: In seclusion several hours. Oct 15 Very destructive & noisy: Frequently in seclusion at times strikes nurses: Neat: Takes out door exercise: Appetite fair: Jan 15 Wt. 110# Has many delusions: usually disagreable Mch 1- Nov 30 1900 Apr 10 Visited by husband: would not converse with him: Attempted to strike him: Very much disturbed, scolds & is disagreable: Apr 20. Attacked nurse: Expresses delusion that people punish her by striking pins into her. Apr 23 Fraus. to C3. June 1 Vaccinated. Nov 17 Visited by husband. Talked with him & was quite agreeable: but struck him in face. Nov 29 Wt. 105# Neat: Does no work. Dec 1- Feb 28 1901 General health good: Very irritable & disagreable: Feb 20 97#

Personal and Medical History of Rose A. Major

Mar. to June 1901 Shows no change in mental or physical condition. May 29 Wt. 99#.
June to Sept. June 4. Trans. A. 2 West. remains in about the same general condition, Aug. 31 Wt. 92 1/2# Sept. to Dec. General health good, takes out door exercise, is unoccupied, is extremely irritable and disagreable, sarcastic in her manner and speech. Nov. 30 Wt. 92#.
Dec. to Feb. 1903 No change. Transfered to West Cottage Jan. 7 - 1903. Wt. about 95#.

Personal and Medical History of Elizabeth M. Blase.

Whole No. 5398

Residence, St. Paul, Minnesota.

Date Admission, September 14th 1899.

Admitted by O. C. Reynolds, M.D. hour, 7 P.M.

How Sent, D.A. Leonard Sheriff Olmsted Co.

Sex, female Age, 32 yrs.

Civil Condition, married.

Children, none

Age Youngest Child, —

Occupation, Housewife. (Life Ins. Agent)

Degree Education, High school.

Profession, Religion, Peoples church.

Habits, Not intemperate.

~~Nativity~~ Nationality, Irish (Father Prus.-Mother Irish.)

Became a resident of St. Paul Minn. in 1894.

Physicians Committing, Dr's. Cross - L. S. Granger.

Correspondents, T. Blase (husband.)

714 Manhattan Bldg. St. Paul. Minn.

No. of Years, 28

Insane Relatives, None.

Cause Exciting, Unknown.

Cause Predisposing,

Form, Melancholia. Obs.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Attempted to hang herself

Date of this Attack, December '97

Duration, One year, ten months.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 30 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. T. A. Dibb Date of Sept. 15'99.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Poor.

Recent Events, Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull - Illusive -

REASONING POWER, Ordinary Subjects, Impaired

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Fears that people will kill or harm her.

HALLUCINATIONS, Apparently none

ILLUSIONS, yes.

The gross signs above being lacking, specify concerning Power of Attention, Emotional, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholia, or Exaltation, with delusions

HISTORICAL.

LENGTH INVASION, About 2 yrs.

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, d. Brights disease + bron. trouble - Drank moderately - In poor health many years before death.

Paternal Relatives,

Mother, Living. has jaundice - Condition serious

Maternal Relatives,

Brothers and Sisters, 1 brother died consumption - No children.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

Had malarial fever years ago, When about 16 had abscess of left ear. No surgical operation.

HABITS, Drinking and Smoking, Liquors used only medicinally.

HEADACHES, save VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,

First attack

Sleep, Appetite, and Bowels, Quite regular - some tendency to constipation.

THEO. E. BLASE,
[illegible] East Fourth Street,
ST. PAUL, MINN.

9 a.m. - 6 p.m.

Residence
614 Bates ave.
St Paul - Minn.

Tel.
1682 Call 2.
Washington Life Ins. Co.
St. Paul - Minn.

5398

M Elizabeth M. Blase.

Copy of Order for Hearing Petition of Theodore E. Blase. for appointment of a guardian for Elizabeth M. Blase insane; served and service admitted April 11' 1900.

(Papers filed with commitment papers.)

History of Elizabeth M. Blase.

PHYSICAL CHARACTERISTICS.

ENT WEIGHT, not Taken USUAL WEIGHT, NUTRITION, Good.

ion of Skin, Skin normal -

f Movement, Clear - Fairly prompt.

Light, and Accommodation, Unequal. Eye slightly dilated especially left. Response to light present - to accom- fair.

nilis, or other troubles, Says eyesight not good. Some pain in eyes + has worn glasses.

Grasp,

s - marked when excited - marked of tongue -

Other Reflexes,

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

ARTERIES, Normal -
Pulse regular

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion good.
B. Sounds normal

9/9/99 EXAMINATION URINE, Quantity, Sp. g. 1015 Reaction, Alkaline Color and Appearance, Yellow - White flaky deposit

Albumen, None Sugar, None -

Casts and Crystals, Excessive amt. oxalate of lime crystals - a few epith. cells + amor. urates.

GYNECOLOGICAL EXAMINATION, External genitals normal. Slight laceration of cervix - mild leucorrhoal discharge - Uterus enlarged + retroflexed.

MENSTRUATION, Says regular + free from pain.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps well.

BOWELS, Present Condition, Constipated -

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Patients statements unreliable. Above history obtained from Mr. Blase + statements of patient. Has a timid, frightened + suspicious expression. Little known of family history. She has always claimed that family had tendency to tumors. Onset of mental trouble gradual commencing about six mos. after marriage with attack of homesickness. These attacks became more frequent. She started for home (Ir. Terra.) + became very hysterical on train - was much disturbed + committed to Hospital within a month. Forgetfulness + loss of memory noticed soon after marriage. Case probably one of Chronic melancholia with suicidal tendencies - Physical condition fair. Father in poor health before patient was born, + she was a very sickly child but appeared very well during recent years. Is always nervous + high strung. Was very bright mentally before this attack.

Personal and Medical History of Elizabeth M. Blase.

Whole No. 5398

Residence, St. Paul, Minnesota.

Date Admission, September 14th 1899.

Admitted by O. C. Reynolds, M.D. hour, 7 P.M.

How Sent, L.A. Leonard Co. of P. Olmsted Co.

Sex, female Age, 32 yrs.

Civil Condition, married.

Children, none

Age Youngest Child, —

Occupation, Housewife. (Life Ins. Agent.)

Degree Education, High school.

Profession, Religion, Peoples church.

Habits, Not intemperate.

~~Nativity~~ Nationality, Germ. (Father Penn. Mother Ind.)

Became a resident of St. Paul Minn. in 1894.

Physicians Committing, St. Paul Mun. Hosp. Ins. Dept. Red Cross - C.N. Granger.

Correspondents, T. Blase (husband.)

714 Manhattan Bldg. St. Paul Minn.

No. of Years, 28

Insane Relatives, None.

Cause Exciting, [illegible]

Cause Predisposing,

Form, Melo

Accompanying F

Suicidal or not

Date of this

Duration,

No. of A

No. of

Age First Attack,

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. T. A. Bibb Date of Sept. 15 '99.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Poor.

Recent Events, Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Dull - Illusive -

REASONING POWER, Ordinary Subjects, Impaired

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Fears that people will kill or harm her.

HALLUCINATIONS, Apparently none

ILLUSIONS, yes.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, About 2 yrs.

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, d. Bright's disease + bron. trouble - Drank moderately in poor health many years before death.

Paternal Relatives,

Mother, living. has jaundice - condition serious

Maternal Relatives,

Brothers and Sisters, 1 brother died consumption
no children.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had malarial fever years ago. When about 16 had abscess of left ear. No surgical operation.

HABITS, Drinking and Smoking, Liquors used only medicinally.

HEADACHES, rare VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,
First attack

Sleep, Appetite, and Bowels, Quite regular. some tendency to constipation.

Personal and Medical History of Elizabeth M. Blase.

PHYSICAL CHARACTERISTICS.

WEIGHT, not taken PRESENT WEIGHT, Not Taken USUAL WEIGHT, NUTRITION, Good.

SOUNDS, Abnormalities and condition of Skin, Skin Normal.

TONGUE, Coatings or Promptness of Movement, Clear - Fairly prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Unequal. Iris slightly dilated especially left. Response to light present - to accom. fair.

SIGHT, Fair

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Says eyesight not good. Some pain in eyes + has worn glasses.

HEARING, Good.

COORDINATION, Arms, Fair R. quite good Lft. uncertain Legs, fair Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands - marked when excited - marked of tongue.

PATELLAR REFLEX, Much increased Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Not slurred.

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal - regular.

ARTERIES, Normal -
Pulse regular

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion good.
B. Sounds normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

9/9/99 EXAMINATION URINE, Quantity, Sp. g. 1015 Reaction, Alkaline Color and Appearance, Yellow - White flaky deposit

Albumen, None Sugar, None -

Casts and Crystals, Excessive amt. oxalate of lime crystals - a few epith. cells + amor. urates.

GYNECOLOGICAL EXAMINATION, External genitals normal. Slight laceration of cervix - mild leucorrhoeal discharge - Uterus enlarged + retroflexed.

MENSTRUATION, Says regular + free from pain.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps well.

BOWELS, Present Condition, Constipated.

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Above history obtained from Mr. Blase Patients statements unreliable. Has a timid, frightened + suspicious expression. Little known of family history. She has always claimed that family had tendency to tumors. Onset of mental trouble gradual Commencing about six mos. After marriage with attack of homesickness. These attacks became more frequent. She started for home (viz. Penn.) + became very hysterical on train. Was much disturbed + committed to Hospital within a month. Forgetfulness + loss of memory noticed soon after marriage. Case probably one of Chronic melancholia with mental tendencies. Physical condition fair. Father ill for many years before death. Patient was born, + like mo a very sickly child but appeared very well during present years. Has always nervous + high strung. Was very bright mentally before this attack.

Rochester State H
Name
R

Personal and Medical History of Elizabeth M. Blase.

1899 This patient was brought here by Sheriff Ast Vine, Blase (husband) and Miss L. Nicholls (nurse) she being transferred from a Tennessee hospital. With the following history:- First symptoms of insanity manifested in December 1897. Disease appears stationary: Is variable with irregular rational intervals: Derangement now manifested by fear of bodily injury & melancholy: Not disposed to injure anyone: Attempted suicide by hanging: No filthy nor destructive habits noted: No peculiarities previously manifested: No severe diseases nor injuries to head: Has been in Western Hospital of Tennessee for a year and nine months. On personal examination no further facts noted.
On admission put upon Infirmary Ward/ G.H.N. Rpt. Complexion fair: Hair red: eyes blue: Skin in normal condition: No marks, scars nor bruises. Is clean: Has 14 upper + 14 lower teeth as near as could be ascertained resisted having them counted: Behavior quiet. Talks intelligently.)
9/14/99 to Sept 28/99 Summary 14 da. record by Dr. Bebb. Temp. pulse + resp. normal. Appetite poor: bowels usually regular, requires occasional laxatives + enemata. Medicine given but at times refused. Sleeps well- Takes outdoor exercise: Very much depressed in manner + rather dazed + stupid. Rarely talks + usually very quiet: Expresses delusions: Remains in room most of time. Sept. 17 Is menstruating. During 2nd week became more talkative Remains unoccupied. — Oct. 14-16 Visited by husband. Oct. 19 to Nov. 27 Menstr. Nov. 30 Appetite has improved, Bowels regular + sleeps well. Neat about person + clothing: Assists a little about work: Reads some, but much of time wanders aimlessly about. Sometimes converses readily at others will not speak. Unusually quiet + depressed + lacks ambition: Thinks medicine put her in dust + refuses to take it. Thinks clothing marked for her is not hers.
Dec 1- Feb 28 1900. Quiet + depressed: At times obstinate + irritable: Lounges about + takes no interest in surroundings: Appetite good: Bowels regular: Sleeps well: Jan 30 Wt. 176¾# Menstruates regularly.
March 1- Nov. 30. 1900 Apr. 9 Visited by friends. May 31 Quite agreeable on ward for some time past: Occasionally very disagreeable + obstinate. June 19 Transferred to A³. July 13. Seemed somewhat better Visited by husband + taken home: Returned a couple of days later would not stay at home with him. Aug 22 Tidy in habits + fairly neat. Takes outdoor exercise Imagines people draw blood from her body. Mutters to herself: Does no work: Appetite good: Very talkative in manner at times + very much disturbed by her delusions Visited any week by husband. Sept 8 Trans. to A². Aug 8-10 Visited by husband. Oct 31. Says her relations wish her to commit suicide-
Dec 30 Trans. to B³. Has become more disturbed + very obstinate +

Personal and Medical History of

disagreeable: Somewhat untidy Jan 2 Visited by husband. Feb 10-15. Sick in bed with grippe in hyp on ward. Feb 28 Wt. 133# Quiet: At times disagreeable sullen + morose. March to Sept. 1901 June 6 visited by husband taken home, June 8 returned very disagreeable in manner would not remain at home, July 13 + 14 visited by husband, out driving with him. Aug. 29 Wt. 137½ #. Sept. to Dec. Sept. 10 went to the city with her husband and remained until Sept. 12, General health good, sleeps well, takes out door exercise, is inclined to be very disagreeable on the ward to both patients and nurses, neat in habits and appearance, menstruates regularly.
Dec. to Feb. 1903. Weight about 152#. Patient on the whole remains about the same during this period: Jan. 19-1901 Patient went to Rochester with her husband and returned the next day. April 12th patient visited by husband. Went driving. July 24th to the 27th. Visited by relatives and went out with them. Sept. 11th to 13th " " husband

Personal and Medical History of Olive Andrews.

Whole No. 5401

Residence, Dundas, Minn.

Date Admission, September 18th 1899.

Admitted by Dr. O.C. Heyerdale hour, 3 P.M.

How Sent, James Hunter Dep. Sheriff Co.

Sex, female Age, 49 yrs.

Civil Condition, married

Children, 3.

Age Youngest Child, four years.

Occupation, Housewife. (Husband a Carpenter)

Degree Education, Common school.

Profession, Religion, Not a church member.

Habits, Temperate (Father intemperate).

~~Nationality~~, Nativity, Pennsylvania (Parents also born there)

Physicians Committing, D. W. Cook + D. S. Seeley.

Correspondents, Joseph Andrews. (Husband)
Dundas, Minn.

No. of Years, 31.

Insane Relatives, Grandmother, mother, father, two sisters.

Cause Exciting, Unknown

Cause Predisposing, Heredity.

Form, Delusional Mania.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not suicidal.

Date of this Attack, One year ago

Duration, One year.

No. of Attack, 2nd

No. of Admission, 2-3rd

Age First Attack, About 30 yrs.

Time of Leaving, —

Time in Hospital,

Result, —

EXAMINATION ON ADMISSION BY DR. Bibb *Date of* 9/18/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick - confused.

MEMORY, Past Events, Impaired -

Recent Events, " Special Subjects, Imp.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert - illusive.

REASONING POWER, Ordinary Subjects, Imp.

Special Subjects,

Own Mental State, Chronic mania.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses no systematized delusions. Believes her neighbors try to take her property

HALLUCINATIONS, Expresses none

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, ~~Moral~~ Impaired and Ethical Failure, Slowness or Dullness, ~~Silliness~~,

Loss of Will Power, Slight Melancholy, or Exaltation, Maniacal.

HISTORICAL.

LENGTH INVASION, Of many years duration.

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Will answer no questions - refuses history.

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housekeeper

Detail Date, Duration, and Character of Previous Attack, if any,

See previous history Vol. XVII p. 281

Sleep, Appetite, and Bowels, Has slept very little for weeks.

Personal and Medical History of

40/397
5401

M Olive L. Andrews

Copy of Order for Hearing Petition of Joseph A. Andrews for appointment of as guardian for Olive L. Andrews insane; served and ~~Service admitted~~ notice filed Oct 30/1900.

(Papers filed with commitment papers.)

ACTERISTICS.

SUAL WEIGHT, NUTRITION, good

ures - more prominent on right - Bruise on outer side of left leg.

normal.

ent trouble.

ad. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Interfers when making tests. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Not slurred. Voice hoarse - probably from much talking

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Normal - regular

ARTERIES,

Pulse regular

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical
Expansion fair
B. Sounds normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Laceration of perineum - labia minora somewhat hypertrophied external genitals otherwise normal - lateral laceration of cervix - leucorrhoea - fracious white offensive discharge uterus normal position

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Restless - sleeps some with sleeping door.

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Hematoma of both ears - right larger. Sores probably specific on left side of chin. Also on back of right forearm. Bruise under upper right arm. Very large + flabby + general health has been good. For a few years (2-3) after discharge in 1895 was quite well mentally. Then gradually became more disturbed; but was able until recently to do her own housework. Was homicidal years ago + killed a woman. Cause of mental trouble probably heredity - Is very untidy, money + inclined to be violent. Conversation is rapid, silly + incoherent - Recurrent mania.

Personal and Medical History of Olive

Whole No. 5401

Residence, Dundas, Minn.

Date Admission, September 18' 1899.

Admitted by Dr. O.C. Heyerdale hour, 3 P.M.

How Sent, James Hunter Dep. Rice Co.

Sex, female Age, 49 yrs.

Civil Condition, married

Children, 3.

Age Youngest Child, four years.

Occupation, Housewife. (Husband a carpenter)

Degree Education, Common school.

Profession, Religion, Not a church member.

Habits, Temperate (Father intemperate).

~~Nationality~~ Nativity, Pennsylvania (Parents also born there)

Physicians Committing, D.W. Cool + D.S. Seeley.

Correspondents, Joseph Andrews. (Husband)
Dundas, Minn.

N

Cause I..

Cause Predisposing,

Form, R. Dem.

Accompanying Bodily Disorder, None

Suicidal or not, Not suicidal.

Date of this Attack, One year ago

Duration, One year.

No. of Attack, 3rd

No. of Admission 2nd

Age First Attack, About 30 yrs.

Time of Leaving, —

Time in Hospital,

Result, —

EXAMINATION ON ADMISSION BY DR. Bell *Date of* 9/19/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick - confused.

MEMORY, Past Events, Impaired -

Recent Events, " Special Subjects, Imp.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert - illusions.

REASONING POWER, Ordinary Subjects, Imp.

Special Subjects,

Own Mental State, Chronic mania.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses no systematized delusions. Believes her neighbors try to take her property

HALLUCINATIONS, Expresses none

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dullness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation, Maniacal.

HISTORICAL.

LENGTH INVASION, Of many years duration.

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, Will answer no questions - refers

Paternal Relatives, to previous history.

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housekeeper

Detail Date, Duration, and Character of Previous Attack, if any,
See previous history Vol. XVII p. 28.

Sleep, Appetite, and Bowels, Has slept very little for weeks.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3 PRESENT WEIGHT, 193 USUAL WEIGHT, NUTRITION, good

WOUNDS, Abnormalities and condition of Skin, Swelling on inner side of knees - more prominent on right - Bruise on outer side of left leg.

TONGUE, Coatings or Promptness of Movement, Prompt - clean

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal.

SIGHT, Apparently good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, No apparent trouble.

HEARING, do.

COORDINATION, Arms, Good Legs, good Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, None.

PATELLAR REFLEX, Interfers when making tests. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Not slurred. Voice hoarse - probably from much talking

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

Normal - regular

ARTERIES,

Pulse regular

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical
Expansion fair
B. Sounds normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Laceration of perineum - labia minora somewhat hypertrophied external genitals otherwise normal - lateral laceration of cervix - leucorrhoea - fracious white offensive discharge. Uterus normal position

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Restless - sleeps some with sleeping door.

BOWELS, Present Condition,

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Hematoma of both ears - right larger. Sores probably specific on left side of chin. Also on back of right forearm. Bruise under upper right arm. Very large + fleshy + general health has been good. For a few years (2-3) after discharge in 1895 was quite well mentally. Then gradually became more disturbed; but was able until recently to do her own housework. Was homicidal years ago + killed a woman. Cause of mental trouble probably heredity. At times untidy, noisy + inclined to be violent. Conversation is rapid, silly + incoherent. Recurrent mania.

Personal and Medical History of Olive Andrews.

1899

This patient was brought here by A.D. Weston, Justice of Peace, attended by her son John J. Andrews with the following history:- No consanguinity known: Grandmother father mother & two sisters insane: father also intemperate: First attack occurred in 1881 and patient was confined in this hospital from March 24. 81 to July 1st 86 (Ores Val. V Vol. 39 No. 219. 1st attack- date from Sept 5 '91 - Apr 13 '95 - Vol 17 Fol 281 - No 2808 - 2nd attack - First symptoms of present attack manifested one year ago: Disease appears increasing, is variable: Derangement now manifested by maniacal attacks, laughs, sings, cries, & is at times violent: Is disposed to harm people and is filthy & destructive in habits: Peculiarity previously noted - a violent temper: No severe diseases nor injuries to head sustained: Has not been in confinement or restraint & has received no treatment since leaving hospital. No further particulars obtained on personal examination.

On admission put upon Infirmary Gth Ept. Complexion dark: eyes brown: hair grayish brown: skin hot & dry: Scars on right wrist: lilen on left side of face: Limbs bruised: Is clean: Maniacal & incoherent: Teeth could not be counted.

Sept 18 to Oct 1900 — Summary 14 da. record by Dr Bibb. Temp. pulse & resp. about normal: Appetite good bowels regular: Often noisy during night: Quite well physically: Very noisy, destructive & untidy. One day destroyed four dresses & three suits of underwear - Trans. to C2.

Nov 1 - Feb 28 1900. Very destructive & noisy: In restraint frequently: Body badly bruised: Throws herself against wall & floor also strikes & punches herself: Requires from 3-4 nurses to hold her. Habits dirty Takes nourishment quite well: Sleeps well at night Nov 29 Appetite good: Habits clean for two weeks: Sleeps well: Dec 30 Appetite good: Sleeps well: Is in restraint occasionally when very destructive. Jan 17. Wt. 173# Appetite poor: Is becoming more disturbed & dirty.

Mch 1 - Nov 30. Refuses to keep clothes on most of time: secluded in room without furniture & in restraint at night. Extremely noisy part of time & sometimes violent: is incoherent. Condition improved during march - but later very violent & destructive: Appetite poor: bowels irregular: slept poorly. Mch 26 Complained of pains in limbs. July 16 Vaccinated Oct 1st. Dressed & on ward most of day. Secluded only a short time. Oct 29. Quiet: reads some: Talks rationally Appetite good: Bowels regular: Sleeps well: Nov 1 Again in spell. Nov 20. More quiet & agreeable. Wt 178½# Dec 1 - Feb 28 1901 - Dec 2 Quiet & agreeable: Talks intelligently: Dec 10, Very much disturbed: General health good: Dec 15 Wt 176#

Mar. to June 1901. General health good, no change in mental condition May 26 Wt. 140#.

June to Sept. No change in either physical or mental condition Aug 31 Wt. 136#.

Sept. to Dec. Patient varies between periods of quiet and spells of mania, when quiet she is very agreeable, assists with the work on the ward and occupies herself by reading, when in her spell is very active, destructive and inclined to be violent at times. Wt. 151# Nov 23.

Dec to Nov. 1902 During this period patient was changeable and variable in mental condition - Wt. 155#. About as usual. Patient is at times noisy and disturbed. Quite meddlesome but not violent. Sometimes secluded. Very destructive. Seldom sufficiently quiet to go walking. Kept in Bay. Physical health good. Bowels regular. Sleeps poorly. Takes exercise but does no work. Jan. 13th Visited by friend.

Personal and Medical History of Olive Andrews.

Personal and Medical History of Emma Maas.

Whole No. 5402

Residence, Winona Co, Minn.

Date Admission, September 18th 1899.

Admitted by Dr. R.A. Bebb. hour, 4 P.M.

How Sent, St. Buck Dept. Winona Co.

Sex, female Age, 27 yrs.

Civil Condition, married

Children, one.

Age Youngest Child, 7½ mos.

Occupation, Housewife (Husband a laborer)

Degree Education, Common school.

Profession, Religion, Lutheran

Habits, Not intemperate.

~~Nationality~~ Nativity, Minn. (Parents born in Germany)

Physicians Committing, G.F. Brady + E.D. Keyes.

Correspondents, H. Maas. 509 E. Broadway St. Winona, Minn. (Husband)

No. of Years, 3 yr

Insane Relatives, None.

Cause Exciting, Confinement.

Cause Predisposing,

Form, Lactational Psy - (mania) Ac - Puerperium.

Accompanying Bodily Disorder, Sugar found in urine.

Suicidal or not, Not.

Date of this Attack, About 4 mths ago.

Duration, 4 mths.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 27 yrs.

Time of Leaving, May 10. 1900

Time in Hospital, 7 mo. 22 d.

Result, Disc. Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Bebb *Date of* 9/18/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - quick.

MEMORY, Past Events, Fairly good.

Recent Events, Special Subjects, Poor.

PERCEPTIVITY, Alert or Dull, Correct or Illusive,
Alert - illusive.

REASONING POWER, Ordinary Subjects, Poor

Special Subjects, "

Own Mental State, "

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Variable - usually exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks there are bad people who wish to do her harm.

HALLUCINATIONS, Thinks she hears her friends near.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Impaired Moral and Ethical Failure, Slowness or Dullness, Silliness,

Loss of Will Power, Slight Melancholy, or Exaltation, Maniacal.

HISTORICAL.

LENGTH INVASION, 3 mths ago.

ONSET, Gradual or Sudden, Gradual.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption),

Father, living + well

Paternal Relatives,

Mother, living + well.

Maternal Relatives,

3 Brothers and 3 Sisters,

1 Child 7½ mos.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

No.

HABITS, Drinking and Smoking, Drinks beer.

HEADACHES, VERTIGO, OR CONVULSIONS, Headache at times.

OCCUPATION, Healthy or not, Housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Poor Appetite, Sage and Bowels, Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. PRESENT WEIGHT, 97½ # USUAL WEIGHT, NUTRITION, Impaired.

WOUNDS, Abnormalities and condition of Skin, None. Skin moist + cool.

TONGUE, Coatings or Promptness of Movement, Heavy yellow coating. Prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal size - responses good.

SIGHT, Good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,

HEARING, Good.

COORDINATION, Arms, Good Legs, Good. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Of tongue.

PATELLAR REFLEX, Exaggerated - equal. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, normal

FACIAL EXPRESSION, Paretic, Sad, Etc.,

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal

ARTERIES,
Atheret

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest Asymmetrical
Expansion fair
B. Sounds Normal.

CRANIAL MEASUREMENTS,

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

9/16/99 EXAMINATION URINE, Quantity, Sp. g. 1035 Reaction, acid Color and Appearance, Reddish-yellow clear with flaky deposit.

Albumen, none. Sugar, Trace by Bismuth + Fehlings.

Casts and Crystals, Amor. urates. a few epith. cells + uric acid crystals.

GYNECOLOGICAL EXAMINATION, Perineum slightly lacerated - external genitals otherwise normal. laceration of cervix - uterus ~~normal~~.

MENSTRUATION, history unreliable.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Restless - Slept 6 hours with Sleeping Dose 9/18/99

BOWELS, Present Condition, Constipated

Give condensed statement of present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the degree of invasion, estimate of previous mental grade, and any physical impairment). Slight enlargement of thyroid. Cause of mental trouble probably due to excessive lactation - a psychosis of exhaustion. General health impaired. Very nervous, restless + capricious. at times worried - again exalted. Then impatient + commands her wishes to be carried out at once.

Personal and Medical History of Emma Maas.

1899

This patient was brought here by Sheriffs deputy G.D. Trench, attended by G. Maas, in rather poor physical condition with the following history:- No consanguinity, heredity nor intemperance known: First symptoms of insanity manifested about four weeks ago, by sleeplessness, commenced to worry about bad people in church. Made husband dress at four A.M. & take her to neighbors: Disease appears increasing; Not variable: Derangement manifested by thinking that the Devil visits her at times: also imagins acquaintances are present & carries on conversations with them neglects baby, tries to leave home: No disposition shown to injure anyone: No filthy nor destructive habits: No peculiarities previously manifested: No severe diseases nor injuries to head. Has been kept at home. Was sent into country and given tonics & sedatives for three weeks: no effect- On personal examination looks ill: Is dissatisfied with existing circumstances & complains of ill treatment on every side. On admission put upon Infirmary Diet. (Cplxn Rose complexion dark. hair & eyes brown: Skin cold & damp: Both limbs bruised some: Is clean: Very communical & incoherent. Teeth could not be counted.)

9/18/1900 to 10/2/1900 Summary 14 da. record by Dr. Bibb. Bath given & put to bed on admission. Liniment & bandages applied to bruises: Talks rapidly & incoherently: Expresses many delusions & has also auditory hallucinations: Is noisy & excited: Sleep much disturbed. Temp. elevated slightly each day until Sept 23 reached 104° then gradually fell until Sept 26 it was subnormal. 97°. After that about normal- Pulse & resp. also normal. Appetite fair, some meals refused nourishment but as a rule took considerable milk. Bowels constipated. given laxatives & enemata. Refuses medicine Sedatives given hypodermically - Continues much disturbed & resistive at times. Cold baths & medicated douches given: Gradually becomes more quiet.

Oct 2 - Dec. 1. Appetite good: Bowels regular: Sleep often disturbed: Takes out door exercise. Often excited, noisy & scolds. Untidy in habits & destructive to clothing. Dec 1- Fr 6-8. Noisy & destructive & incoherent: In seclusion part of each day & Jan 5 Wt. 103¾ Fr. Jan 30 Less disturbed. Fr 6-8. More & quiet. At times rather exalted & noisy: Talks a great deal. Assists with work. appetite good: Bowels regular: Sleeps well.

March 1- May 10, 1900. At times somewhat noisy: Converses readily Talks sensibly & works on ward: Takes out door exercise: May 10 Taken home by husband.

Discharged

