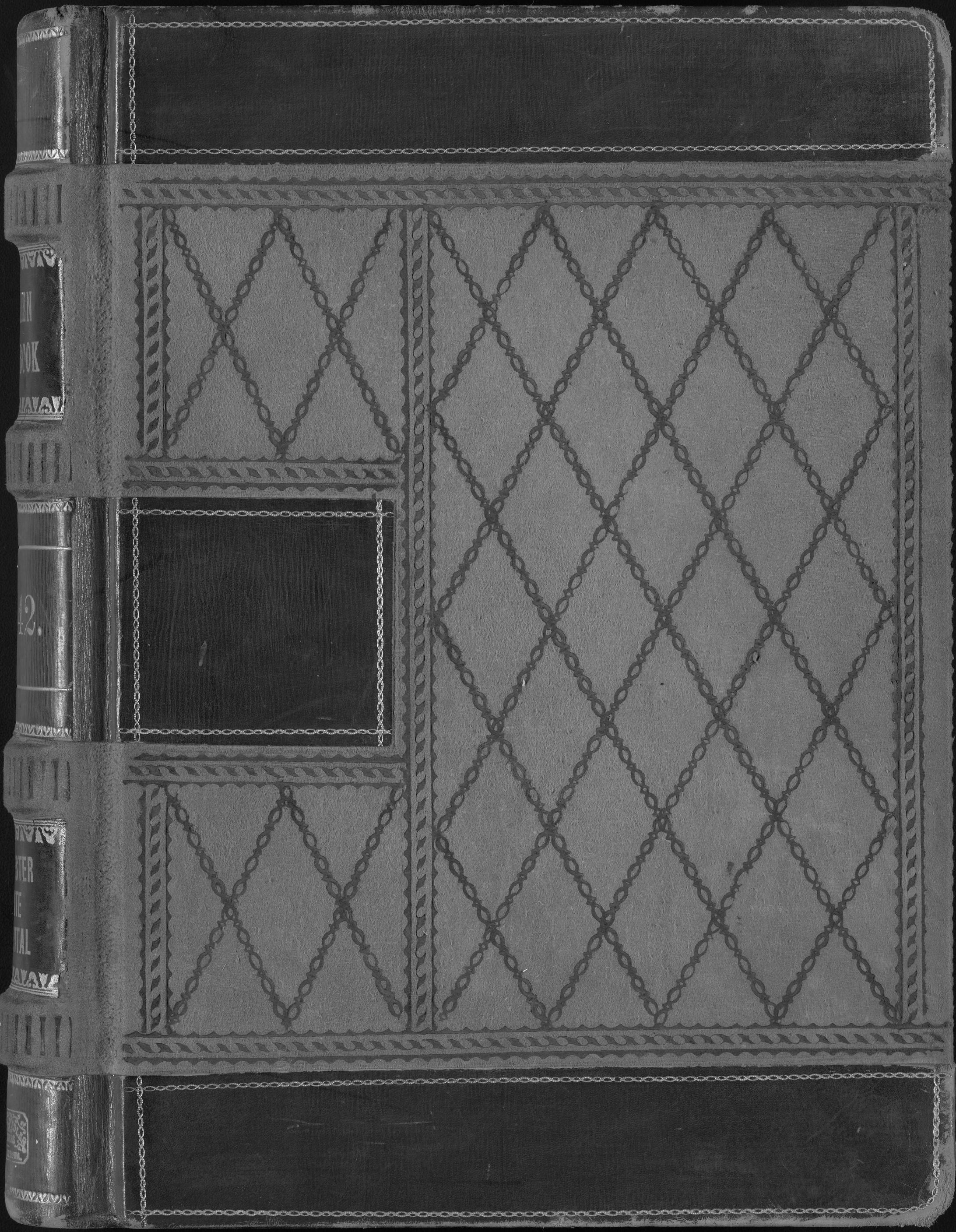


Rochester State Hospital (Minn.). Patient Case Books.

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Version 3
August 20, 2018



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Respectfully,

Egbert, Fidler & Chambers.

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Personal and Medical History of

Personal and Medical History of Augusta Lawrence.

Whole No. 5405
Residence, St. Paul, Minn.
Date Admission, September 19th 1899.
Admitted by Dr. C. J. Mannous. hour, 7 P.M.
How Sent, C.W. Bazille & Co. Ramsey Co.
Sex, Female Age, 71 yr.
Civil Condition, Married
Children, Two.
Age Youngest Child, 30 yrs.
Occupation, Housework.
Degree Education, Can read & write.
Profession, Religion, Lutheran.
Habits, Not intemperate.
Nativity, Germany (Parents also born in Germany)
Physicians Committing, Charles R. Ball & Haldor Dueno.
Correspondents, Richard Lawrence (son) Crookston, Minn

No. of Year, 35
Insane Relatives, Unknown.
Cause Exciting, ?
Cause Predisposing, ?
Form, Epileptic Insanity
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not suicidal.
Date of this Attack, One year ago.
Duration, About one year.
No. of Attack, 1st
No. of Admission, 1st Adm (at C.H.C. Hospital & Rail)
Age First Attack, 71 yrs.
Time of Leaving, November 13 - 1902
Time in Hospital, 3 yrs. 1 mos 25 ds
Result, Died: Apoplexy (Cachillexia & Do)

EXAMINATION ON ADMISSION BY DR. O.C. Heyerdale *Date of* Sept 21 '99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Fairly quick.
MEMORY, Past Events, poor
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive. Quite alert.
REASONING POWER, Ordinary Subjects, Special Subjects, Own Mental State, } Not poor.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Normal.
DELUSIONS, Systematized, Transitory, Special Subjects,
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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,
2 Brothers and 2 Sisters, well.
2 children - well
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No history of disease.
HABITS, Drinking and Smoking, She says good.
HEADACHES, VERTIGO, OR CONVULSIONS, No.
OCCUPATION, Healthy or not, General work & Housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, All good.

Personal and Medical History of Augusta Lawrence.

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft. 10 in. PRESENT WEIGHT, 135 USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, Skin healthy.
TONGUE, Coatings or Promptness of Movement, Slight white coat - 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, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Normal.
PATELLAR REFLEX, present. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Quite clear & correct.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Murmurs over apex & one over the aortic orifice
Apex Beat, Regularity, S. sounds strong. Size about normal. apex beat normal. Quite regular.
ARTERIES,



January 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,
Chest symmetrical
Expansion good.
B. Sounds normal

9/25/99 EXAMINATION URINE, Quantity, Sp. g. 1010 Reaction, Acid Color and Appearance, Yellow - clear -
Albumen, None Sugar, none
Casts and Crystals, Amor. urates & a few epith. cells.

GYNECOLOGICAL EXAMINATION, Laceration of cervix & perineum. Uterus & cervix atrophied - cervix & vaginal walls inflamed. A few adhesions posterior to uterus. Uterus in about normal position - urethral orifice inflamed.
MENSTRUATION, Menopause passed about 25 yrs. ago - Menses. When present was normal.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleep good.
BOWELS, Present Condition, Regular

Give condensed statement of the 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 says she is 72 years old - speaks no English is in very good physical condition considering her age - Her memory is somewhat impaired but she speaks quickly & clearly & has a good understanding of ordinary subjects. There is a very marked heart murmur over apex & mitral regurgitation also a marked diastolic murmur over aortic valve & transmitted along great vessels - an aortic stenosis - While these lesions are compensated for as there is no general disturbance.

Personal and Medical History of Augusta Lawrence.

1899

This patient was brought here by Sheriff's deputy H. Hanson attended by Mort. Hanson, in good physical condition, with the following history:- No information concerning consanguinity or heredity. No history of intemperance in patient nor parents. First symptoms appeared about a year ago; became mixed & confused at times. Disease appears increasing. Is variable. Derangement now manifested by confusion of memory, restlessness, filthy habits. Is noisy. Not disposed to injure anyone. No previous peculiarities manifested. Had stroke of apoplexy two years ago. Patient was restrained in bed at City Hospital. On personal examination displays difficulty in remembering familiar things. Is stolid. On admission put upon Infirmary West (Lt. H. Dept. Complex in dark. Eyes brown. Hair grayish brown. Has a mole on right cheek & three on left. also two on right side of abdomen. A few scratches on forehead & left leg. A few small bruises on left leg. Is dirty. Has no teeth except three or four roots in lower jaw. Behavior quiet. Talks intelligently.

Sept 19 to Oct 1/1900 Summary 14 da. record by Dr. Bibb. Temp. pulse & resp. about normal. Appetite fair. Bowels usually regular. Sleeps well. Takes outdoor exercise. Very quiet in behavior. Talks quite sensibly on ordinary subjects but seems to have some delusions. At times excitable. Assists with ward work.

Oct 28 - Patient Neat in habits. Quiet & contented. Nov 8 During night had a convulsion & quite stupid all next day. Remained in bed. Nov. 9-30 Very noisy & excited at times also irritable & even violent at times. Conversation incoherent & sometime she would call in a loud pleading voice for her son Richard. Has auditory hallucinations. Hears voices talking to her. Untidy in habits. Appetite not so good. Bowels constipated & sleep much disturbed. Complains of pain in right leg. Liniment applied. Thinks her brothers & sister are sick in the house. Hears people scolding her & calling her names. Dec. 3 Is more quiet & agreeable. neat in habits & appearance. Assists with ward work. Had convulsion during night of Nov. 29. Irritable for several days following. Jan. 15 Wt. 143#

Feb 8, 1900 Quiet & agreeable altho not as well physically of late.

March - Nov. 30, 1900. March 1 had three convulsions during night, epileptiform in character. Pulse feeble. Apr 18 Noisy at times also obstinate & untidy. Apr 22 Had five convulsions during day. Very weak. Is bed. Apr. 29 Attempted suicide by tying string around neck. May 3 Again attempted suicide. Trans. to B. May 28 Trans. to Infirmary. May 30 Noisy at times. Tidy in appearance. Assists with work. Takes outdoor exercise. Appetite good. June 7 3 Convulsions during night. June 25. Very noisy & irritable. Does no work. Trans. to B. July 20 Somewhat more quiet. Trans. to A.

Aug 13 Had convulsion. Fell from bed bruising nose. Sept 8 Had a convulsion Sept 16 & 18 do. Wt. 149 # Nov 16th. Dec 1 - Feb 8 1901 Appetite good. Bowels regular. Does not speak English. Sometimes noisy & put in seclusion. Feb 8, 1901. No change. March - June 1 - 1901 Does no work. no change in mental or physical condition. May 28 Wt. 155#

June to Dec. July 29 had paralysis of left hand and arm, cerebral apoplexy more or less loss of use of left leg also. Nov. 29 had convulsion was sick in bed for several days; confined to bed since July 29. Wt not taken, seems quite helpless, has received massage 3 times a week during the time, has lost considerable in Wt. Nov. 30 Wt. 110#

Jan 20-03 During the early part patient was noticed to be failing rapidly; appetite very poor, was fed three times daily with milk. slept poorly, uneasy most of the night. Nov 11th 1902 had two convulsions during the night followed by reversal on Nov 12-02. consciousness was never regained; gradually failed. Died Nov 13th 1902. 8 15 a.m.

Personal and Medical History of

Personal and Medical History of Ida Marlett.

Whole No. 5409
Residence, St. Paul, Minn.
Date Admission, Sept. 29 1899.
Admitted by Dr. Ez Mawsons hour, 7 PM.
How Sent, Ctw. Bazille & Off. Ramsey Co.
Sex, Female Age, 43
Civil Condition, married (has not lived with husband for 6 or 7 yrs.
Children, three
Age Youngest Child, Ten years.
Occupation, Housewife
Degree Education, Common school.
Profession, Religion, Methodist.
Habits, Not intemperate
Nativity, Wisconsin - Father Canada - Mother Ng
Physicians Committing, Ctw. Buckley & Arthur Sweney
Correspondents, Ethel Marlett (daughter)
307 Aberdeen Ave., St. Paul, Minn.

No. of Year, 39
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing,
Form, Acute Melancholia
Accompanying Bodily Disorder, Ocular paralysis.
Suicidal or not, not.
Date of this Attack, 2 mos. ago.
Duration, 2 mos.
No. of Attack, 1st
No. of Admission, 1st (at City Hosp. St. Paul 2 mos)
Age First Attack, 43 yrs.
Time of Leaving, Dec. 13. 1899
Time in Hospital, 2 m. 14 d.
Result, Discharged Feb. 6. 1900 Recovered.

EXAMINATION ON ADMISSION BY DR. OC Heyerdahl *Date of* Oct 2/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Fairly clear & quick.
MEMORY, Past Events, Not very good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Fairly alert.
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, A great many delus
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
exalted.
DELUSIONS, Systematized, Transitory, Special Subjects,
In regard to children.
HALLUCINATIONS,
ILLUSIONS, Yes.
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 - age 68
Paternal Relatives,
Mother, living & fairly well - age 67
Maternal Relatives,
Brothers and Sisters, Well.
3 children 2 boys & one girl.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had a fall 2 years ago & received an injury to right side of head. Few months later eyes failed & she had a marked dyplopia.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housewife
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Good Fair Constipated.

Personal and Medical History of Ida Marlett.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3½ PRESENT WEIGHT, 112 lbs USUAL WEIGHT, NUTRITION, Impaired
WOUNDS, Abnormalities and condition of Skin, Skin fair -
TONGUE, Coatings or Promptness of Movement, heavy gray coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Unequal: Right enlarged. Complete Ptosis of right lid. + partial of left. Response to light fair - To accom. R. impaired - left good.
SIGHT, Fair in left - R. Not good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Ocular Paralysis - Partial Ptosis of right lid -
HEARING, Fair -
COORDINATION, Arms, fair Legs, poor. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands & tongue.
PATELLAR REFLEX, Increased. Other Reflexes, Elbow increased.
ARTICULATION, Slurred, Hesitating, Slow, Somewhat hesitating.
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,

11/16/99 EXAMINATION URINE, Quantity, Sp. g. 1022 Reaction, Alkaline Color and Appearance, Clear white flaky deposit. Reddish yellow
Albumen, Trace by Tsuits Sugar, None
Casts and Crystals, Amor. urates, a few oxalate of lime cryptals, uric acid crystals & epith. & pus corpuscles.
GYNECOLOGICAL EXAMINATION, Laceration of perineum - externals genitals otherwise normal Cystic degeneration also slight erosion of os. Mild leucorrhoal discharge. Uterus normal position fibrs specifics history.
MENSTRUATION, Usually regular & free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, fairly well -
BOWELS, Present Condition, Constipated.

Husband also troubled with sore Throat & also had sores on various parts of body for which he received continuous treatment.

Give condensed statement of the 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 impaired physical condition Walks unsteadily & has to take hold of a chair or wall to steady herself. Has delusions & hallucinations & thinks that someone is drowning or killing her children.
Had sore throat for years & has been troubled with catarrh since - Said she had none of this trouble until after hemorrhage. Husbands habits bad (as above)

Personal and Medical History of Ida Marlett.

Personal and Medical History of

Hosp

This patient was brought here by Sheriff's deputy H. Hanson, attended by Ethel Marlett, in fair physical condition, with the following history:- No history of consanguinity, heredity, nor intemperance in patient nor parents: First symptoms of insanity manifested about two months ago by delusions: Requires restraint: Disease appears increasing: Not variable: No rational intervals: Derangement now manifested by delusions in regard to death of her son & of people attempting to kill her: Not disposed to injure anyone: Is occasionally destructive in habits: No peculiarities previously manifested: Suffers from ocular paralysis Has been at city hospital for two months past: Has received general tonic treatment. On personal examination: has ptosis & ocular paralysis, talks clearly on subjects not connected with her delusions but is at times rather violent. On admission put upon Infirmary Complexion dark: hair brown: eyes gray: skin in normal condition: Small bruise on left foot. Is clean: Has 7 upper & 10 lower teeth most of which are in bad condition: Is quiet: Talks intelligently)

Sept 19 to Oct 13 1900

Summary 14 da record by Dr. Bob. Temp. 98° to 101°. P. 78-108- Resp. normal. First week seemed very weak: Appetite fair: Bowels usually regular: Given medicine & occasional laxatives. Sleeps fairly well: Takes out door exercise: After first two days up & dressed: Co-ordination much impaired & gait unsteady: Expresses many delusions but at times talks sensibly on ordinary subjects: Thinks her children are here. Is very troublesome on ward. During 2nd week temp. pulse & resp. normal. And a general improvement noted both mentally & physically: Coordination improved: less troublesome; usually quiet, conversation much more sensible; takes an interest in work: Does not express delusions. Oct 4 Menstruated. Summ. continued Oct 13 - Dec. 12. Appetite good: sleeps well: Bowels constipated: Has a small sore on left side of neck which discharges some. Neat in habits & appearance: Quiet & cheerful & interested in work & surroundings. Converses readily. To day (Dec 12) sent home on Trial

Discharged.

Personal and Medical History of Sarah L. Bartholomew.

Whole No. 5415

Residence, Janesville, Minn.

Date Admission, October 7th 1899.

Admitted by Dr. O. C. Heyerdale hour, 8:45 PM.

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

Sex, female Age, 57 yrs.

Civil Condition, married.

Children, four

Age Youngest Child, Twenty one.

Occupation, Housework.

Degree Education, Common school.

Profession, Religion, Baptist.

Habits, Not intemperate.

Nativity, Penn. (Father Ng. Mother Penn.)
Became a resident of Minn. in 1869 of Waseca Co. in 1879.

Physicians Committing, L. Corey & J. B. Lewis.

Correspondents,

No. of Year, 45

Insane Relatives, Mother, sister & 2 aunts.

Cause Exciting, Unknown.

Cause Predisposing, "

Form, Chorea Insa.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Tried to take poison.

Date of this Attack, One year ago

Duration, one year.

No. of Attack, 3rd.

No. of Admission, 2nd

Age First Attack, 52 yrs.

Time of Leaving, 21st November 1901.

Time in Hospital, 2 yr 1 mo. 14 ds

Result, Recovered. Discharged Nov 30/1901.

EXAMINATION ON ADMISSION BY DR. Drob Date of 10/10/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear but weak minded.

MEMORY, Past Events, Fairly good.

Recent Events, do Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Not dull - so correct.

REASONING POWER, Ordinary Subjects, Fair

Special Subjects, "

Own Mental State, Partial dementia.

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none.

HALLUCINATIONS, None apparent.

ILLUSIONS, "

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
Fathers family had heart disease

Father, dead.

Paternal Relatives, See previous history.

Mother, dead

Maternal Relatives,

4 Brothers and 5 Sisters, 5 Sisters dead

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says had uterine trouble - Typhoid fever at 4 yrs. Lung fever - Bilious fever. Scarlet fever. Measles.

HABITS, Drinking and Smoking, None.

HEADACHES, VERTIGO, OR CONVULSIONS, Severe headaches formerly. Fatigue on mounting.

OCCUPATION, Healthy or not, Housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,
See previous history.

Sleep, Appetite, and Bowels, (Sleep: usually good; Appetite: poor; Bowels: regular)

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1in. PRESENT WEIGHT, 86 lbs. USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Skin moist & cool.

TONGUE, Coatings or Promptness of Movement, Slight coat. Not prompt. Cannot control.

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

SIGHT, Fairly good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Has worn glasses about seven years.

HEARING, Always troubled with earache in left ear. Hearing impaired. Says caused by catarrh.

COORDINATION, Arms, Very poor Legs, poor. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Marked of hands. of tongue. Chorea movements of face & limbs.

PATELLAR REFLEX, Greatly exaggerated Other Reflexes, do.

ARTICULATION, Slurred, Hesitating, Slow, Somewhat slurred.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,
Roughness at apex systolic.

Apex Beat, Regularity,
S. Sounds full at apex - Regular.

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,



January 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,

11/29/99 EXAMINATION URINE, Quantity, 3 XXX ℥ Sp. g. 1022 Reaction, acid Color and Appearance, Yellow-clear with flaky deposit.

Albumen, None Sugar, None.

Casts and Crystals, A few pus corpuscles. Amor. urates - Excessive amt of all kinds of epith. cells.

GYNECOLOGICAL EXAMINATION, Laceration of perineum. marked hypertrophy of cervix bleeds on touch leucorrhoea profuse, thick, bloody discharge - Numerous adhesions about uterus - especially posteriorly decided bi-pel tenderness + Uterus & cervix atrophied, U. retroflexed

MENSTRUATION, Menopaused past 7 yrs. During menstrual period - regular but dysmenorrhoea

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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). Chorea progressive & considerable loss of power in affected muscles - Dementia also increasing - also shows mild melancholia She still converses quite sensibly on many subjects altho it is an effort for her to express herself

Personal and Medical History of Sarah L. Bartholomew.

1899

This patient was brought here by sheriff Frank Collins attended by Mrs J. Willyard in fair physical condition, with the following history: No consanguinity, mother, aunts & sister insane: First attack of insanity manifested in 1894 Patient has been here twice before - from Mch 15, 99 to May 17, 99 (Vol. 34 Fol. 105 No. 4703) ~~from to (Vol. Fol. No.)~~ First symptoms of present attack manifested one year ago: Disease appears increasing: Is variable with irregular rational intervals: Derangement now manifested by imagining that someone is trying to do her bodily injury & she is trying to escape: Not disposed to injure anyone: No filthy nor destructive habits: No severe diseases nor injuries to head: No confinement nor restraint employed since leaving probates. No further particulars noted on personal examination. On admission put upon Infirmary Mest. (Gt. N. Rpt. Complexion dark: hair grayish black: eyes gray: Skin in normal condition: One bruise on right eye: left side of neck, both hips & shoulders bruised, caused by falling downstairs Is rather dirty: Has five upper & 16 lower teeth: Co-ordination poor, choreic movements: Behavior quiet. Talks intelligently.

Oct 7/99 to Oct 21/99 Summary of 14 da. record by Dr Bebb. Temp. pulse & resp. remained about normal. Appetite good: Bowels usually regular, takes occasional cathartics: Receives medicine: sleeps well: Is usually quiet & agreeable: Converses quite intelligently but often hesitates & finds it difficult to express herself: Remains unoccupied. Neat in habits & appearance. Choreic movements have become very marked, involving most of the muscles - especially noticeable in movements of head, face, tongue arms & legs Nov 25 (Dr Heyerdale) Restless: usually inactive: Neat in habits: Converses readily: Appetite good: Bowels regular: Has choreic movements: Talks a great deal: Rather disagreeable on ward: Jan. 19. Wt. 85# Feb 8 no change. Mch 1 - Nov 30/1900 Mch. 6 Went home with husband: returned May 17. July 1 - Eats & sleeps well: Bowels regular: Goes riding & walking: Quite old & feeble: Talks a great deal. Is very sensible. July 17 Vaccinated successfully: Oct 8 Tooth extracted Nov 16 Wt. 95#. Dec 1 - Feb 28/1901 Jan. 9. Has been suffering from toothache for several days: Tooth extracted. Feb 28. Wt 98#. General health fair:

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

June to Sept Patient remains the same in general condition Aug. 30 Wt. 103#.

Sept. to Dec. General health good, is inclined to be irritable and restless, quite nervous, talks a great deal, neat in habits and appearance, intelligent, is fussy in disposition Nov. 21 went home, discharged Nov. 30, 1901.

Discharged -

Personal and Medical History of

Personal and Medical History of Mrs Anna Larson.

Whole No. 5416
Residence, St. Paul, Minn.
Date Admission, October 7th 1899
Admitted by Dr. R.A. Ebbs. hour, 7 P.M.
How Sent, Ells Bazille & of P. Ramsey Co.
Sex, female Age, 42 yrs.
Civil Condition, married.
Children, none.
Age Youngest Child, —
Occupation, Housework. (Husband paperhanger & painter)
Degree Education, Common school.
Profession, Religion, Lutheran
Habits, not intemperate.
Nativity, Norway (Parents also born there.)
Physicians Committing, M.D. Kelly. F.M. Merrick.
Correspondents, Mr Emil Larson (husband). 135 E. 13th St. St. Paul, Minn.

No. of Year, 46
Insane Relatives, None
Cause Exciting, menopause.
Cause Predisposing, none mentioned.
Form, Acute mania
Accompanying Bodily Disorder, none mentioned
Suicidal or not, not.
Date of this Attack, 3 mos. ago.
Duration, 3 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 42 yrs.
Time of Leaving, Oct. 16. 1899
Time in Hospital, 8 da.
Result, Died Pyonephrosis.

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Oct. 9'99.

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. dull.
REASONING POWER, Ordinary Subjects, poor.
Special Subjects,
Own Mental State, Confused.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects, on money matters.

HALLUCINATIONS,
ILLUSIONS, yes.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 get no history from patient
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Gives history of syphilis beginning 14 years ago.
HABITS, Drinking and Smoking, hard drinker.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housewife
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, poorly nourished -
WOUNDS, Abnormalities and condition of Skin,
TONGUE, Coatings or Promptness of Movement, prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, equal - size normal - responce to light poor - to accomodation
SIGHT, seems good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, seems good.
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, Normal.
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,

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, restless & disturbed at night.
BOWELS, Present Condition, somewhat constipated.

Give condensed statement of the 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 Mrs. Anna Larson

1899.

This patient was brought here by sheriffs deputy H. Hanson, attended by Emil Larson in fair physical condition with the following history:- No history of consanginuity, herdity nor intemperance in patient nor parents. First symptoms of insanity manifested about three months ago. Disease appears increasing: Not variable: Derangement manifested on subject of money matters + an injury: Not disposed to injure anyone: No filthy nor destructive habits: Previous to accession of disease was irritable + eccentric. No severe diseases nor injuries to head sustained. No confinement nor restraint employed: No treatment pursued. On personal examination talks irrationally on various subjects. On admission put upon Inf. Gen. Pat. Complexion dark: hair black: eyes grayish brown: Skin hot + dry: Scar on left leg: ulcer on lower part of leg + foot. Very dirty. Behavior maniacal: Talks incoherently.)

10/7/99

Oct. 7/99 to Oct. 16/99

Summary of 14 days Notes by Dr. Bibb. During first week temp. moderately elevated 99-101 4-5. Pulse 80-112. Resp. 19-34. Appetite much impaired: Bowels require laxatives: Sleep poor, some nights did not sleep at all: At times during day + night extremely noisy, active + destructive: In restraint part of time: From October 13 a decided failure was noticed on 13th very restless - on Oct. 14 became quieter + weaker. Oct. 15 Pulse became very weak: Temp. rose from 102 2-5 on Oct. 14. to 105 8 on the 16th. Stimulants + cold baths given to reduce temp. On afternoon of Oct. 16 unable to retain nourishment or enemata. Sank rapidly + died at 5:30 P.M.

Note. Mr. Sorenson a student at Hamline came down to see about disposition of remains + stated that her friends wished her buried here. He made the necessary arrangements with Rev. Mr. Flagstaad and the funeral was held at 2. P.M. Oct. 18th 99. The remains were deposited in the hospital burying ground (a.f.x.)

Died.

Personal and Medical History of

Personal and Medical History of Mrs. Amelia Grady.

Whole No. 5417
Residence, St. Paul, Minn.
Date Admission, October 9th 1899.
Admitted by Dr. J. A. Bebb hour, 7 PM
How Sent, C.W. Bazille Dep't Ramsey Co.
Sex, Female Age, 30 yrs
Civil Condition, widowed.
Children, Two.
Age Youngest Child, Seven years.
Occupation, Seamstress.
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
Nativity, Minnesota (Parents born in Germany.
Physicians Committing, F.R. Wenick & V.D. Hawkins
Correspondents, Mr. Guat Augustine (bro.) 228 Grove St. St. Paul, Minn.

No. of Year, 47
Insane Relatives, None.
Cause Exciting, Mental worry.
Cause Predisposing, Previous Attacks.
Form, Recurrent Mania ac.
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, 2 mos. ago.
Duration, Two months.
No. of Attack, 2nd
No. of Admission, 2nd
Age First Attack, 28 yrs.
Time of Leaving, Oct. 13' 1900.
Time in Hospital, 1 yrs. 4 da.
Result, Dschg. Recovered Apr. 30' 1901.

EXAMINATION ON ADMISSION BY DR. P. A. Bebb. Date of 10/10/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - quick.
MEMORY, Past Events, Statements on all subjects unreliable and irrelevant.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Fair - illusive.
REASONING POWER, Ordinary Subjects, Special Subjects, Own Mental State, } Impaired.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent.
DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none - apparently many transitory ones on religion.
HALLUCINATIONS, Expresses none -
ILLUSIONS, "
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, Long.
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, } Can secure no information from her - See previous history
2 children 1 4 or 7 yrs.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Surg. operation.
HABITS, Drinking and Smoking, Says has drank to excess.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
See previous history.
Sleep, Appetite, and Bowels,

Personal and Medical History of Mrs Amelia Grady.

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft. 5 in PRESENT WEIGHT, 105 lb USUAL WEIGHT, NUTRITION, Impaired-anaemic.
WOUNDS, Abnormalities and condition of Skin, Skin normal condition.
TONGUE, Coatings or Promptness of Movement, White Coating - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - response to light slow.
SIGHT, Says good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Says good.
COORDINATION, Arms, Quite good Legs, Quite good - Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, of hands - especially of left.
PATELLAR REFLEX, normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Apex beat & pulse over 4th left intercostal space ~~Apex Beat, Regularity,~~ Mitral murmur. (Peculiar metallic sound.) Irregular.
ARTERIES, Pulsation in epigastrium.
LUNGS, Chest, Symmetry, Expansion, Breath Sounds, Chest Symmetrical - Expansion fair - B. sounds shallow.



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,

11/16/99 EXAMINATION URINE, Quantity, Sp. g. 1023 Reaction, Neutral Color and Appearance, Yellow - cloudy - flaky deposit.
Albumen, None Sugar, None.
Casts and Crystals, Excessive amt. oxalate of lime crystals - a few pus corpuscles & epith. cells.
GYNECOLOGICAL EXAMINATION, External genitals normal. Uterus normal position - Chocolate colored discharge.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Restless & disturbed.
BOWELS, Present Condition, Somewhat constipated.

Give condensed statement of the 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 an anaemic impaired condition physically. Is maniacal & active in her movements. Gives history of having drank to excess.

Personal and Medical History of Mrs. Amelia Grady.

1899

This patient was brought here by Sheriffs deputy H. Hanson attended by Mr Guest Augustine, in fair physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor parents. First attack of insanity occurred in 1897 when patient was confined in this hospital from Apr 17 '97 to Sept 21 '97. (Rec Vol. 34 Fol. 161 No. 4751.) First symptoms of present attack manifested about two weeks ago by delusions: Disease appears increasing: Not variable: Derangement now manifested by delusion that someone is trying to injure him: Is filthy & destructive in habits: No peculiarities previously manifested: No serious diseases nor injuries to head: No confinement nor restraint employed, no treatment pursued. On personal examination is very anaemic, talks irrationally. On admission put upon Inf. W. (G.H.N.R.) Complexion dark: hair brown: eyes gray: skin in normal condition: Mark on right shoulder: Is clean. Behavior quiet talks intelligently.)

Oct 1/99 to Oct 25/99 — Summary 14 day record by Dr Bobb. Temp slightly elevated most of time but not over 100. Pulse usually 90-100. Resp. 17-36. Appetite fair: Bowels constipated: Receives laxatives & tonics. Sleep poor, frequently noisy & out of bed at night & during day, excited, noisy & destructive: Habits untidy: Difficult to engage in conversation as her mind wanders & answers are sarcastic & irrelevant & generally incoherent. Rambles on in a peculiar fashion, with out any regard to those about her, talking incoherently to herself in a laughing, bright, singsong tone, some word in sentence suggesting next remark & thoughts being disconnected & irrelevant. Also asks & answers, two or three questions.

Nov 30 — Patient Excited, noisy, untidy, destructive. Conversation incoherent. Appetite good. Bowels constipated: sleeps poorly: Jan 5/00 Requires hypnotics: Wt. 10 st 3/4. Jan. 30 Rest disturbed: Takes more interest in surroundings & appearance. Answers questions readily: Appetite good: Bowels regular

Febr 8 1900. At times is depressed: Assists with ward work.

March 1 - Oct 13 1900. March 3 Restless & noisy: Talks & sings: Conversation incoherent. Fairly neat: Assists with ward work: Apr 4. Visited by friends. May 30 Quiet & agreeable: & sensible: Tidy: Attends amusements & interested in surroundings: General health good. July 21 Vaccinated Oct 13. General health good: Very sensible & agreeable. Sent home.

Discharged.

Letter from Mrs A Rehder May 1. Says sister is well & will go to work later.

Personal and Medical History of

Personal and Medical History of Annie Biell.

Whole No. 5420
Residence, St. Paul, Minn.
Date Admission, October 24th 1899.
Admitted by Dr. E.J. Marcus hour, 7 P.M.
How Sent, E.W. Bazille & of P. Ramsey Co.
Sex, female Age, 38 yrs.
Civil Condition, married.
Children, none.
Age Youngest Child, —
Occupation, Housewife.
Degree Education, Common school.
Profession, Religion, Roman Catholic.
Habits, Patient intemperate.
Nativity, Ireland (Parents also born there)
Physicians Committing, E.W. Buckley & H.G. Johnson.
Correspondents, Frank Biell 550 Rice St. St. Paul.

No. of Year, 50
Insane Relatives, Brother here - (James Foley)
Cause Exciting, unknown.
Cause Predisposing,
Form, Chronic Mania
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, 5th yrs ago
Duration, 5 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 33 yrs
Time of Leaving, Jan. 12 1901.
Time in Hospital, 1 yr. 2 mos. 19 da.
Result, Died: General Peritonitis

EXAMINATION ON ADMISSION BY DR. A.A. Bebb *Date of* Oct 25 '99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick - Confused.
MEMORY, Past Events, Fair.
Recent Events, " Special Subjects, do.
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,
Normal.

DELUSIONS, Systematized, Transitory, Special Subjects, many.
of persecution.

HALLUCINATIONS, probably
ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 obtain no history
Father, Living & well.
Paternal Relatives,
Mother, Living & well.
Maternal Relatives,
5 or 1/2 Brothers and 3 Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None
HABITS, Drinking and Smoking, drinks
HEADACHES, VERTIGO, OR CONVULSIONS, Sometimes headache & vertigo.
OCCUPATION, Healthy or not, Gen. housework.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Good Appetite, Good and Bowels,

Personal and Medical History of Annie Biell.

ROCHESTER STATE

Mr Frank Biell.
Great Northern Baker Shop
St Paul
or 550 Rice St.
Anna Biell's
husband

Date

PHYSICAL CHARACTERISTICS.

GHT, 111th USUAL WEIGHT, NUTRITION, fair
.2 small scars back of right ear & on right side of neck.
ft side Skin dry.
t. White coating - breath foul. Tongue prompt.
l Accommodation, Equal - normal.

her troubles,

Legs, Fair. Grasp,
eneral, Slight of hands - Marked of facial muscles at times.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Slightly slurred.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, hyperaesthesia
HEART, Murmurs, Strength, Sounds, Size,
Systolic murmur at apex.
Apex Beat, Regularity,
Sounds full at apex - weak at base
apex beat downward & to left.
Regular.
ARTERIES,



January 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,
Right side fuller -
Resp. on Rt. side more limited
Sounds Limited on Rt side
Expansion " "

11/16/99 EXAMINATION URINE, Quantity, — Sp. g. 1010 Reaction, alkaline Color and Appearance, Reddish-yellow. Cloudy.
Albumen, None Sugar, None -
Casts and Crystals, amor. urates. a few pus corpuscles & epith. cells.

GYNECOLOGICAL EXAMINATION, Ex. genitals normal - uterus retroflexed & adherent to right -

MENSTRUATION, history unreliable - says regular & free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, restless - does not sleep well.
BOWELS, Present Condition, Constipated

Give condensed statement of the 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 fair. Somewhat exalted at times but usually suspicious in manner & full of delusions of persecution: fears that food is poisoned.

Personal and Medical History of Annie Biell.

Whole No. 5420
Residence, St. Paul, Minn.
Date Admission, October 24th 1899.
Admitted by Dr. E.J. Watson hour, 7 PM.
How Sent, E.W. Bazille & Co. of St. Ramsey Co.
Sex, female Age, 38 yrs.
Civil Condition, married.
Children, none.
Age Youngest Child, —
Occupation, Housewife.
Degree Education, Common school.
Profession, Religion, Roman Catholic.
Habits, Patient intemperate.
Nativity, Ireland (Parents also born there)
Physicians Committing, E.W. Buckley & H.G. Johnson
Correspondents, Frank Biell 550 Rice St. St. Paul.

No. of Year, 50
Insane Relatives, Brother [illegible]
Cause Exciting, unknown
Cause Predisposing, "
Form, Chronic Mania
Accompanying Bodily Disorder, [illegible]
Suicidal or not, Not.
Date of this Attack, 5th yrs
Duration, 5 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 33 yrs
Time of Leaving, Jan. 12 1901.
Time in Hospital, 1 yr. 2 mo. 19 da.
Result, Died: General Peritonitis

EXAMINATION ON ADMISSION BY DR. A.A. Bebb. *Date of* Oct 25 '99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick - Confused.
MEMORY, Past Events, Fair -
Recent Events, " Special Subjects, do.
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,
Normal.

DELUSIONS, Systematized, Transitory, Special Subjects, many.
Of persecution.

HALLUCINATIONS, Probably
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 obtain no history.
Father, Living & well.
Paternal Relatives,
Mother, Living & well.
Maternal Relatives,
5 Brothers and 3 Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None
HABITS, Drinking and Smoking, Drinks
HEADACHES, VERTIGO, OR CONVULSIONS, Sometimes headache & vertigo.
OCCUPATION, Healthy or not, Gen. housework.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Good, Appetite, Good, and Bowels,

Personal and Medical History of Annie Biell.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3½ PRESENT WEIGHT, 111 lbs USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, 3 small scars back of right ear & on right side of neck. Inguinal hernia on left side. Skin dry.
TONGUE, Coatings or Promptness of Movement, White coating - breath foul. Tongue prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal.
SIGHT, Good -
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Quite good
COORDINATION, Arms, Fair Legs, Fair. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands - Marked of facial muscles at times.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Slightly slurred.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, hyperaesthesia
HEART, Murmurs, Strength, Sounds, Size, Systolic murmur at apex.
Apex Beat, Regularity, Sounds full at apex - weak at base. Apex beat downward & to left. Regular.
ARTERIES,



January 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,
Right side fuller - Resp. on Rt. Side more limited
Bounds limited on Rt side
Expansion " "

11/16/99 EXAMINATION URINE, Quantity, — Sp. g. 1010 Reaction, alkaline Color and Appearance, Reddish-yellow. Cloudy.
Albumen, None Sugar, None -
Casts and Crystals, Amor. urates. a few pus corpuscles & epith. cells.

GYNECOLOGICAL EXAMINATION, Ex. genitals normal - uterus retroflexed & adherent to right.
MENSTRUATION, history unreliable - says regular & free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, restless - does not sleep well.
BOWELS, Present Condition, Constipated

Give condensed statement of the 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 fair. Somewhat exalted at times but usually suspicious in manner & full of delusions of persecution: Fears that food is poisoned.

Personal and Medical History of Annie Bill.

1899

This patient was brought here by Sheriff's deputy K. Hanson attended by husband, Frank Bill, with the following history:- Consanguinity unknown are brother here in hospital (Amos Foley) First symptoms of insanity manifested about fifs years ago: by delusions of prosecution by neighbors: Disease appears increasing: Is variable: 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 speech rambling and incoherent.

On admission put upon Infirmary Most. G.P.W. Cpt. Complexion dark: hair brown: eyes blue: Skin in normal condition: Scar on lower part of back: Inguinal hernia on left side. Is very dirty: Has 8 lower + 4 upper teeth all of which are very much decayed. Resisted some when being bathed: Has delusions.)

Oct 24/99 to Nov 1/99 — Summary 14 da record by Dr Bebb Pulse + resp. normal. Temp. Higher in afternoon frequently 100-100⅘. Appetite fair: Bowels require laxative: First two nights restless + did not sleep any after that slept quite well: Quiet during day, sits about unoccupied: Takes outdoor exercise: Expresses many delusions

Nov 14 Dec 1/99 — Ozanam. vs. 153. Neat in habits: Is obstinate + suspicious probably on account of her delusions often refuses medicine: Gradually became more agreeable, taking an interest in dining-room work also more careful in dress. Thinks Drs are Maddox Dr. Is. Visited by a lady friend: Dec. 25 Visited by husband

Jan 16 Wt. 116 Ft 6 vs. Neat. Appetite good: Bowels regular: Takes outdoor exercise Menstruates regularly: Very suspicious + obstinate: Has delusions + hallucinations: Thinks people pull her nose + that the nurses are men in women's clothing.

Mch 1 - Nov 30/1900. Mch 25 Agreable: assists with ward work: Rather quarrelsome + has trouble occasionally: Thinks people try to poison her: Occasionally strikes other patients without cause: June 23 Disturbed 2 raus. to C 3. July 4 Visited by husband: Sept 30 Attacked nurses: Nov 21. Wt 117 lbs Nov 9. Struck another patient: General health good.

Personal and Medical History of

Personal and Medical History of Anna Brandt.

Whole No. 5421
Residence, Jumbro Falls, Minnesota.
Date Admission, October 26th 1899.
Admitted by Dr. O. C. Hazendale hour, 4 P.M.
How Sent, M. Kennedy J. of P. Wabasha Co
Sex, Female Age, 46
Civil Condition, married
Children, Five
Age Youngest Child, 3 yrs.
Occupation, Housewife - (husband a miller)
Degree Education, Common school.
Profession, Religion, Not a church-member.
Habits, Not intemperate.
Nativity, Indiana (Father Ohio - Mother Penn.) Became resident of State of Co. in 1866.
Physicians Committing, L. C. Watson + L. C. Claydon.
Correspondents, Husband. Bacon Brandt Jumbro Falls, Minn.

No. of Year, 51
Insane Relatives, None.
Cause Exciting, Female trouble.
Cause Predisposing, Previous attacks.
Form, Climacteric Ins. (Acute Melancholia)
Accompanying Bodily Disorder, Asthmatic attacks.
Suicidal or not, not
Date of this Attack, 5 days ago.
Duration, 5 days.
No. of Attack, Annual.
No. of Admission, 1st
Age First Attack, 44 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Bebb *Date of* Oct. 27/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Not quick - Confused.
MEMORY, Past Events, Quite good -
Recent Events, " Special Subjects, do.
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Not dull - Illusive -
REASONING POWER, Ordinary Subjects, Fair.
Special Subjects, Poor.
Own Mental State, Incoherent. Confused.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal.

DELUSIONS, Systematized, Transitory, Special Subjects, of persecution unnecessary worry about financial affairs

HALLUCINATIONS, Hears her children cry and
ILLUSIONS, talks to them thro' the registers.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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. 2 yrs. ago, 79 "old age"
Paternal Relatives,
Mother,
Maternal Relatives, Brother insane - In Indiana Hosp. 1-2 yrs. Mother's mother had disturbed spells but never sent away from home
6 Brothers and 2 Sisters, 1 bro. dyspepsia 1 sister catarrh
5 children
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had Diphtheria when 6 yrs. Very susceptible to Colds since. Lungs weak - Has Uterine trouble
HABITS, Drinking and Smoking, None
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 Anna Brandt.

42/25/5421

M Anna Brandt

~~Copy of~~ Order for Hearing Petition of M. Brandt of Co. Wabasha and State of Minnesota for appointment of E. J. Hogner of Jumbro Falls, in Town who Institute Petn as guardian for Dau Anna Brandt insane; served and service admitted 4th September 1901. (Hearing 18th Sept 1901)
Memoranda
(~~Papers~~ filed with commitment papers.)
no copy sent for service

ACTERISTICS.

SUAL WEIGHT, NUTRITION, Quite good.
e in normal condition.
ompt.
- Rge normal respond slowly to light.
d. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None -
PATELLAR REFLEX, diminished Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal -
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, Normal.
HEART, Murmurs, Strength, Sounds, Size, mitral
Apex Beat, Regularity, Left
apex beat displaced slightly downward - Regular
ARTERIES,
Pulse weak.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest Clavicles prominent Symmetrical.
Expansion poor.
R. lung shallow over R. lung.
Sounds tubular over L. lung. B. sound exaggerated
Percussion dullness over left lung



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,

11/16/99 EXAMINATION URINE, Quantity, ℥ XXXV ℥ Sp. g. 1015 Reaction, alkaline Color and Appearance, Yellow - clear.
Albumen, None Sugar, None.
Casts and Crystals, Amor. urates, + a few fat droplets, epith. cells + uric acid crystals.

GYNECOLOGICAL EXAMINATION, Laceration of cervix + perineum. Endometritis with thick yellowish discharge. Deep erosion of cervix. Uterus + cervix hypertrophied Uterus retroflexed. Vulva pustulous
MENSTRUATION, Says Regular until recently during last six months over time - free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, good.
BOWELS, Present Condition, Regular

Give condensed statement of the 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). Always suspicious + reticent - Very positive in opinions + assertions with little regard for opinions of others. Delusions of persecution most prominent now. Also worries over financial matters. At time of father's death 2 yrs ago. the most decided change in her noticed but change supposed to have been coming on gradually.
Physical condition fairly good aside from condition of lungs + heart.

Personal and Medical History of Anna Brandt.

Whole No. 5421

No. of Year, 51

Residence, Zumbro Falls, Minn

Date Admission, October 26th 1899.

Admitted by Dr. O. L. Heyerdale ho

How Sent, M. Kennedy J. of P. Wab

Sex, Female Age, 46

Civil Condition, married

Children, Five

Age Youngest Child, 3 yrs.

Occupation, Housewife - (husband a

Degree Education, common school

Profession, Religion, Not a church-member.

Habits, Not intemperate.

Nativity, Indiana (Father Ohio - Mother Penn.) Became resident of State prior to 1866.

Physicians Committing, C. C. Watson & O. L. Claydon.

Correspondents, Husband. Bacon Brandt Zumbro Falls, Minn.

Age First Attack, 44 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Bebb *Date of* Oct 27/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Not quick - Confused.

MEMORY, Past Events, Quite good -

Recent Events, Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Not dull - Illusive -

REASONING POWER, Ordinary Subjects, Fair.

Special Subjects, Poor.

Own Mental State, Incoherent. Confused.

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

DELUSIONS, Systematized, Transitory, Special Subjects, of persecution unnecessary worry about financial affairs.

HALLUCINATIONS, Hears her children cry and

ILLUSIONS, talks to them thro' the register.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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. 2 yrs. ago, 79 "old age"

Paternal Relatives,

Mother,

Maternal Relatives, Brother insane - In Indiana Hosp 1-2 yrs. Mothers mother had disturbed spell but never sent away from home

6 Brothers and ? Sisters, 1 Sr. dyspepsia 1 sister catarrh

5 Children

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had Diphtheria when 6 yrs. Very susceptible to Colds since. Lungs weak - Has Uterine trouble

HABITS, Drinking and Smoking, None

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, Appetite Very good

Personal and Medical History of Anna Brandt.

PHYSICAL CHARACTERISTICS.

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

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, Equal - Size normal respond slowly to light.

SIGHT, has been good. says failing.

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

HEARING, Good

COORDINATION, Arms, Quite good Legs, good - Grasp,

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

PATELLAR REFLEX, diminished Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal -

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, normal.

HEART, Murmurs, Strength, Sounds, Size, mitral

Apex Beat, Regularity, Left apex beat displaced slightly downward - Regular

ARTERIES, Pulse even.



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, Clavicles prominent Chest Symmetrical. Expansion poor. R. Lung shallow over R. lung. Sounds tubular over L. lung. B. Bronchi exaggerated. Percussion dullness over left lung.

11/6/99 EXAMINATION URINE, Quantity, ℥ XXXV ℥ Sp. g. 1015 Reaction, alkaline Color and Appearance, Yellow - clear.

Albumen, None Sugar, None.

Casts and Crystals, Amor. urates, + a few fat droplets, epith. cells + uric acid crystals.

GYNECOLOGICAL EXAMINATION, Laceration of cervix + perineum. Endometritis with thick yellowish discharge. Deep erosion of cervix. Uterus + cervix hypertrophied. Uterus retroflexed. Uterus suspension Ovaries

MENSTRUATION, Days Regular until recently. during last six months over time - free from pain.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, good.

BOWELS, Present Condition, Regular

Give condensed statement of the 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). Always suspicious + reticent - Very positive in opinions + assertions with little regard for opinions of others. Delusion of persecution most prominent now. Also worries over financial matters. At time of Father's death 2 yrs ago. the most decided change in her noticed but change supposed to have been coming on gradually.
Physical condition fairly good aside from condition of lungs + heart.

Personal and Medical History of Anna Brandt.

1899

This patient was brought here by sheriff's deputy Jno. J. Ritter, attended by husband, in fair physical condition, with the following history:- No history of consanguinity, hredity nor intemperance in parents nor patient: Has had various attacks during the past two years, lasting from two hours to one week: First symptoms of present attack manifested five days ago by delusions of persecution & financial affairs: Disease appears increasing: Is variable, symptoms seem exaggerated at menstrual periods: Derangement now manifested on money matters & property. Thinks husband insane; thinks people try to poison her. Is disposed to injure her: No filthy nor destructive habits: No previous peculiarities noted: Patient has had lung trouble & asthmatic attacks: No treatment pursued: Has not been confined nor restrained. On personal examination shows considerable emaciation: Has delusions of persecution, somewhat hysterical: delusions on financial affairs. On admission put upon

On admission put upon Infirmary Complexion dark: hair & eyes black: skin hot & dry: No marks, scars nor bruises: Is rather dirty has four lower teeth - upper set false: Behavior quiet: Has delusions)

Oct 26/99 to Nov 9/99 Summary 14 da record by Dr Beebe. During period had slight elevation of temp in afternoon averaging 99°. P. 60-92 R. Normal. Appetite fairly good: Requires laxatives. At first fairly quiet & cheerful & assisted a little with work, went out for exercise frequently and talked readily at times sensibly but more frequently expressed delusions: Untidy in habits & appearance: After first few days became irritable & fault finding, more restless & lost all interest in surroundings & Auditory hallucinations noted - listens at ventilator & hears her children crying & calls to them: Oct 3 Visited by husband Nov. 24 & 25 by sister. Is indifferent to appearance: Irritable & fault finding: very restless: Has many delusions: Hears voices calling to her: Inactive - Appetite good. Dec. 24 Visited by husband - Jan. 5 100½°

Feb 8 No particular change. Expresses delusions freely: Neat in habits but rather careless in appearance.

Mch 1 - Nov 30. Mch 24 Restless & quarrelsome: Conversation incoherent & irrational hears voices: Claims she owns the institution & name is not Brandt. Occasionally has asthmatic attacks which confine her to her bed. Mch 24 Sick in bed. Apr. 27, Trans. to A². May 5 Very troublesome Trans. to A³. June 2 Visited by sister & on 13 by brother: May 19 Trans. to C³. July 21 Vaccinated. 30 Visited by lady friend

Oct. 31 Quarrelsome & disagreeable on ward at times losing Wt 97½#

Dec 1 - Feb 28/1901 - Jan 13. Became very sick during night with asthma. Jan 15 Trans. to Infirmary: Quite sick. Jan 18 Trans. to C³. Very much improved

Personal and Medical History of Anna Brandt.

Mar. to June 1901 General health fair, at times has asthmatic attacks, is very delusional and talks irrationally, menstruates regularly, takes out door exercise May 29 Wt. 93#. June to Sept. Does no work, takes out door exercise, Sept 1 Wt. 97#. Sept. to Dec. In bed menstruating; from Oct. 8 to 14 in bed with attack of asthma, Oct. 15 visited by relatives quite violent on Oct 30 and attacked nurses on Oct. 31, Nov. 7 menstruating, attacked and struck nurses, very disagreeable Nov. 30 Wt. 98#.

Dec to Feb 1903 Patient is at times quite disagreeable on the ward and is occasionally secluded. Talks to herself in an incoherent way: has no lucid intervals. Very delusional in every respect. General health rather poor. Is asthmatic and has frequent attacks: Menstruates regularly. Appetite fair: sleeps well: takes exercise when obliged to do so. Attends no amusements. Dec. 5th visited by sister and friend.

Personal and Medical History of Caroline Diedrich.

Whole No. 5423
Residence, Winona Co. Minn.
Date Admission, October 30th 1899.
Admitted by Dr. R. A. Babb. hour, 4 PM.
How Sent, H. L. Buck J. of P. Winona Co.
Sex, female Age, 52 yrs.
Civil Condition, single -
Children, none
Age Youngest Child, —
Occupation, farm work.
Degree Education, reads.
Profession, Religion, Catholic church
Habits, Not intemperate.
Nativity, Germany - (Parents also born there.)
Physicians Committing, N. Lichtenstein & Thos. D Pierce -
Correspondents, Paul Diedrich (bro.) Rollingstone, Winona Co. Minn.

No. of Year, 53.
Insane Relatives, none.
Cause Exciting, unknown
Cause Predisposing,
Form, Certain (Epileptiform Insanity Progressive Dem.)
Accompanying Bodily Disorder, Epilepsy
Suicidal or not, not.
Date of this Attack, 49 yrs -
Duration, 3 yrs -
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 49 yrs.
Time of Leaving, Feb. 13. 1900
Time in Hospital, 3m. 14 d.
Result, Died Status Epilepticus

EXAMINATION ON ADMISSION BY DR. Babb Date of Nov. 1 99.

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 - illusive
REASONING POWER, Ordinary Subjects, Impaired -
Special Subjects,
Own Mental State, demented
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent.

DELUSIONS, Systematized, Transitory, Special Subjects,
Probably has some but cannot determine them -

HALLUCINATIONS, Says she hears her father but statements are unreliable.
ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, History goes 3 yrs -
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters, Says 2 bros. & 1 sister had typhoid - 1 sister Consumption 1 bro. Convulsions
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Epileptic Convulsions
HABITS, Drinking and Smoking, No
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches & Vertigo.
OCCUPATION, Healthy or not, Farm work.
Detail Date, Duration, and Character of Previous Attack, if any,
1st attack - Onset 3 yrs. ago.
Sleep, Appetite, and Bowels, Constipated.

CAROLINE DIEDRICH.

A single woman, 53 years of age, born in Germany. Family history is negative; has ten brothers and sisters, all well. Father died when she was eleven years old. Mother when she was sixteen. Her brother says that she seemed to be normal till the age of seven, when he left her and came to this country. Sisterinlaw states that she cannot tell when the "bunches" first appeared, as she did not discover them until patient's condition became such that she was unable to care for herself, and had to be dressed and undressed. Neither parents nor brothers and sisters had these "bunches". Patient never menstruated until about the time of the menopause, when mestruation came on irregularly for a time. Says she took cold when young and that stopped it and it did not return until as above stated. Epilepsy developed at the age of 49, and she has required close watching since. Has a disposition to harm children is careless and untidy in her habits. Speaks only German, and only when spoken to. She is dull and stupid and we can notice a low grade of mental and physical development.

OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleep good.
BOWELS, Present Condition, Constipated

Give condensed statement of the 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). Mauriboian prominent & short Region chested. Head large & masculine in appearance. Hands also large. Fingers of both hands suggest arthritic deformans, especially left hand. Mental condition probably always below (average). Has appearance of progressive dementia.

Personal and Medical History of

...o.
Feb. 13. 1900
3m. 14 d.
...cid Status Epilepticus
...rium.

Ph...
Correspo...

EXAMINATIO... Feb... Date of Nov. 1899.

ARACTERISTICS.

MENTAL ACTIVITY, Clear o...,
Sluggish - confu...
MEMORY, Past Events, Poor.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
dull - illusive
REASONING POWER, Ordinary Subjects, Impaired -
Special Subjects,
Own Mental State, demented
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent.

DELUSIONS, Systematized, Transitory, Special Subjects,
Probably has some but cannot determine them -

HALLUCINATIONS, Says she hears her father but statements are unreliable.
ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, History gives 3 yrs -
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters, says 2 bros. & 1 sister had typhoid - 1 sister consumption 1 bro. convulsions
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Epileptic Convulsions
HABITS, Drinking and Smoking, No
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches & Vertigo.
OCCUPATION, Healthy or not, Farm work.
Detail Date, Duration, and Character of Previous Attack, if any,
1st attack - Onset 3 yrs. ago.
Sleep, Appetite, and Bowels, Constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 10 PRESENT WEIGHT, 111½ USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, Multiple fibromas on body varying in size: most numerous on abdomen & back, also on chest. a few on limbs - on trunk. skin rough & dry.

TONGUE, Coatings or Promptness of Movement, Clear. Quite prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, about Equal - size normal: responds slowly to light.

SIGHT, says not good -

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

HEARING, Says poor - especially impaired in right ear.

COORDINATION, Arms, Impaired Legs, Impaired. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, slight of hands

PATELLAR REFLEX, diminished. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Slurred & hesitating.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, diminished

HEART, Murmurs, Strength, Sounds, Size, No Sounds forcible - Pul. accented

Apex Beat, Regularity,

apex beat normal. Regular

ARTERIES,

Full & firm. Some sclerosis - Resp. labored

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Percussion note hyperresonant - Breath sounds exaggerated on R. side on left side Percussion note duller & breath sounds less distinct -

Expans. fair & Chest symmetrical.

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, Yellow. clear & white flaky deposit

Albumen, Trace by Tanrets. Sugar, —

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

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact. hyperaemia of cervix & vagina. bleeds on touch - uterus retroflexed - many haemorrhoids - much congested.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleep good.

BOWELS, Present Condition, Constipated

Give condensed statement of the 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). Mauriceau prominent & short Pigeon Chested. Head large & masculine in appearance. Hands also large. Fingers of both hands suggest arthritic deformans, especially left hand. Mental condition probably always below average. Has appearance of progressive dementia.

Personal and Medical History of Caroline Diedrich.

1899.

This patient was brought here by Sheriff Adv. Fuhrmann attended by her Mother/sic fair physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor parents: First attack manifested three years ago by epileptic fits disease appears increasing: is not variable: Derangement now manifested by dementia: Patient is disposed to harm children: Is filthy + destructive in habits: No peculiarities previously manifested: Has been watched constantly but not confined: No treatment pursued: On personal examination face expressionless + stolid: answers no questions except giving her name.

10/30/99 On admission put upon Infirmary West. (G.P.W. Ppt Complexion dark: hair brown: eyes brown: a few small bruises on legs + arms: Is dirty: Has a great many tumors (500) all over body. Teeth:- 7 upper, 7 lower first + second toes overlap:- Behavior quiet: Does not speak English:)

Oct 30/99 to Nov 13/99 Summary 14 da record by Dr Bebb. T. 98°-100- Pulse + Resp. normal: Appetite poor: Requires laxatives: Sleeps well: Untidy in habit + appearance. Upon ward after first few days usually quiet, dull + stupid, face brightens up when addressed + she sometimes talks a little in German- remarks usually incoherent, however,

Nov 12 Quite helpless: complains of dizziness + headache: has slight cut on back of head: Nurse thinks she fell out of bed: Quite weak + put in restraint to keep her in bed: Is often obstinate + irritable + always resists being dressed.

Nov 1- Fr 24 1900 (Dr. Heyerdale) Nov. 12 Slight cut on back of head: believed she fell out of bed. Kept in bed in restraint during day. Irritable + very obstinate Resists being dressed: Is demented: Bowels moved by Cathartics. Has occasional convulsions. Jan 18 1900. Wt. 101½. Feb. 18 Bowels regular Appetite good: Sleeps well: Sits on bench all day. Dirty in habits.

Feb. Began having Convulsions which continued in rapid succession until 11:30 PM. when she died in States Epileptics.

Died.

Personal and Medical History of

Personal and Medical History of Margaret Bachmann.

Whole No. 5424

Residence, St. Paul, Minn.

Date Admission, October 30' 1899.

Admitted by Dr. R. A. Bebb, hour, 7 PM.

How Sent, Ed. Bazille & A. of P. Ramsey Co.

Sex, female Age, 28 yrs.

Civil Condition, married.

Children, Five

Age Youngest Child, four weeks.

Occupation, Housewife (husband a laborer)

Degree Education, Common school.

Profession, Religion, Catholic.

Habits, Not intemperate.

Nativity, Germany (Parents also born there.)

Physicians Committing, H.M. Davis E.G. Sparks.

Correspondents, Joseph Bachmann. 1007 Black St. % G.P. Pat Box 318 - St Paul.

No. of Year, 54

Insane Relatives, None.

Cause Exciting, Puerperium

Cause Predisposing, Unknown.

Form, Melancholia Ac.

Accompanying Bodily Disorder, —

Suicidal or not, Not.

Date of this Attack, Oct. 4th or 5th 99.

Duration, about 25 days.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 28 yrs.

Time of Leaving, Mar. 6, 1900

Time in Hospital, 4 m. 6 d.

Result, Discharged Sept. 22, 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Bebb Date of 11/1/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Fairly clear & quick.

MEMORY, Past Events, Quite good

Recent Events, " Special Subjects, do.

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert. Quite correct on many subjects - Illusive on others.

REASONING POWER, Ordinary Subjects, Quite good.

Special Subjects, Fair.

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none. Probably has some.

HALLUCINATIONS, Hears voices of mother & children

ILLUSIONS, no.

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

HISTORICAL.

LENGTH INVASION, Oct. 4

ONSET, Gradual or Sudden,

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

Father, Dead. Sick yrs. Cause not known

Paternal Relatives, Says no mental trouble

Mother, Living

Maternal Relatives, Says no mental trouble

Brothers and Sisters, 1 sister has spinal trouble 5 Children

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None.

HABITS, Drinking and Smoking, None.

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches at times not dizzy.

OCCUPATION, Healthy or not, housekeeper.

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

Sleep, Appetite, and Bowels, Good Good Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 PRESENT WEIGHT, 123. USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, dry skin.

TONGUE, Coatings or Promptness of Movement, heavy white coat. Quite prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size dilated

SIGHT, Says good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Many glasses for close work, but says she sees better without them

HEARING, Says good.

COORDINATION, Arms, Quite good Legs, do. Grasp,

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

PATELLAR REFLEX, Diminished. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc. About normal.

SENSIBILITY, About normal.

HEART, Murmurs, Strength, Sounds, Size, Apex beat forcible + over pulmonary area
Apex Beat, Regularity, Sounds greatly accentuated - Apex beat displaced outward Irreg. in rhythm - Irritable.

ARTERIES,
Pulse weak & rapid.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion fair
B. sounds normal.



January 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,

11/4/99 EXAMINATION URINE, Quantity, Sp. g. 1025 Reaction, acid Color and Appearance, Yellow cloudy, flaky deposit.

Albumen, None Sugar, None.

Casts and Crystals, Amor. urates & a few epith. cells.

GYNECOLOGICAL EXAMINATION, Laceration of cervix (lateral) & perineum also general hypertrophy of cervix. Offensive leucorrhoea, moderate amount. Uterus slightly retroflexed. Treatment of uterus & operation for hemorrhoids advised.

MENSTRUATION, Regular. Sometimes has pain in head, also pelvic pain.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Usually does not sleep very well.

BOWELS, Present Condition, Constipated.

Give condensed statement of the 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). Pterygium forming over both eyes. General physical condition fair. Converses quite sensibly on most subjects. Asks continually for her children & husband & worries because detained here. Quite restless most of time. Previous mental condition probably quite good. Onset of present mental disturbance recent following puerperium.

Personal and Medical History of Margaret Bachmann.

1899.

This patient was brought here by Sheriffs deputy G.R. Ritt attended by Joseph Bachmann, in fair physical condition, with the following history:- First symptoms of insanity manifested Oct. 4th or 5th '99. by delusions in conversation & actions: Disease appears increasing Not variable: Derangement now manifested by injury to family is extremely noisy, sings a great deal. Not disposed to injure anyone: Habits filthy & destructive. No peculiarities previously manifested: No severe diseases nor injuries to head. Has been confined in City Hospital St. Paul, & been in restraint. Has been given sedatives: On personal examination no further facts noted. On admission put upon Infirmary list (Gtd. Rpt. Complexion dark: hair light: eyes gray: Skin in normal condition: So clean: has 16 upper & 16 lower teeth: Behavior quiet: Talks intelligently.)

10/30/99 to 11/13/99 Summary of 14 da. record Temp. 98° - 100°. Pulse 68-96. Appetite fair: Bowels constipated: requires Cathartics: usually sleeps well: Takes out door exercise: Often complains of pain in abdomen & of headache: Is usually quiet & depressed & at times obstinate: Frequently cries & asks to go home: Worries about her children: Often sits in room alone: Answers questions quite rationally: Neat in habits & appearance: Assists with ward work.

Dec 1. Patient quiet & depressed: Cries: answers questions intelligently: Is neat: Does some work on ward: Bowels constipated: Appetite poor: Always complains of pain in abdomen & of headache: Wants to go home.

Dec 26 Visited by husband & children. Jan 2 Wt. 127½ lbs. Patient remains about same: Has short periods of excitement when she screams & cries. Jan. 28 Quiet & neat: Takes some interest in surroundings Appetite good: Sleeps well: Takes out door exercise Feb 8 About the same

Mch 6. Allowed to go home on trial.

Discharged

Letter from patient Mch 19, 1900 says she feels very well & is getting stronger.

Personal and Medical History of

Personal and Medical History of Alice Bourguin

Whole No. 5425

Residence, St. Paul, Minn.

Date Admission, November 3' 1899.

Admitted by Dr. R. A. Bebb. hour, 7 P.M.

How Sent, H. Gallick Ct. Conv. Ramsey Co.

Sex, Female Age, 25 yrs.

Civil Condition, Single.

Children, –

Age Youngest Child, –

Occupation, Housework. (Step father Engineer.)

Degree Education, Common School.

Profession, Religion, Roman Catholic.

Habits, Not intemperate. (Father inebriate)

Nativity, Switzerland (Parents also born there.)

Physicians Committing, H.G. Johnson & O.W. Archibald.

Correspondents, M. Bourguin (Stepfather) 94 So. Robert St. St. Paul, Minn.

No. of Year, 55

Insane Relatives, Sister (Ida Bourguin) here.

Cause Exciting, Disappointment in love.

Cause Predisposing, Possibly heredity.

Form, Adolescent

Accompanying Bodily Disorder, none mentioned

Suicidal or not, Not.

Date of this Attack, Six weeks ago

Duration, 6 wks.

No. of Attack, 1st

No. of Admission, first

Age First Attack, 25 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Bebb *Date of* 11/6/99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear & quick.

MEMORY, Past Events, Good

Recent Events, Quite good Special Subjects, fair.

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

REASONING POWER, Ordinary Subjects, Good.

Special Subjects, Impaired.

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none.

HALLUCINATIONS, Yes

ILLUSIONS, No.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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. Inebriate & very cruel to mother (See below)

Paternal Relatives,

Mother, living - health not good. (From history must had syphilis)

Maternal Relatives,

Brothers and Sisters, 9 (1 half bro.) 3 are brothers died within a few days.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None except Labrippe

HABITS, Drinking and Smoking, Says drinks moderately

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches

OCCUPATION, Healthy or not, Housework.

Detail Date, Duration, and Character of Previous Attack, if any,
First attack.

Sleep, Appetite, and Bowels, Very poor 5-6 weeks ago did not sleep for a week since has slept quite well.

Personal and Medical History of Alice Bourguin.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft PRESENT WEIGHT, 103 lbs USUAL WEIGHT, NUTRITION, Somewhat impaired.

WOUNDS, Abnormalities and condition of Skin, No wounds - (See ~~under~~ gyne. exam.) Skin normal.

TONGUE, Coatings or Promptness of Movement, Slight coating - protruded promptly - deviates to left.

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

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 nervous movements of facial muscles.

PATELLAR REFLEX, diminished Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, About normal

HEART, No Murmurs, Strength, Sounds, Size, Apex Beat, No Regularity, regular Both sounds strong

ARTERIES,
Pulse weak. regular.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion fair
B. sounds normal - 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,

11/10/99. EXAMINATION URINE, Quantity, ℥ LX Sp. g. 1010 Reaction, Neutral Color and Appearance, Pale yellow - clear - few deposit.

Albumen, None. Sugar, None.

Casts and Crystals, Amor. urates - a few epith. cells & oxalate of lime crystals.

GYNECOLOGICAL EXAMINATION, Eruption on external genitals - otherwise normal - hymen intact. Vagina divided by a m. s. partition which extends almost full length of vagina - right side terminates in pouch - cervix opens into canal on left side - a few adhesions in vagina - leucorrhoea.

MENSTRUATION, Discharge - abundant thick & yellowish - says menstruation regular until this month - & free from pain except - aching in limbs.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, quite good.

BOWELS, Present Condition, Regular

Give condensed statement of the 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

Personal and Medical History of Alice Bourguin.

1899

This patient was brought here by sheriffs deputy John Moriarty attended by Mr. Bourguin in fair physical condition with the following history:- No history of consanguinity: sister here insane: No intemperance in patient nor parents: First symptoms of attack manifested six weeks ago, by imagined persecution: disease appears increasing: So variable: Thinks that an unsun man is about to do her injury: Not disposed to harm anyone: No filthy nor destructive habits. Previous to accession of disease was very religious: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued. On personal examination nervous & excitable: has crying spells. On admission put upon
Nov. 3 Infirmary West (G.H.M. Rpt. complexion dark: hair brown: eyes gray: Skin in normal condition: a slight eruption on legs & arms: So clean: Has 14 upper & 12 lower teeth: behavior quiet: Talks intelligently.

Note History given by her on admission. History probably specific: Her father was an inebriate & very cruel to wife. There were 13 children, 4 girls and 9 boys. The 4 girls were the oldest & lived. After that time the Mother had "sickness in her head" for 4-5 yrs. and the 9 boys born later all had large sores on their scalps, and were all either stillborn or died within a few days after birth. 13-14 years ago her parents separated and mother married again. Mother had one child with 2nd husband & this child died same as the others. Miss Alice Bourguin's mental trouble had probably been coming on gradually for several years. She said a young man planned to meet her places when she went out & annoyed her. She disliked him & to avoid him began to remain at home. seldom going anywhere. She had been doing housework in private family for several years & seldom left house even to go home or to church. Gradually she began to hear voices talking to her. often this young man talked to her at night & threatened to kill her. The lady for whom she worked had always been very kind to her but she heard her scolding & finding fault with her work when in the next room altho when she came into the kitchen she was as pleasant as usual & never complained, in fact spoke very nicely of her work. Miss Bourguin could not understand it. She felt there must be some mistake - tried to overcome it but became so restless & nervous that she was obliged to give up her place. On admission says she does not hear the voices nearly so often. She is very pleasant & talks sensibly on most subjects. Says she really did not believe that there could be these voices, that it was probably due to her mind being a little affected. & she will try to overcome it by not listening to voices. Does not express any delusions at this time.

Personal and Medical History of Alice Bourguin.

1899

Nov 3 '99 to Nov. 17 '99 Summary 14 da record by Dr Bibb. Temp. & Resp. about normal. Pulse 60-78 frequently sub-normal. Appetite fairly good. Bowels usually regular, requires occasional laxatives. Sleep disturbed, often hears people calling her. Neat in habits & appearance. Assists with ward work. Moods changeable, usually restless, at times excited at others depressed. Behavior usually quiet & agreeable, however & converses readily & rationally at the rather childishly. Is very anxious to go home Nov. 29 Trans. to B.3. Jan 1 1900 Habits & appearance neat: appetite good: At times wilful & obstinate & refuses to go to chapel, walking &c. Still rather silly but manner more natural & some mental improvement noted. Does not express delusions nor hallucinations now. In compliance with urgent request of parents she was allowed to go home on trial today.

Jan 12 1900 While at home caused endless trouble & there expressed delusions which she concealed while here, was obstinate & disagreeable & demanded money: prepared to leave home: no relatives wrote to have her returned & Miss Morris brought her back here today. Since return expressed delusions much more freely: often talks & sings to herself & appears much more confused mentally.

Jan 15. Returned. Very irritable & suspicious & fault finding: Fairly neat: Does no work: Appetite good: Bowels regular: Jan 19. Attempted to elope while out walking: Jan 25 Attacked nurses: Feb 28 No change.

March - Nov 30 1900 Mch 10 Attacked Nurses. Very disagreeable. Apr 12. Recedes & expresses some delusions: particularly of persecution: At times quite agreeable & converses readily but a great deal of time is very obstinate & sits quietly about ward. refusing to do any work whatever. July 21. Vaccinated. Attacks nurses at times Norm. 100°. Appetite good: Bowels regular: Takes outdoor exercise: Thinks she was stolen & 2 or murdered & that people are wearing her clothes. Dec. - Feb 28 1901 88°. General health good: Very disagreeable in manner as a rule.

Mar. to June Apr. 7 menstruated also May 5. not neat. is agreeable on ward. takes out door exercise, does no work, incoherent in speech May 28. Wt. 85½#.

June to Sept. June 30 July 25 menstruated, Sept. 1 Wt. 89#. Sept to Dec. Nov. 13 menstruating, no change during quarter Nov. 30 Wt. 86#.

Dec to Feb 1903 General health good: bowels regular: sleeps well: does no work: takes exercise: Patient is very delusional sometimes noisy and disagreeable: careless in appearance & habits: sometimes answers questions sensibly. At times uses profane language. Wt 85#.

Personal and Medical History of Olive Johnson.

Whole No. 5434
No. of Year, 64
Residence, Wilmington, Minn.
Insane Relatives, 2 sisters + Maternal Uncle - (Ole Moen)
Date Admission, November 15' 1899.
Cause Exciting, Suppressed Menstruation
Admitted by Dr. R. A. Bebb hour, 4 PM.
Cause Predisposing, Heredity.
How Sent, L. Budahl & A. of P. Houston Co.
Form, Stup. Mel. Ac.
Sex, female Age, 19.
Accompanying Bodily Disorder, Suppressed menstruation.
Civil Condition, Single
Suicidal or not, Not.
Children, —
Date of this Attack, October 26'99.
Age Youngest Child, —
Duration, 3 mo.
Occupation, housework.
No. of Attack, 1st
Degree Education, Common school.
No. of Admission, 1st
Profession, Religion, Lutheran.
Age First Attack, 19 yrs.
Habits, Not intemperate.
Time of Leaving,
Nativity, Minnesota (Parents born in Norway)
Time in Hospital,
Physicians Committing, Dr. D. C. Rhines + Ry. Ferguson.
Result, Disc. Nov. 6. 1900
Correspondents, Hans Johnson (father) Wilmington, Minn. Recovered
Telephone to Mr. Blexrud. Sheriff. Caledonia, Minn.

EXAMINATION ON ADMISSION BY DR. Bebb *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Sluggish - confused.
MEMORY, Past Events, Will not converse
Recent Events, do. Special Subjects,
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,
Mentally indifferent.

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses no fixed delusions. Remarks vague + incoherent
Power of attention impaired.
HALLUCINATIONS, None apparent.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 - quite well.
Paternal Relatives,
Mother, living - quite well.
Maternal Relatives,
~~Brothers~~ and Sisters, insane, ? No children.
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, not taken PRESENT WEIGHT, Not taken. USUAL WEIGHT, NUTRITION, Impaired.
WOUNDS, Abnormalities and condition of Skin, None. of hands rough + hard - skin dry warm + feverish
TONGUE, Coatings or Promptness of Movement, Red. dry. coated tongue + teeth - protrudes slowly + reluctantly.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. size dilated - response to light slow - to accomodation
SIGHT, appears to be fair.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, appears good
COORDINATION, Arms, Too stupid to test Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, none
PATELLAR REFLEX, Diminished. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, whispers + mutters to self. Articulation slow hesitating + indistinct. When angry speaks quite distinctly.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, diminished
HEART, no Murmurs, Strength, Sounds, Size, full.
Apex Beat, N Regularity, regular



ARTERIES,
Normal -

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion normal
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,

11/28/99 EXAMINATION URINE, Quantity, Sp. g. 1042 Reaction, acid Color and Appearance, Yellow - clear.
Albumen, none Sugar, none.
Casts and Crystals, Amor. urates. a few epith. cells, a few pus corpuscles + fat globules.

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact - uterus normal position.
MENSTRUATION, Cannot obtain history.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Quite disturbed.
BOWELS, Present Condition, Constipated.

Give condensed statement of the 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 Dull - stupid + very obstinate - often resists when cared for. Anorexia + has considerable mucous in stomach. Sordes on teeth + dry coating on tongue - moderate continuous fever. Very restless much of time - sleep quite disturbed.

Personal and Medical History of Oline Johnson.

1899

This patient was brought here by Sheriff Gl. Blegvad, attended by her father, in rather poor physical condition, with the following history:- No history of consanguinity; two sisters & one uncle insane (Uncle here - Dec. Mom.) First symptoms of insanity manifested 3 weeks ago at time of menstruation. Disease not variable. Derangement now manifested by fear of impending danger & trouble: Not disposed to injure anyone: No peculiarities previously manifested: No severe diseases nor injuries to head manifested: Has been kept in house three weeks: has received medical care, - no effect. On personal examination presents a melancholic condition & is in fear of trouble; does not appear well nourished: does not converse with intelligence.

11/25/99 On admission put upon Infirmary West (Gyn. Pat.) Complexion fair: eyes blue; hair light brown: skin hot & dry: So dirty: Could not count teeth: Refuses to talk or walk: Is quiet.)

Nov. 15th 99 to Dec. 29th 99 Summary 14 da. record by Dr. Bro. Temp. 98°-102°. P. 80-120. R. 19-30. Appetite very poor: takes milk occasionally but generally fed mechanically. Beef-juice, eggnogs & Whiskey given daily by tube: Bowels constipated, salts & Cumata given as needed: Sleep fair: occasionally requires mild hypnotics: Habits untidy: At times disturbed, excited & noisy, resistive & violent. Speech rambling & incoherent: Remains in bed. Lavage of stomach daily: Considerable mucous present. Teeth covered with sordes: lips & tongue dry: brownish coating on tongue. Dec. 6 Visited by friends.

Summ. Continued Dec. 29 Following early maniacal stage of restlessness varying with depression, came a stupid period during which she refused to speak for weeks & paid little attention to those about her. This stage was cataleptoid in character, she resisted any change in position & after being placed in any position remained motionless. Later had rather an anxious expression & would watch furtively those about her, at times pouting & appearing annoyed. Physical improvement gradual but Temp. Pulse & Resp. became normal & after Dec. 25. took nourishment better. Lavage continued some days, also forced feeding, stimulants & oil baths: sponge baths given frequently: Sleep fair. - To day (Dec. 29) Commenced sitting up for a short time.

Note Patient says she was not well when she left Home, had always done a great deal of hard work, tho not strong: Father drank, not hard, but was very unkind to her & the rest of the family: Her mother always good to her: Says she feels as if she had come to life after being dead: the time here all a blank excepting a few incidents which she remembers.

Jan 5 to 30th Gives massage & electrical treatment: Slept fairly well: Bowels constipated. Mch 15 Depressed & inactive: Seldom moves about: Sits quietly about ward. Appetite good. Trans. to Q3. Apr 21 Visited by father & taken Home. Discharged.

Personal and Medical History of

Letter July 29. 1900 from father states that patient is getting along very nicely & has completely recovered.

Personal and Medical History of Sarah M. Anderson

Whole No. 5739
Residence, Washington Co, Minn.
Date Admission, Nov. 18th 1899.
Admitted by Dr. A. F. Kilbourne hour, 7 P.M.
How Sent, Frank T. Nelson J. of P. Wash. Co.
Sex, female Age, 41
Civil Condition, Single.
Children, one
Age Youngest Child, 4 yrs.
Occupation, Housework.
Degree Education, Common school.
Profession, Religion, Lutheran.
Habits, not intemperate.
Nativity, New Scandia - (Parents born in Sweden)
Physicians Committing, G.M. Waters & G.E. Clark.
Correspondents, Engal Johnson Bro-in-law Scandia, Wash Co. Minn.
Anna Anderson - father - Scandia
Brotherinlaw says she has always been feeble minded.

No. of Year, 69
Insane Relatives, None -
Cause Exciting, Unknown
Cause Predisposing,
Form, Defective Acute Melancholia
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, Not.
Date of this Attack, Congenital -
Duration, -
No. of Attack, 1
No. of Admission, 1st
Age First Attack, -
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Babb *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear - quick.
MEMORY, Past Events, Fairly good.
Recent Events, do. Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Appears dull but is quite ready & correct in remarks
REASONING POWER, Ordinary Subjects, fair
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal - Indifferent -
DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none now.
HALLUCINATIONS, do.
ILLUSIONS, do.
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
None known.
Father, living always troubled with headache.
Paternal Relatives,
Mother, living. has stomach trouble -
Maternal Relatives,
2 Brothers and 5 Sisters, 1 bro. died suddenly from accident. youngest sister died at 4 yrs. probably miscegia from description. Mother badly frightened when baby was child a brother drowned also.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Earache and toothache a great deal. Subject to rheumatism.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches & Vertigo occasionally.
OCCUPATION, Healthy or not, at home, assisted with housework.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Not Appetite, Not and Bowels, Constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. PRESENT WEIGHT, 96½ lbs. USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, Skin dry & warm.
TONGUE, Coatings or Promptness of Movement, Clear - protruded slowly.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal - responses fair -
SIGHT, Impaired - Cannot see to read etc - in evening.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Impaired.
COORDINATION, Arms, fair Legs, Quite good - Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Tremors of hands & tongue.
PATELLAR REFLEX, delayed. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, not very distinct.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, diminished -
HEART, No Murmurs, Strength, Sounds, Size,
Apex Beat, No 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,
Normal -
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair

11/29/99 EXAMINATION URINE, Quantity, ℥ XXV ½ Sp. g. 1030 Reaction, acid Color and Appearance, Yellow. very cloudy -
Albumen, none. Sugar, Trace by Bismuth (2)
Casts and Crystals, Excessive amt. amor. urates: Normal oxalate of lime crystals & epith cells & a few pus corpuscles.
GYNECOLOGICAL EXAMINATION, External genitals normal. hymen lax: uterus normal position. cervical polypus.
MENSTRUATION, Some pain in abdomen & breasts during menstruation.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Appetite good now, always thirsty.
BOWELS, Present Condition,

Give condensed statement of the 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). Talks fairly intelligently but wanders from subject & is inclined to go fully into detail when questioned - Very talkative - Says never well & so did not work In appearance is dull & rather stupid - probably partly due to inability to understand English - but probably somewhat defective - Troubled with earache a great deal when a child - Physical condition fair.

Personal and Medical History of Sarah M. Anderson.

1899. This patient was brought here by sheriffs deputy Engal Johnson, in poor physical condition, with the following history:- No consanguinity nor heredity known: Patient has always been quite unsided: Disease appears increasing: Not variable: Derangement now manifested by propensity to run away & wander about: Not filthy nor destructive in habits: Before accession of disease had fits of passion, grew excessively angry especially with children: Very seldom talks: Is very restless at night: No severe diseases nor injuries to head - but complains of head: No confinement nor restraint employed: No treatment pursued.

11/18/99 On personal examination shows insanity in manner of talking & general attitude. On admission put upon

On admission put upon Veranda / Gt. Apt. Complexion fair: hair light: eyes blue: skin in normal condition: No marks, scars nor bruises. Is rather dirty. Has 6 upper & 9 lower teeth: Behavior quiet: Does not talk freely.

Nov 1899 to Dec 2/99 Summary 14 da. Record by Dr. Bobb. T. 98³-101° P. 68-95- R. 14-22, Appetite good: Bowels require occasional laxative: Sleeps well: Takes out door exercise: Is very quiet & seldom speaks unless spoken to then answers hesitatingly: Is rather depressed: Expresses no delusions: Very neat about person and clothing: Nov 30 + Dec 1 in bed. complained of headache & had slight rise of temperature

Dec 3 Trans. to C³. Jan 1900 Quiet & well behaved. Seldom speaks unless addressed: Appetite fair: Bowels constipated: Sleeps well. Remains in about same condition: Is stupid: Eats & sleeps well: Bowels constipated.

Mch 1. Aug 31 1900 (Dr Linton) Patient untidy & careless: restless & troublesome: has delusions: answers questions sensibly: Appetite good: Sleeps well: General health good: Takes out door exercise: Apr 25 Slipped going down stairs & bruised leg, wrist & inflamed for several days.

July 3 Vaccinated. July 31 No change. Sept 1-Nov 30 1900 Appetite good. Bowels regular: General health good: Sleeps well: Takes out door exercise: untidy & dirty: usually quiet: Nov 3. Wt. 99# Dec 1- Feb 28 1901 Appetite & general health good: Takes out door exercise. Does no work: untidy & dirty: March 3 Wt. 100#. Mar 1- June 1- 1901 Does no work: no change in mental or physical condition May 31 Wt. 101 1/2 #.

June to Sept. Takes out door exercise, attends no amusements, Sept. 3. Wt. 100#.

Sept. to Dec. Occasionally attends chapel, converses a little, occasionally does a little work, seems brighter, is still untidy and dirty, Nov. 30 Wt. 110#.

Dec to Feb. 1903 No change. Wt about 109#. Is quiet on the ward: at times volunteers conversation: answers questions sensibly: takes exercise: at times assists with the work: appetite good. Bowels regular. sleeps well: habits & appearance rather untidy & careless: sometimes rather dirty. Dec 1st Wt. 109 1/2 #

Personal and Medical History of

Personal and Medical History of Anna M. Cederberg.

Whole No. 5444
Residence, Washington Co, Minn.
Date Admission, November 21st 1899.
Admitted by Dr. E. J. Warnow hour, 7 PM.
How Sent, F. T. Wilson & agt. Washington Co.
Sex, female Age, 47 yrs.
Civil Condition, married
Children, 3
Age Youngest Child, 10 yrs.
Occupation, Housewife (husband a watchman)
Degree Education, Can read & write.
Profession, Religion, Lutheran -
Habits, Not intemperate.
Nativity, Sweden (Parents also born there)
Physicians Committing, W. C. Voight & W. H. Pratt.
Correspondents, Martin Cederberg, So. Stillwater Minn.

No. of Year, 74
Insane Relatives, None.
Cause Exciting, unknown.
Cause Predisposing, unknown.
Form, Melancholia Acute.
Accompanying Bodily Disorder, Cessation of menstruation.
Suicidal or not, Attempted by hanging -
Date of this Attack, 2 mos. ago.
Duration, 2 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 47 yrs.
Time of Leaving, 25th March 1901.
Time in Hospital, 1 yr. 4 mos 4 Ds.
Result, Recovered — Dis't. Dec 22/1901

EXAMINATION ON ADMISSION BY DR. Bebb. Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Sluggish slightly confused by talks quite sensibly.
MEMORY, Past Events, Fair
Recent Events, do Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Dull - seems correct.
REASONING POWER, Ordinary Subjects, Fair
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed
DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any.
Power of attention impaired - is melancholy.
HALLUCINATIONS, No.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
Not so far as we can learn.
Father, Dead - don't know cause of death -
Paternal Relatives,
Mother, died lung trouble - days ill 2 weeks.
Maternal Relatives,
2 Brothers and ~~Sisters~~,
3 children
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No serious illness, operation or injury -
HABITS, Drinking ~~and Smoking~~, Not to excess.
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches - dizzy spells
OCCUPATION, Healthy or not, housekeeper,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Poor Appetite, Poor and Bowels, Constipated.

Personal and Medical History of Anna M. Cederberg.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6 PRESENT WEIGHT, 110½ USUAL WEIGHT, NUTRITION, Impaired.
WOUNDS, Abnormalities and condition of Skin, Skin dry & warm.
TONGUE, Coatings or Promptness of Movement, Clear - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - dilated - responses quite good.
SIGHT, Impaired - has had no glasses but cannot read.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Impaired.
COORDINATION, Arms, Quite good Legs, do, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight of tongue -
PATELLAR REFLEX, diminished - especially in L. limb Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Somewhat hesitating.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, N. Size,
Apex Beat, N. Regularity, regular.



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,
Some sclerosis
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
R. side a little more prominent
Expansion slightly greater on R. side
Sounds hypersonant ant. over both lungs.
1/23/99 EXAMINATION URINE, Quantity, 3 XXV 11/19 Sp. g. 1021 Reaction, acid Color and Appearance, Yellow - clear - flaky deposit
Albumen, none Sugar, none.
Casts and Crystals, Amor urates - all kinds of epith. cells & a few oxalate of lime crystals.
GYNECOLOGICAL EXAMINATION, Laceration of perineum - hypertrophia of vaginal orrifice - external genitals otherwise normal. Irregular lateral laceration of cervix - mild leucorrhoeal discharge altering normal position - erosion of cervix - haemorrhoids.
MENSTRUATION, Says has not menstruated for 2 mos. Quite regular previous & that time & free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 trouble came on by rest-lessness - Inability to sleep & had pains all over - No serious illness until this but tired & worn out for years. No delusions apparent at present. Physical condition somewhat impaired. anaemic - Appetite quite poor at times & never good - Has a moderate use of temperature.

Personal and Medical History of Anna C. Cederberg.

1899

This patient was brought here by Martin Cederberg, attended by Edith Cederberg, in fair physical condition, with the following history:- No information concerning no history of intemperance in parents nor patient: No heredity known: First symptoms of insanity manifested two months ago, by delusions of poisoning, continuous walking; pains in trunk; cessation of menstruation: disease appears increasing: Now manifested by delusions of poisoning etc. Not disposed to injure anyone: Habits filthy & destructive: No peculiarities previously manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: Has been under medical treatment in Minneapolis & St. Paul. On personal examination is apathetic, admits poisoning etc. On admission put upon Infirmary Rest. Complexion dark: hair & eyes brown: Skin in normal condition: No marks, scars nor bruises noted. Is clean: Has no teeth: behavior quiet: Talks very little but answers questions intelligently.

11/22/99 to 12/7/99 Summary 14 da. record by Dr. Bebb. T. 98°-105 Pulse 68-96 - R. 18-30. Appetite fair: Bowels rather constipated: Takes medicine: Takes out door exercise: Sleeps quite well, but first few nights very restless: Seldom speaks except to answer a few questions: Expresses no delusions: Very quiet in behavior: wanders aimlessly about, indifferent to surroundings: Neat about person & clothing: Face almost expressionless, eyes sad. — Dec 20 Trans to B3. Jan 15 1900 Wt 105# Jan 17 No change - Talks quite sensibly when addressed: Has expressed no delusions today Visited by husband & taken home on trial - She told him she was pregnant (examination made by Dr. Bebb - found to be a delusion.) While at home did fairly well: Did not attempt to harm anyone & was kind to children, but would not allow husband to leave house: required close attention as she would go out of doors with insufficient clothing: she also avoided people. Feb 1 1900 Returned Restless & constantly wandering about: will answer when addressed: Appetite good: Bowels regular: Sleeps well: Is depressed: Feb 28 - no change

Mch 1 - Nov 30 1900. Quiet on ward: Appetite fair: Walks up & down ward in an aimless manner: Answers questions readily: July 21 Vaccinated Oct 17. Struck in eye: no permanent injury: Nov 21 Wt. 110. Refuses out door exercise - Dec 26 untidy: very quiet: rarely speaks: Feb 28 1900 Wt 103# Has improved some Mch 5 1900 Converses more freely with nurses: Says she is weak & wants medicine: Very anxious to get well: Mch 25 Very well mentally: Talks rationally & sensibly: General health fair. Must home with husband.

Personal and Medical History of

Personal and Medical History of Mary Mc Namara #2

Whole No. 5443
Residence, St. Paul, Minn.
Date Admission, November 21' 1899.
Admitted by Dr. O.C. Heyerdale hour, 7 P.M.
How Sent, E.W. Bazille & agt. Ramsey Co.
Sex, Female Age, 32 yrs.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Domestic
Degree Education, Common school.
Profession, Religion, Roman catholic.
Habits, Not intemperate.
Nativity, Ireland. (Parents also born there.)
Physicians Committing, A. Macdonald - H.R. Merwick
Correspondents, John Mc Namara #10 Fairfield Ave - St. Paul, Minn.

No. of Year, 73
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing,
Form, Epileptic (Dementia) Insanity
Accompanying Bodily Disorder, Has had epilepsy.
Suicidal or not, Not.
Date of this Attack, Nov. 19' 99.
Duration, 2 days.
No. of Attack, 1st.
No. of Admission, 1st.
Age First Attack, 32 yrs.
Time of Leaving, Aug. 30' 1900.
Time in Hospital, 9 mos. 9 da.
Result, Dischg. Improved Feb 6' 1901.

EXAMINATION ON ADMISSION BY DR. Bebb. Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Slightly confused and sluggish
MEMORY, Past Events, Quite good.
Recent Events, Special Subjects, Impaired
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
rather dull - (not incorrect)
REASONING POWER, Ordinary Subjects, fair
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal.

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

HALLUCINATIONS, now.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Living Had stomach trouble for years.
Maternal Relatives, Mother's brother consumption
3 Brothers and 2 Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, Epileptic Convulsions Dizziness & headache at times says they are growing worse.
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Good Appetite, Variable and Bowels, Regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in PRESENT WEIGHT, 106 lbs. USUAL WEIGHT, NUTRITION, Impaired
WOUNDS, Abnormalities and condition of Skin, Small scar on palm of right hand - Skin cool & moist
TONGUE, Coatings or Promptness of Movement, Slightly coated - protruded promptly.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size & accom - normal.
SIGHT, Good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Impaired - especially in right ear - about 8 yrs. ago discharge from ear -
COORDINATION, Arms, Quite good Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Tibitlary tremor of hands - marked of tongue - of facial muscles - especially around mouth when talking -
PATELLAR REFLEX, Exaggerated - Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, distinct - canadian accent.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, Normal -
HEART, No Murmurs, Strength, Sounds, Size, Fairly strong, N.
Apex Beat, N Regularity, regular



ARTERIES,
Normal

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical -
Expansion fair - Lags on rt. side -
Sounds - fine whistling rales over rt. apex most noticeable on inspiration - Vesc. increased. Rough & harsh especially over apices - Excursion rale hyperresonant.

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,

11/29/99 EXAMINATION URINE, Quantity, ½ xx ℥ Sp. g. 1030 Reaction, acid Color and Appearance, Yellow - Cloudy Flaky sediment.
Albumen, None Sugar, None -
Casts and Crystals, Triple phosphates - Amor. urates & a few epith cells.

GYNECOLOGICAL EXAMINATION, External genitals normal, uterus normal position. Profuse whitish leucorrhoea.
MENSTRUATION, Regular - has headache but otherwise free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 impaired - Says she has lost about 40 lbs. during past five years. Has a frightened, anxious expression & is over anxious to do just what is asked of her. Naturally of a retiring disposition - Becomes very nervous & rather silly when addressed. Is very exact in many of her statements. Apparently always below the average mentally. But has been fading of recent years. Since she has had convulsions. Talks quite sensibly.

Personal and Medical History of Mary McNamara.

1899

This patient was brought here by Sheriffs deputy H. Hanson attended by father & mother, in fair physical condition, with the following history: No history of consanguinity, heredity, nor intemperance in patient nor parents: First symptoms of insanity manifested Sunday Nov. 19' 1899. Disease appears increasing in variable with irregular, rational intervals: Derangement now manifested on religious subjects: Not disposed to injure anyone: No filthy nor destructive habits: No peculiarities previously manifested: Has had epilepsy: No confinement nor restraint employed: No treatment pursued. On personal examination is violent & talks incoherently: On admission put upon Infirmary West (G.H.N. Rpt. Complexion dark: hair & eyes dark brown. skin hot & dry: a few bruises on legs & right arm: So dirty: Nipple of right breast depressed: Has 11 lower & 12 upper teeth: Behavior Rather maniacal: Has delusions.)

Summary 14 da. Record by Dr Bell. T. 98-100° P. 78-88 R. normal. In bed first few days after

Nov 21/99 to Dec 5/99 that up on ward, unoccupied; seemed confused mentally & expressed morbid ideas first few days. (after that improved mentally) Eyes are widely opened & had an inquiring manner & confidential tone of voice, over anxious to please: Usually quiet & agreeable but at times noisy & excited. Has expressed no delusions: Talks sensibly & readily: Neat in habits & appearance: Takes outdoor exercise: Appetite fair, bowels constipated: given laxatives & medicine: sleeps well. Complains of bladder trouble. Dec 4 Trans. to G³. Dec. 15 Trans. to B³. Assists in dining room: Exerts herself to be pleasant & obliging but likes to be alone in her room most of time. Dec. 25 & 29 Had slight convulsions Dec 29 Visited by Sister. Jan 15 M. 124.7 Jan 20 1900 Has improved somewhat mentally & physically: Appetite good: bowels regular: Has largely lost her over-anxious expression & appears quite cheerful & contented: Went home to day on trial (alone) March 2/1900. Friends telegraphed that patient had grown violent & was in jail- Miss Morris went for her bringing her back today.

March Quiet but depressed: converses readily when addressed: Seems to prefer being alone: Appetite good: Trans. to B³. Apr. 6 Had 3 convulsions quite irritable afterward May 31 Very pleasant on ward: Assists with work. July 21. Vaccinated. Aug 25 Slight convulsion. Aug 27. Convulsion - Aug 30 Went home.

Discharged.

Personal and Medical History of

Personal and Medical History of Maria Wahl.

Whole No. 5446
Residence, St. Paul. Minn.
Date Admission, Novymber 25th 1899.
Admitted by Dr. R. A. Bebb. hour, 7 PM.
How Sent, E.W. Bazille & afd. Ramsey Co.
Sex, Female Age, 53 yrs.
Civil Condition, married.
Children, 5
Age Youngest Child, 7 yrs
Occupation, Housewife (Husband Sexton at Cemetary
Degree Education, Common school.
Profession, Religion, Roman Catholic.
Habits, Not int-emperate.
Nativity, Hungaria (Parents also born there)
Physicians Committing, O. Mdahl - & H.R. Minnick.
Correspondents, Joseph Wahl, Sexton - Mt. Lion Cemetery
C.O. address % Or Payne Ave & Minneapolis Ave St. Paul, Minn -

No. of Year, 76.
Insane Relatives, Insanity in family.
Cause Exciting, unknown.
Cause Predisposing, Probably heredity.
Form, Melancholia
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, About one year ago.
Duration, One year ago.
No. of Attack, 2nd
No. of Admission, 1st
Age First Attack, 31 yrs
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Bebb *Date of* 12/5/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused & sluggish apparently -
MEMORY, Past Events, Cannot determine - will not talk -
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Dull - illusive -
REASONING POWER, Ordinary Subjects, Probably impaired
Special Subjects, but will not talk.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Slightly depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Probably has some - expresses none but manner would indicate it.
also at times refuses to talk & eat.
HALLUCINATIONS, Can determine none.
ILLUSIONS, " " "
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Says living Statements not reliable.
Paternal Relatives,
Mother, Says living -
Maternal Relatives,
Brothers and Sisters,
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, Housewife
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5in. PRESENT WEIGHT, 127# USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, (none) dry & cool.
TONGUE, Coatings or Promptness of Movement, Clear & prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - slightly dilated.
SIGHT, apparently good -
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, do
COORDINATION, Arms, fair Legs, fair Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight at times - makes frequent nervous movements of head & hands - especially when spoken to.
PATELLAR REFLEX, Other Reflexes, Exaggerated.
ARTICULATION, Slurred, Hesitating, Slow, normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, No forcible
Apex Beat, Regularity, irregular - rapid -
ARTERIES,
Irregular fulness -
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical - Expansion fair B. sounds normal -



January 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,

11/27/1900 EXAMINATION URINE, Quantity, 3jXX Sp. g. 1032 Reaction, Acid Color and Appearance, Yellow - cloudy - heavy flaky sediment
Albumen, None Sugar, Trace by Haines
Casts and Crystals, Amor. & Ammon. mats, a few epith cells, & ox. of lime crystals. + uric acid crystals & fat droplets.
GYNECOLOGICAL EXAMINATION, Laceration of perinium - external genitals & thurnies Normal - Adhesions posterior to uterus - haemorrhoids.
MENSTRUATION, history unobtainable.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition, Requires laxatives.

Give condensed statement of the 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 quite good - Often appears to understand what is said to her but usually only responds with a silly meaningless smile. Occasionally answers sensibly but statements are not often reliable. Watches movements & conversation of others carefully & often laughs in a silly manner. Seems to be afraid & often suspicious - Appetite has been poor

Personal and Medical History of Maria Wahl.

1899

This patient was brought here by Sheriffs deputy H. Hanson attended by Mrs. Mary Johnson, in fairly good physical condition with the following history: No history of consanguinity, but heredity supposed: No history of intemperance in patient nor parents: First attack occurred July 19'99 - examined in probate Court at this time & discharged: First Symptoms of present attack manifested about a year ago: Has refused to speak since & has illusions: Disease appears increasing: Not variable: Derangement now manifested by refusal to talk, also threatens to injure husband & children: No filthy nor destructive habits: Cousin states that there is insanity in family: No severe diseases nor injuries to head sustained: No confinement nor restraint employed: No treatment pursued: On personal examination refuses to talk & is unconcerned about her surroundings.

11/25/99 On admission put upon Infirmary Unit: (G.Pt. Gen. Pt.) Complexion dark: hair & eyes brown: skin in normal condition: Has small brown mark on right side of chest. Is very dirty: Could not count teeth: Very stubborn & resisted bathing: Refused to speak.)

Summary from Record by Dr Bros. Temp. 99⁴-100⁴. Pulse 78-108. Resp. 20-24. Appetite very poor, at first refused food & was fed by tube once, after that took nourishment fairly well when fed by nurse: Requires laxatives: Sleeps fair after first few nights: Takes outdoor exercise: Is very quiet & rather depressed: seldom speaks: Stands stupidly about ward taking little interest in surroundings: At times smiles & appears to appreciate attention: Neat in habits but indifferent to appearance: Extremely resistive at times. Dec 29 Patient quiet & depressed: Sits stupidly about ward: Seldom speaks: Is indifferent to surroundings: Bowels constipated: Appetite poor: Fed by nurse: Sleeps fairly well: Dec 30 Struck M. Schmider. Fought & had to be secluded.

Jan 13. Wt. 171½ lbs. Feb. 15 No change. March 1 - Aug 31' 1900 (Dr. Linton) Is at times violent: untidy: does not converse readily: Appetite fairly good: Takes outdoor exercise: July 1. Menstruated. July 4 Visited by friends - Sept 1 - Nov 30 Appetite good: Bowels regular: Takes outdoor exercise occasionally: Is stupid: Does not converse: Sits about on ward: untidy in appearance.

Nov 28. Wt. 135 lbs. Dec 1 - Feb 24' 1901 Appetite good: bowels regular: Menstruates readily, Sleeps well: Takes outdoor exercise: Does no work: Stupid Does not converse readily untidy & at times violent March 4 Wt. 132 lbs

May 1 - June 1 - 1901 Patient expectorates; does no work, no change in mental or physical condition. May 31 Wt. 113 #. June to Sept. July 26 fought nurses, does no work, takes out door exercise, does not converse, has to be dressed, Aug. 29 Wt. 173 #. Sept. to Dec. Sept 4 menstruating, Nov. 30 Wt. 141 #.

Personal and Medical History of

Personal and Medical History of Addie Landers.

Whole No. 5448

Residence, Millville, Minn.

Date Admission, November 25th 1899.

Admitted by Dr. O. C. Hazendale hour, 7 PM.

How Sent, M. Kennedy J. of P. Wabasha Co.

Sex, female Age, 37 yrs.

Civil Condition, married.

Children, four.

Age Youngest Child, 5 mos.

Occupation, housekeeper. (husband a laborer)

Degree Education, common school.

Profession, Religion, Methodist

Habits, Not intemperate.

Nativity, Nebraska. (Parents born in Penna.)

Physicians Committing, R. J. Button + Jas. L. Davis.

Correspondents, Frank Landers (Husband) Millville, Minn.

No. of Year, 78

Insane Relatives, brother insane as result of injury.

Cause Exciting, Confinement + menstrual difficulties.

Cause Predisposing, not known.

Form, Melancholia (with great agitation at times)

Accompanying Bodily Disorder, Confinement.

Suicidal or not, Not.

Date of this Attack, Nov. 20 '99.

Duration, 5 days.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 32 yrs.

Time of Leaving,

Time in Hospital,

Result,

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

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
apparently quite clear - not sluggish.

MEMORY, Past Events, Quite good.

Recent Events, do. Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
not dull - fairly correct.

REASONING POWER, Ordinary Subjects, fair.

Special Subjects, poor

Own Mental State, ~~Depressed~~

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Possibly delusions of persecution - Thinks people trace + annoy her + make her cry.

HALLUCINATIONS, } Express none
ILLUSIONS, }

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
No consumption
Father, living well.

Paternal Relatives, no insanity

Mother, Died 11 year ago - was a little nervous.

Maternal Relatives,

6 Brothers and 5 Sisters, 1 bro. in asylum - result of injury, 1 bro. a hard drinker.

4 children well - miscarriage 2 yrs. ago.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had La Grippe 4 yrs. ago. 2-3 yrs. ago some bowel trouble + blood + mucous passed - Pelvic Complications. 7 mos. first baby was born

HABITS, Drinking and Smoking, None.

HEADACHES, VERTIGO, OR CONVULSIONS, In summer always troubled with Headache

OCCUPATION, Healthy or not, housekeeper.

Detail Date, Duration, and Character of Previous Attack, if any,
has had attack for last 4 yrs. of very short duration. - Wanted to commit suicide.

Sleep, Appetite, and Bowels, Constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6½ PRESENT WEIGHT, 156. USUAL WEIGHT, NUTRITION, Very good

WOUNDS, Abnormalities and condition of Skin, Scratch on left limb from barbed wire fence Skin cool. Perspires by hands + feet.

TONGUE, Coatings or Promptness of Movement, Heavy yellowish coating. prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size dilated - responses fair

SIGHT, Good.

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

HEARING, Not very good last six mos. especially left ear.

COORDINATION, Arms, Good Legs, good Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Slight at tongue + face especially, of muscles under right eye. Occasional subconscious movements of limbs.

PATELLAR REFLEX, about normal. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, normal.

HEART, No Murmurs, Strength, Sounds, forcible Size, n.
Apex Beat, Not Regularity, regular.



ARTERIES,
Pulse weak

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,

1/27/99 EXAMINATION URINE, Quantity, ℥ XXXV ¼ Sp. g. 1032 Reaction, acid Color and Appearance, Yellow. clear with flaky deposit.

Albumen, none Sugar, none.

Casts and Crystals, Several oxalate of lime crystals + uric acid crystals. a large amount of epith. cells of all kinds.

GYNECOLOGICAL EXAMINATION, Lac. of perineum - external genitals otherwise normal. Stellate laceration of cervix also hypertrophy of cervix - profuse purulent leucorrhoea, uterus normal position. perineal operation advised

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Quite well.

BOWELS, Present Condition, Constipated

Give condensed statement of the 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). Appears to have a fair degree of intelligence + talks quite sensibly on most subjects - at times is slightly incoherent. Says worried a great deal about unimportant matters + noise of children at home Confused her critically when she had feminine spells with rush of blood to head. Somewhat suspicious of others but usually quite reasonable + will accept explanations. Physical condition quite good. Circulation rather poor. Says has had 'gravel' for 4-5 yrs. Has pain + discomfort over bladder now at times - also pain in back.

Personal and Medical History of Addie Landers.

1899

This patient was brought here by Sheriff Geo. Dickman attended by husband, in fair physical condition, with the following history:- No consanguinity in family one brother insane as result of injury received. First symptoms of insanity manifested by melancholia & violence: Disease appears increasing: Not variable: derangement manifested on subject of religion: Not disposed to injure anyone: No destructive nor filthy habits: No peculiarities previously manifested: ~~Has~~ had puerperal convulsions July 26'90 at birth of first child: No confinement nor restraint employed: No treatment pursued. On personal examination has plethoric expression of lobetude, tongue tremulous & deviates to right: right pupil slightly dilated, pulse 64. On admission put upon Spiramyc. (5th. Rpt. Complexion dark: hair brown: eyes gray: skin in normal condition: Eruption on back: Is clean: 14 upper & 13 lower teeth: Behavior quiet: Talks intelligently.

Nov 25 to Dec 8 99 Summary ~~Nurses~~ record. by Dr Bebb. Nov. 25 - Dec. 8. Temp. 98°-99°. P. 63-90. Resp. normal. Appetite normal. medicine & lavatives given as needed: Bowels constipated usually sleeps well: Takes out door exercise: Has considerable milk in breasts, oil applied & breasts pumped: usually quiet in behavior. Converses quite sensibly: Expresses no delusions now but is depressed & worries about children. Complains some of backache & pain over bladder also painful micturition. Bladder irrigated with Bichl. Sol. 1-1000. Usually unoccupied but at times works on ward. Is neat in habits but rather careless in appearance.

On first night after admission cried & was much depressed. but talked quite sensibly from that time on; was reasonable, kind to others & tried to be patient, ~~but~~ was quiet in behavior & slightly depressed. made peculiar remarks at times. One morning at breakfast asked for paper & pen. said she wished to write something that would save us all. Later sang & muttered to herself & shortly afterward suddenly became extremely excited Called & sang in loud voice that The Lord would save us etc. Ward demon. & expression of eyes glaring & wild. Delusions expressed during disturbed period that followed were principally religious in character - Said that God did not want her to eat - that she was a queen etc.

Dec 15 99. Habits clean but is rather untidy in appearance: Is depressed: Conversation incoherent: Inactive: Appetite fair: Sleeps well: Assists some with ward work.

Jan 3. Seemed to be improving rapidly until today when she became excited & noisy. Jan. 5 Wt. 158 3/4#. Feb. 10 Excited & noisy at times at others quiet & depressed: Very obstinate also indifferent. Conversation incoherent

Feb 28. Appetite good: Stubborn & noisy. Has many delusions: Thinks she is Queen

Personal and Medical History of

Victoria: Bowels regular. Mch 30 1900 Habits clean but is careless in appearance: Sometimes violent: Has many delusions: Does not converse readily: Appetite fairly good: Takes out door exercise: Menstruates regularly: Sleeps well. July 21 Vaccinated. Sept 10. Eats & sleeps well: At times violent. Takes out door exercise: Expresses delusions: Oct 29. General health good. At times quite noisy. Nov 23 Wt. 146#. Dec 28 1901. General health good: Takes gynecological treatments.

Mar. to June 1901 Is very delusional, menstruates regularly, is irrational, May 29 Wt. 148#. June to Sept. Patient remains unchanged in mental or physical condition. Aug. 31 Wt. 145#

Sept. to Dec. General health good, takes out door exercise, is frequently profane in language and very loud, often restless, at times is restless and occasionally threatens violence. Nov. 23 Wt. 142½#.

Dec. to Feb. 1, 1903 No change. Wt. 143#. Visited by a friend on Nov. 3rd & on Aug. 28th.

Personal and Medical History of Amanda Lohse

Whole No. 5449

Residence, Winona Co. Minn.

Date Admission, November 28' 1899.

Admitted by Dr. R. A. Bebb. hour, 10 AM.

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

Sex, female Age, 26 yrs.

Civil Condition, single.

Children, —

Age Youngest Child, —

Occupation, housework (father a laborer.)

Degree Education, public school.

Profession, Religion, Lutheran.

Habits, Not intemperate.

Nativity, Germany (Parents also born there.

Physicians Committing, E. D. Keyes & G. P. Lundy.

Correspondents, (father) Karsten Lohse 567 E. Wabasha St. Winona Minn

No. of Year, 79

Insane Relatives, Henry Lohse brother - here -

Cause Exciting, unknown.

Cause Predisposing, Possibly heredity.

Form, Mel. Ab. with suicidal tendency)

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Threatens it.

Date of this Attack, 3 or 4 wks ago.

Duration, 3-4 wks.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 26 yrs.

Time of Leaving, Sept. 10. 1900

Time in Hospital, 2 m. 12 d.

Result, Discharged Sept. 22, 1900

Returned

EXAMINATION ON ADMISSION BY DR. Bebb Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - not quick & often sluggish.

MEMORY, Past Events, Fair.

Recent Events, Special Subjects,

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, (many) Transitory, Special Subjects,
of persecution. Thinks people do not want her here.

HALLUCINATIONS, Thinks someone is down cellar & runs (at her)

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Living - well.

Maternal Relatives,

2 Brothers and 3 Sisters, Brother here - Epileptic

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Does not seem to remember.

HABITS, Drinking and Smoking, Very little

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches

OCCUPATION, Healthy or not,

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

Sleep, (Poorly) Appetite, (very hard) and Bowels, (Constipated)

To Kill Her.

In the probate court this morning Amanda Lohse, a young lady 26 years of age, was declared of unsound mind and her commitment ordered in the insane asylum at Rochester. While somewhat hysterical in the court room she answered all questions put to her in a perfectly rational manner, but in bringing her to the court-house force had to be used, she contending that some one was going to kill her. It is claimed that a disappointment in a love affair is the cause of it all. The family since her affliction have been compelled to keep a close watch of her, she several times threatening to kill herself, as she believed others would attempt the deed if she did not.—Winona Herald.

Medical History of

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 121 lbs USUAL WEIGHT, NUTRITION, fair

and condition of Skin, Skin warm & dry.

omptness of Movement, prompt - slight coating.

Response to Light, and Accommodation, Equal - size normal - responses fair.

SIGHT,

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Weak - slight inflammation - no serious trouble apparent.

HEARING, Probably not good.

COORDINATION, Arms, fair Legs, fair. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, slight of tongue.

PATELLAR REFLEX, ~~the~~ Unequal - L, increased Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, normal - rather slow. whining.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, normal

HEART, No Murmurs, Strength, Sounds, Normal Size, n

Apex Beat, n Regularity, Regular.

ARTERIES,
Normal.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical - Expansion good
R. 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. 1035 Reaction, Acid Color and Appearance, Yellow - cloudy & pink flaky deposit. 12/5/99

Albumen, none Sugar, none -

Casts and Crystals, Amor. urates. a few Epith. cells & oxalate of lime crystals a few fat droplets.

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact. Slight retroversion of uterus. mild leucorrhoel discharge.

MENSTRUATION, Says pain in back when Menstruating (some part of period) regular - subject to headache. flows about two days - since admission to hospital has not menstruated, previous to this time flowed every three weeks.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 full of delusions - frightened, distressed expression. So often afraid & suspicious. Has startled, nervous, timid manner. Voice whining. answers many questions promptly & accurately. Often bursts out crying at same time expecting some imaginary wrong or injury. Thinks she is going to be murdered. That she hears people down cellar who are going to cause trouble - Physical condition fair.

Personal and Medical History of Amanda Lohse

Whole No. 5449

Residence, Winona Co. Minn.

Date Admission, November 28' 1899.

Admitted by Dr. R. A. Bebb. hour, 10 AM.

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

Sex, female Age, 26 yrs.

Civil Condition, single.

Children, —

Age Youngest Child, —

Occupation, housework (father a laborer.)

Degree Education, public school.

Profession, Religion, Lutheran.

Habits, Not intemperate.

Nativity, Germany (Parents also born there.

Physicians Committing, E.D. Keyes & G.F. Lundy.

Correspondents, (father) Karsten Lohse 567 E. Wabasha St. Winona Minn

No. of Year, 79

Insane Relatives, Henry Lohse brother - when he could find somebody to

Cause Exciting, unknown.

Cause Predisposing, Possibly Senility.

Form, Mel. Ag. with suicidal tendency

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Threatens it.

Date of this Attack, 3 or 4 wks ago.

Duration, 3-4 wks.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 26 yrs.

Time of Leaving, Dec. 10. 1900

Time in Hospital, 2 m- 12 d-

Result, Discharged Dept. 22 1900

Recovered

looked quite as young as ourselves. Mrs. Lohse mother-in-law had ... Mrs. Lohse ... making herself up as ... This mother-in-law had ... was very rosy and ... head to pass for a ... could do it at a distance. ... She was a distinct ... Tim and made it quite as ... mother-in-law are apt ... Tim as mother-in-law ... suspected that Tim was ... other ladies that he was ... Her surmises had already awakened ... jealousy of her daughter, and ... had been so warm at his house ... late as their former's did. ... himself on as a single man, and ... yearned to prove it. ... But Tim was a persevering cuss, and ... whenever he felt himself at a safe distance from home he would unbend him- ... self and be happy, for happy he was ... when he could find somebody to flirt ...

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 4½ in. PRESENT WEIGHT, 121 lbs. USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, Skin warm & dry.

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

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

SIGHT, Good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Weak - slight inflammation - no serious trouble apparent.

HEARING, Probably not good.

COORDINATION, Arms, fair Legs, fair. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, slight of tongue.

PATELLAR REFLEX, ~~Okay~~ Unequal - L, increased Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, normal - rather slow. whining.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, normal

HEART, No Murmurs, Strength, Sounds, Normal Size, N

Apex Beat, N Regularity, Regular.

ARTERIES, Normal.

LUNGS, Chest, Symmetry, Expansion, Breath Sounds, Chest symmetrical - Expansion good R. 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. 1035 Reaction, Acid Color and Appearance, yellow - cloudy & pink flaky deposit. 12/5/99

Albumen, none Sugar, none -

Casts and Crystals, Amor. urates. a few Epith. cells & occasional of lime crystals a few fat droplets.

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen intact. Slight retroversion of uterus. mild leucorrhoal discharge.

MENSTRUATION, says pain in back & lower part of pelvis when Menstruating: regular - subject to headache. flows about ~~two~~ days - since admission to hospital has not menstruated, previous to this time flowed every three weeks.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 full of delusions - frightened, distressed expression. Is often afraid & suspicious. Has startled, nervous, timid manner. Voice whining. Answers many questions promptly & accurately. Often bursts out crying at same time expecting some imaginary wrong or injury. Thinks she is going to be murdered. That she hears people down cellar who are going to cause trouble - Physical condition fair.

EXAMINATION ON ADMISSION BY DR. Bebb Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Confused - not quick & often sluggish.

MEMORY, Past Events, Fair.

Recent Events, Special Subjects,

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, ~~Many~~ Transitory, Special Subjects, of persecution. Thinks people do not want her here.

HALLUCINATIONS, Thinks someone is down cellar & swears (at her)

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Living - well.

Maternal Relatives,

2 Brothers and 3 Sisters, Brother here - Epileptic

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Does not seem to remember.

HABITS, Drinking and Smoking, Very little

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches

OCCUPATION, Healthy or not,

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

Sleep, Poor (Appetite, Poor and Bowels, Constipated

Personal and Medical History of Amanda Lohse.

1899.

This patient was brought here by Sheriff A.W. Fuhrmann, attended by sister Lizzie Lohse, in fair physical condition, with the following history:- No history of consanguinity nor of intemperance in patient nor parents brother insane & confined here: First symptoms of insanity manifested three or four weeks ago by fear of personal injury: Disease appears increasing: is variable, patient being more rational during day: Derangement now manifested by fear of being killed & desire to kill herself before others do it: has never, however, attempted suicide: No filthy nor destructive habits: No previous peculiarities manifested: No severe diseases nor injuries to head sustained: Has recently been kept at home & has been given sedatives. On personal examination looks & feels pretty well, answers questions imperfectly & shows mental instability.

11/28/99 On admission put upon Infirmary (Gtt. Rpt) Complexion fair: hair light: eyes blue: Condition of skin normal: Is clean: Has few upper & twelve lower teeth: Is noisy & resisted when being Taken to Ward: Talks intelligently.)

Summary 14 da record by Dr. Bebb. Nov 28 - Dec. 11. Temp. 1st week. 98°-100°. Pulse 90-110. Resp 20-32, Bowels regular with laxative. Appetite fair: Sometimes refuses food & is usually fed by nurse. Receives medicine: During first few days very restless & nervous, starting up at least sound, necessary to keep her in restraint part of time in order to keep her in bed: much depressed: cried a great deal & slept very little for one or two nights: expressed delusions freely & had hallucinations. She frequently spoke of hearing fiends in hall & listened for them. Appeared bewildered & in constant fear that something would happen. After first few days able to be up & much quieter in manner: Very depressed, unoccupied & not interested in work. Dec. 6 Temp. pulse & resp. about normal. To day attempted to elope while out walking: During this time manner confused & anxious, speech hesitating & incoherent: answered questions fairly sensibly after a little thought but appeared absent-minded mind easily wandering from subject under discussion. While pleasantly conversing would stop & cry at times expressing her delusions. Gradually became less depressed altho still melancholy. Took outdoor exercise: assisted a little with dining room work: eats in habits,

Dec. 11 99 - Feb 11 1900. Appetite improved: slept better: gained in weight: Jan 5/1900 127 lbs. Altho less melancholy her suicidal impulses manifested at times. Jan 6 While out walking attempted to throw herself under wheels of a passing wagon a few days later also attempted to jump down dumb-waiter shaft.

Personal and Medical History of Amanda Lohse.

During January she improved mentally & physically, gradually ceased to express her delusions, became less restless & lost her timid frightened manner. usually quite cheerful & only occasionally depressed; was friendly & sociable with other patients & conversed freely. Neat in habits & appearance, & assisted with work.

Feb. 10/900. Sister & husband came for her & took her home on trial.

Discharged

(Married & living in Rochester) Sister writes May 24 1900. that patient was entirely cured when taken home.

Personal and Medical History of Mary Prosil.

Whole No. 5453
Residence, Winona Co, Minn.
Date Admission, December 1st 1899.
Admitted by Dr. O.C. Heyerdale hour, 5 P.M.
How Sent, H.L Buck Sh.ff Winona Co.
Sex, Female Age, 24 yrs.
Civil Condition, single
Children, —
Age Youngest Child, —
Occupation, Housework (Father a laborer)
Degree Education, reads & writes.
Profession, Religion, Catholic.
Habits, not intemperate.
Nativity, Germany. (Parents also born there)
Physicians Committing, C.P. Rossius & L.G. Wilburton)
Correspondents, Jacob Prosil (father) 153 E. King St. Winona Minn.

No. of Year, 83
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, "
Form, Acute Mania
Accompanying Bodily Disorder, none mentioned,
Suicidal or not, not.
Date of this Attack, 9 days ago.
Duration, 9 days.
No. of Attack, 2nd
No. of Admission, 2nd
Age First Attack, 19 yrs.
Time of Leaving, Apr. 21. 1900
Time in Hospital, 4 mo. 20 d.
Result, Discharged Nov. 7. 1900. Improved

EXAMINATION ON ADMISSION BY DR. Bebb *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick but confused.
MEMORY, Past Events, Impaired
Recent Events, do. Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert, illusive.
REASONING POWER, Ordinary Subjects, Impaired.
Special Subjects, Imp.
Own Mental State, Delirious.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Ideas confused & incoherent.

HALLUCINATIONS, None determined
ILLUSIONS, " "

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, History not obtainable
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, Not Taken PRESENT WEIGHT, Not Taken USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, Right eye part brown, part gray. Left gray.
TONGUE, Coatings or Promptness of Movement, prompt. dry brown coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, equal. normal.
SIGHT, apparently good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, No trouble — Peculiarity above mentioned.
HEARING, Good.
COORDINATION, Arms, too disturbed to try Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, none.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, no Murmurs, Strength, Sounds, normal Size,
Apex Beat, Regularity, Regular, rapid.
ARTERIES,



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,

12/29/99 EXAMINATION URINE, Quantity, Sp. g. 1028 Reaction, acid Color and Appearance, Yellow,
Albumen, none Sugar, Trace by Fehlings & Bromine
Casts and Crystals, Amor. urates. a few fat droplets, epith. cells & oxalate of lime crystals

GYNECOLOGICAL EXAMINATION, External genitals normal. hymen intact. uterus normal position. Slight hypertrophy of labia minora.
MENSTRUATION, history cannot be obtained.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, much disturbed.
BOWELS, Present Condition, Constipated.

Give condensed statement of the 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). Very noisy. restless - incoherent. tosses head about restlessly. Often resists & tries to bite when anything is done for her. Has rise of temp. rapid pulse & general health is impaired. Is very incoherent in all remarks. Rarely pays any attention when spoken to.

Personal and Medical History of Mary Prowell.

1899.

This patient was brought here by Sheriff A.W. Fuhrmann, attended by Jacob Prowell in good physical condition, with the following history. No consanguinity, heredity nor intemperance in patient nor parents. First attack of insanity occurred in May 1894 & patient was sent from May 1'94 to Augt 8'94 (Rec Vol. H Fol. 109 No. 3713) First symptoms of insanity manifested nine days ago; became incoherent, sang, was in an acute exalted state. Disease appears increasing not variable. Derangement now manifested as above stated. Not disposed to injure anyone. Is destructive of clothing. No peculiarities previously shown. 15 years ago had typhoid which impaired his hearing. Has taken nerve sedatives, no result. On personal examination is greatly excited, incoherent singing. On admission put upon Infirmary. (Gen. Rpt. Complexion fair, hair light, eyes gray, skin hot & dry; No marks scars nor bruises. Is dirty. Has 16 upper & 14 lower teeth. Is maniacal & refused to walk. Is incoherent.)

Dec 14'99 to Dec 18'99 Summary 14 da record by Dr Bliss. Temp. 99³-102⁴. Pulse 88-108 Resp. 18-34. Face always flushed. Appetite impaired & generally necessary to feed her mechanically. Frequent laxatives given. Rest much disturbed in spite of hot baths at bedtime & frequent hypnotics. Extremely restless, noisy & destructive & kept in protection sheet greater part of time. Much confused mentally. Manner maniacal, emotions usually exalted; very talkative; rambling as in a meaningless jargon. Usually laughing & cheerful with eyes dancing with fun but when opposed irritable, angry & even violent. Incoherent & has definite delusions expressed.

Dec. 15 to Jan 18/1900 Little change to note, but temp. a little lower, slept better & not so constantly noisy & excited. Lavage of stomach continued for some days. Feeding by tube discontinued Jan. 6'1900 Jan 12 Taken out for walk, next day asked to be taken out again. This brings the about the only sensible remark which she has made. Jan 5 Wt. 116½#

Jan 30'1900 Still fed by tube. Feb 7 Becoming more quiet. Still untidy & destructive. Appetite good. Sleeps well. Feb 28 Very changeable, at times quiet at others noisy & destructive of clothing. Tidy in habits. Talks a great deal, in germany. Has many delusions. Eats & sleeps well. Fed on tray. Assists with ward work. Bowels regular.

March-Apr 21. 1900 Neat & clean. assists with work. Appetite good. Bowels regular. very agreeable & pleasant. Apr 21. Went home.

Letter received from patient July 23'1900. She states she is doing fairly well but is not entirely recovered.

Discharged.

Personal and Medical History of

Personal and Medical History of Emma D. Streich.

Whole No. 5454

Residence, Wabasha Co. Minn

Date Admission, December 1 1899

Admitted by Dr. A.F. Kilbourne hour, 5 P.M.

How Sent, M. Kennedy & Asst. Wabasha Co.

Sex, Female Age, 20 yrs.

Civil Condition, married

Children, none living (one born 2 mos. ago. died 2 wks.)

Age Youngest Child, -

Occupation, Housework (Husband a farmer)

Degree Education, Common school.

Profession, Religion, Lutheran.

Habits, Temperate.

Nativity, Wisconsin (Parents born in Germany)

Physicians Committing, Dr. Claydon & Dr. Kirkpatrick.

Correspondents, Herman Streich (husband) Hammond, Minn. (Telephone to So. Troy)

No. of Year, 82

Insane Relatives, "Softening of Brain before death of patients Mother"

Cause Exciting, Labor & puerperal infection.

Cause Predisposing, probably heredity.

Form, Puerperal Ins.

Accompanying Bodily Disorder, Puerperal infection recently.

Suicidal or not, Attempted by poisoning & hanging.

Date of this Attack, 2 mos. ago.

Duration, 2 mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 20 yrs.

Time of Leaving, Feb. 22 1900

Time in Hospital, 2 mo. 21 d.

Result, Discharged Aug. 8. 1900 Improved

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

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear - quick

MEMORY, Past Events, quite good

Recent Events, " Special Subjects, Not very good

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Clear & fairly correct.

REASONING POWER, Ordinary Subjects, quite good.

Special Subjects, " "

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none -

HALLUCINATIONS, Hears baby cry. (at onset - not now.)

ILLUSIONS, None determined.

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

HISTORICAL.

LENGTH INVASION, Recent

ONSET, Gradual or Sudden, Sudden -

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

Father, living

Paternal Relatives,

Mother, died 2 yrs ago - Ill 7 yrs.

Maternal Relatives,

Brothers and Sisters, living 2 normal 1 child dead. brothers dead 1 bro. foolish

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Pleurisy 2 mos after confinement during yrs 4-5 yrs ago - Struck on head by stroke - could scarcely walk. Also fell & hit on back of head - sick a long time.

HABITS, Drinking and Smoking, No

HEADACHES, VERTIGO, OR CONVULSIONS, Severe headaches & vertigo.

OCCUPATION, Healthy or not,

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

Sleep, Appetite, and Bowels, normal good

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1 PRESENT WEIGHT, 117 lbs. USUAL WEIGHT, NUTRITION, Good -

WOUNDS, Abnormalities and condition of Skin, Scar above R. breast where abscess was lanced. Left ear injured - born once by foolish brother - many years. Set on stove

TONGUE, Coatings or Promptness of Movement, no coating - prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - somewhat dilated - responses good -

SIGHT, Good until this illness - Weak now - tire easily

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

HEARING, good

COORDINATION, Arms, good - Legs, do Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, slight

PATELLAR REFLEX, diminished Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, normal -

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, No Full N

Apex Beat, Regularity, Regular

ARTERIES,
Normal.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical
Expansion impaired
Dulness shallow on right side
Effusion over base left lung. also friction sounds.



Taken 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,

12/4/900 EXAMINATION URINE, Quantity, Sp. g. 3 XXXIV Reaction, alkaline Color and Appearance, Yellow cloudy White flaky deposit

Albumen, none Sugar, Trace (+) by Bismuth.

Casts and Crystals, Amor. urates a few oxalate of lime crystals - & pus corpuscles - Epithelial cells of all kinds -

GYNECOLOGICAL EXAMINATION, Extensive laceration of perineum also lateral laceration of cervix. Slight erosion of cervix. Leucorrhoeal discharge, profuse & offensive. A few adhesions anteriorly to left of uterus & normal position

MENSTRUATION, Regular. Sometime has pain over ovarian region. History of septicaemia following recent confinement.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Usually sleeps well.

BOWELS, Present Condition, Constipated

Give condensed statement of the 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). Talks very sensibly - says memory is failing - that ever before she was taken sick she forgot easily. Complains of stiffness & pain in knees - Had pleurisy 2 mos. after confinement & has not fully recovered yet. Considerable pain in lungs still. At first effusion in R. now in L. lung. Was confined 2 mos. previous to admission. Abnormal presentation & child taken with instruments. One arm of child fractured. Also a sore on head which spread over head & neck - child died. Acute melancholia followed puerperium - Suicidal impulses prominent. From hist. would judge that she was somewhat defective and unstable previous to severe acute attack.

Personal and Medical History of Emma D. Strick.

1899

This patient was brought here by sheriff Strickman attended by husband in poor physical condition with the following history. No consanguinity, mother insane (?) First symptoms of insanity manifested by during labor by opisthotonos, great excitement, crying loudly: Disease appears increasing. Is variable: rational durring day: Derangement now manifested by delusions of persecution, Suicidal tendencies and emotional excitement. Not disposed to injure anyone. Suicide attempted by poisoning & hanging: No filthy nor destructive habits. Previously had a violent temper: Father intemperate: Patient had puerperal infection: Has been given nerve sedatives & tonics. On personal examination at first seemed to improve after labor, but lately has been growing worse. On admission put upon Infirmary. (Gen. Hospt. Complexion dark: eyes brown: hair black: No marks, scars nor bruises: Is clean: Has 14 upper & 14 lower teeth: Behavior quiet: Talks intelligently)

Dec 1 to Dec 16 Summary 14 da. Record Dr Bebb. Dec 1-14 99 Given bath & put to bed on admission: Temp. 98° - 99°. Pulse 70-100 Resp. 16-27. Appetite usually good: Bowels regular: usually remains quiet during day, sometimes sleeps so much disturbed but usually good with occasional hypnotic. Dec 3-7 Complained of pain in side & chest. Flax-seed poultices applied: Dec 9 very restless & cried for hours: Dec 10 & 13. Visited by husband: & sister Usually pleasant & Converses quite sensibly but is inclined to be quite hysterical & melancholy at times

Dec 16 Visited by husband. Jan 9 untidy in habits at times: cheerful but very sulky & fault finding: Lounges about: Is inactive: Appetite good: Bowels constipated: Sleeps well: Feb 3-6 Visited by husband: Cried for some hours after he left. Feb 19 visited by relatives. Cheerful & pleasant Does some work: Talks very intelligently: Very anxious to go home. Seems almost fully recovered. Feb 22 Taken home by husband.

Discharged

Letter received from husband July 26 1900. States patient was "queer" for two months after leaving hospital, after that recovered.

Personal and Medical History of

Personal and Medical History of Emma Loos.

Whole No. 5466
Residence, Olmsted Co, Minn.
Date Admission, December 14th 1899.
Admitted by Dr. O. C. Hazendale hour, 1 P.M.
How Sent, J. A. Leonard Jap P Olmsted Co.
Sex, female Age, 32 yrs.
Civil Condition, married.
Children, Three.
Age Youngest Child, Two years.
Occupation, Housewife (Husband a farmer)
Degree Education, usual
Profession, Religion, Lutheran.
Habits, Not intemperate.
Nativity, Minn (Olmsted Co) (Parents born in Germany)
Physicians Committing, C. Graham + C. J. Granger.
Correspondents, Husband – (near Chatfield.)

No. of Year, 96
Insane Relatives, None.
Cause Exciting, unknown.
Cause Predisposing, unknown.
Form, Mild Melancholia (with some confusion + neurasthenia)
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, 32 yrs.
Time of Leaving, January 9 – 1902
Time in Hospital, 2 yrs 1 mo 26 ds
Result, Improved. Disch. Jan 15. 1902
By Bd. C

EXAMINATION ON ADMISSION BY DR. Bebb. Date of 12/15/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Occasionally confused but usually clear - quick.
MEMORY, Past Events, seems quite good.
Recent Events, " Special Subjects, —
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,
About normal - Depressed -

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none unless ideas about husband + his brothers are delusions.
HALLUCINATIONS, None apparent.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
Says none
Father, Living + well - very strong
Paternal Relatives,
Mother, Died 13 yrs. ago. Had kidney trouble 3 yrs.
Maternal Relatives,
1 Half brothers + 2 half sisters
2 Brothers and Sisters,
3 children
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says passed blood from kidneys + womb 3 yrs ago - Had suppression of urine + gums were much swollen at same time.
HABITS, Drinking and Smoking, Drinks beer + whiskey
HEADACHES, VERTIGO, OR CONVULSIONS, Headache + dizziness Had convulsions when young.
OCCUPATION, Healthy or not, Housekeeper,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Good

Personal and Medical History of Emma Loos.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 10 PRESENT WEIGHT, 172 USUAL WEIGHT, NUTRITION, Good
WOUNDS, Abnormalities and condition of Skin, Skin about normal - gums pale -
TONGUE, Coatings or Promptness of Movement, White coating - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - somewhat dilated - response normal -
SIGHT, Says she does not see very well. Says right eye troubles her some.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Much impaired - especially in left ear.
COORDINATION, Arms, quite good Legs, fair. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, none -
PATELLAR REFLEX, Diminished, especially in right limb. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, About normal - foreign accent.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, Normal.
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity, Regular.



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,
Dec 7/99 Dymmetrical
Expansion fair.
B sounds normal - Broncho-Vesicular
EXAMINATION URINE, Quantity (1) ~~3 xxxx~~ (2) none Sp. g. (1) 1020 (2) 1010 Reaction, (1) alkaline (2) acid Color and Appearance, (1) yellow cloudy heavy white flaky deposit (2) yellow cloudy white flaky deposit
Dec 7/99 Albumen, Sugar,
Dec 12/99 Casts and Crystals, (1) Amor. urates - Triple phosphates, all kinds of epith + a few blood corpuscles (2) Excessive amt. all kinds of epith + many overlapping - oxalate of (2) Lime crystals + a few fat droplets.
GYNECOLOGICAL EXAMINATION, External genitals normal aside from laceration of perineum - extensive laceration of cervix. Leucorrhea: uterus retroflexed
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Not very good – slept very little last night.
BOWELS, Present Condition, Constipated

Give condensed statement of the 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 worked too hard - Says felt weak + sick + husband was so unkind to her it frightened her. Thinks husband + his brothers are all against her + have placed her here. Says with pain + headaches if she talks too much. No positive delusions apparent at present. Says is very nervous + easily frightened. Physical condition quite good. From account of neighbors we learn that husband drinks heavily + has been abusive + she has been so afraid of him at times that she was almost desperate. Is rather nervous - slightly confused + rather forgetful.

Personal and Medical History of Emma Laas.

1899

This patient was brought here by Sheriff Vine attended by Mrs. Vine, in fair physical condition, with the following history: No consanguinity, heredity nor intemperance in patient nor her parents: First symptoms of insanity manifested two years ago: Disease appears increasing: Nat variable: Derangement was manifested by delusions of persecution & confusion of mind: Is disposed to do harm to others: No filthy nor destructive habits: No peculiarities previously manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: Has been given sedatives. On personal examination is very excitable: Has delusions in regard to her people. On admission put upon Infirmary. Gen. Rpt. Complexion dark: hair light brown: Eyes gray: Skin in normal condition: No marks nor scars: Small bruise on left knee: Is rather dirty: Has 13 upper & 13 lower teeth: Is deaf in right ear: Behavior quiet: Has delusions.

Summary 1st day record Dr Bebb. Dec. 14-27.99. Temp. 98°-99°. Pulse 78-96. Resp normal. Appetite fair: bowels rather constipated usually regulated with laxatives. Medicine given: After first three nights slept quite well. Complains frequently of headache & pain in various parts of body: Talks quite sensibly in a whining, fault finding tone. Expresses no delusions at this time; is much depressed: Cries & worries a great deal about her children. Is usually quiet but restless at times. After first four days able to be up- complains of not being well & frequently lies down. Dec. 16 Remote. Dec. 18 Visited by relatives. Seems to dwell constantly on her own feelings, complaining daily of pains, shifting from place to place.

Mch 1- May 26, 1900. Mch 9 Visited by husband: Is Has improved some mentally: is more agreeable. Occasionally scolds: Is hypochondriacal & complains of pains & aches. Mch 29. Trans. to D^3. May 5 Visited by relatives: May 24 Visited by husband. Works regularly in dining room & laundry. May 26 Visited by husband & taken home.

June 1st. - Nov 30th 1900. Patient very quiet: Appetite good: General health good. Trans. to D^1. June 15 Trans. to D^3. June 16 Attempted to escape: Broke windows & violent during night Trans. to C^2, & on June 18 to B^3. July 21 Vaccinated More agreeable. Aug 13 Suffering from ulcerated roots of teeth, a number extracted. Nov 24 Wt 180 lbs. Neat: appetite good: Assists with work: Converses readily: Complains occasionally of pain in side Dec. 1- Feb 28 1901 Feb 28th Wt 189. General health good: assists daily with work. Takes gynaecological treatments. Mar. to June 1901 No change in general condition, Apr 30 Wt 183

June to Sept. June 13 visited by niece and friends, July 9 by husband, neat in habits and appearance, fairly agreeable, assists with ward work, takes out.

Personal and Medical History of Emma Laas.

June to Sept. 1901 door exercise. May 29 Wt. 196#. Sept. to Dec. Patient is hypochrondriacal, frequently complains of being sick, No change in general condition, Nov. 30 Wt 191½#, Dec. to Mar 1902 Dec. 30 visited by husband. Jan. 9 general health good, is agreeable, assists with ward work very much improved. Went home with husband Jan. 9-1902.

Personal and Medical History of Fannie Kusig.

Whole No. 5467
Residence, London Tp. Freeborn Co. Minn.
Date Admission, December 15' 1899.
Admitted by Dr. R. A. Bebb hour,
How Sent, H. Blackmer P.M. Freeborn Co. Minn.
Sex, Female Age, 32 yrs.
Civil Condition, married.
Children, Three.
Age Youngest Child, 2 yrs.
Occupation, Housewife - (husband a farmer)
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
Nativity, Bohemia - (Parents also born there.)
Physicians Committing, G.G. Belscheim & Geo. Barck.
Correspondents, Frank Kusig Myrtle P.O. Freeborn Co. Minn. (Husband)
Telegraph station Glenville

No. of Year, 97
Insane Relatives, None
Cause Exciting, unknown.
Cause Predisposing, Previous attack.
Form, Melancholia
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Attempted by jumping in river.
Date of this Attack, ?
Duration, ?
No. of Attack, 2nd
No. of Admission, 1st
Age First Attack, 31 yrs.
Time of Leaving, May 2. 1900
Time in Hospital, 4 mo. 17 d
Result, Disc. Nov. 7. 1900 Improved

EXAMINATION ON ADMISSION BY DR. R.A. Bebb Date of Dec 15 99.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - sluggish.
MEMORY, Past Events, Impaired.
Recent Events, fair but some imp. Special Subjects, Imp.
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Rather dull.
REASONING POWER, Ordinary Subjects, Fair.
Special Subjects, "
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Somewhat depressed -
DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express definite delusions at this time.
HALLUCINATIONS, Cannot determine
ILLUSIONS, "
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
Statements unreliable.
Father, Dead - 5-6 yrs.
Paternal Relatives,
Mother, living
Maternal Relatives,
3 Brothers and Sisters, 2 Brothers dead.
3 Children
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Husband thinks not.
HABITS, Drinking and Smoking, no
HEADACHES, VERTIGO, OR CONVULSIONS, no.
OCCUPATION, Healthy or not, Housekeeper.
Detail Date, Duration, and Character of Previous Attack, if any.
Sleep, Appetite, and Bowels, regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. 1. PRESENT WEIGHT, 110# USUAL WEIGHT, NUTRITION, Impaired.
WOUNDS, Abnormalities and condition of Skin, Goitre - left nipple depressed. Skin blotchy & flabby.
TONGUE, Coatings or Promptness of Movement, Quite prompt & clean.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size somewhat dilated - responses fair
SIGHT, Says good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, says good.
COORDINATION, Arms, Quite good Legs, Quite good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Very slight of hands.
PATELLAR REFLEX, diminished - especially right - Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Somewhat slurred
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, About normal.
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,
EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Laceration of perineum, external genitals otherwise normal. Hyperaemia & laceration of cervix - uterus retroflexed. Slight purulent discharge.
MENSTRUATION, Says cessation for nearly 2 yrs.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Quite good
BOWELS, Present Condition, Slightly constipated

Give condensed statement of the 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). Commencing goitre - Principal central Abscess (?) forming in left buttock - probably in rectal fossa. Says her brother (Rev. John Mikel) during last year she has been rather nervous - worries because her boy is not a Christian - Sometimes answers questions clearly & promptly but wanders from subject at times & is quite incoherent - Does not understand English well & part of her confusion may be due to this - But manner & some remarks would indicate that she has delusions & is somewhat depressed - General nutrition impaired.

Personal and Medical History of Fannie Krug

1899

This patient was brought here by Sheriff W.C. Mitchell attended by Frank Krug in fair physical condition with the following history: No history of consanguinity heredity nor intemperance manifested. First attack occurred about one year ago, was absent-minded with tendency to suicide; lasted about three mths. Disease now appears increasing, is variable: Derangement now manifested by hallucinations, thinks mind is carrying her away: Tried to burn some clothes on floor: Threatens suicide: Not disposed to injure anyone: Last November attempted suicide by jumping in well: No filthy nor destructive habits: no peculiarities previously manifested: No severe disease nor injury to head: No confinement nor restraint employed: No treatment pursued: On personal examination has impression someone is pursuing her; that there is something wrong with her own mind & therefore pitches her children. On admission put upon Infirmary Wrt. (Strabt. Complexion dark: hair brown: eyes blue: condition of skin normal: Abscess on left buttock: Is dirty: Left nipple depressed. Has eight upper & nine lower Teeth. Behavior quiet: Answers questions intelligently.)

12/15/99

Summary 14 day record by Dr Bebb. Temp. 98°-99°. Pulse 59-96. usually subnormal Resp. normal. Appetite fair: Bowels inclined to be constipated: requires occasional laxatives: Usually sleeps quite well: Usually quiet but restless & very nervous at times: quite melancholy & cries often: assists a little with ward work. Has a timid confused manner: Appears to dread being left alone: follows others about ward; often talking incoherently in a low voice, apparently asking for something. Talks Bohemian & cannot understand much English.

Mch 1 - Apr 27 1900. General health good. Takes out door exercise: Is stubborn: Unable to talk much English. Mch 27. Visited by husband. Apr 27 Very neat in habits. Appetite fair: quiet & agreeable: Trans. to A3 on Apr 26. on 27. Visited by friends. May 1 Went home.

Discharged

Letter received Nov 8 1900. Says patient is about as when she left Hospital. Is doing her housework.

Personal and Medical History of

Personal and Medical History of Gertrude A. Doran

Whole No. 5471
Residence, Washington Co. Minn.
Date Admission, December 20th 1899.
Admitted by Dr A. F. Kilbourne hour, 7 P.M.
How Sent, F. T. Wilson Supt. Washington Co.
Sex, Female Age, 28
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, None (Father a boiler-maker)
Degree Education, High school.
Profession, Religion, Catholic.
Habits, Not intemperate.
Nativity, Wisconsin (Parents born in Ireland)
Physicians Committing, W.H. Pratt + A.G. Clark.
Correspondents, Mrs H.E. Thompson (sister) 411 No. 4th St. Stillwater, Minn.

No. of Year, 101
Insane Relatives, Unknown - Mrs Maternal uncle
Cause Exciting, Unknown unless uterine derangement.
Cause Predisposing, Probably heredity.
Form, Suicidal (High grade) (?)
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, 2nd
Age First Attack, 25 yrs old.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Babb *Date of* 12/29/99

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Somewhat confused + sluggish.
MEMORY, Past Events, Fair - not always reliable
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive. Impaired. Rather dull
REASONING POWER, Ordinary Subjects, Impaired.
Special Subjects, "
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Indifferent
DELUSIONS, Systematized, Transitory, Special Subjects, Probably has delusions but does not express them at this time. Power of attention impaired - Slow - dull. Decided loss of will power.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, Long.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Dead - Thinks had Catarrh of abt 70 yrs of
Paternal Relatives,
Mother, Living - healthy.
Maternal Relatives,
3 Brothers and/ Sisters, 1 bro. has lung trouble.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says had whooping cough (severe) at 7
Says had diphtheria at 3-4 yrs. Large abscess on L. side face which was opened on forehead. Catarrh of bowels last fall.
HABITS, Drinking and Smoking, No.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Assisting home with work at home. also canvassing a little.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, usually good / usually good / Constipation

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3 PRESENT WEIGHT, 109. USUAL WEIGHT, NUTRITION, Fair but Anaemic
WOUNDS, Abnormalities and condition of Skin, Small scar on forehead + chin result of abscess - Skin warm, moist + waxy
TONGUE, Coatings or Promptness of Movement, Slight hesitation in protruding. Clear.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal. responds light slow.
SIGHT, Quite good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Eyelids painful + swollen at times.
HEARING, Good.
COORDINATION, Arms, Quite good Legs, fair. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands - tongue tremulous - Slight nervous twitching of facial muscles -
PATELLAR REFLEX, diminished. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Slurred - hesitating - slow.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, Size, Normal at apex sounds slightly muffled at base.
Apex Beat, Regularity, Regular
ARTERIES, Regular - normal.
LUNGS, Chest, Symmetry, Expansion, Breath Sounds,
Chest symmetrical. Expansion limited - especially on R. side. B. sounds shallow. Percussion dullness at apices. Hyperresonant elsewhere - Tremitus diminished especially on L. side.



Jan. 1900.

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 - Hymen intact but lax - uterus retroflexed. Erosion of os: Milky leucorrhoeal discharge:
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Fairly good
BOWELS, Present Condition, Constipated.

Give condensed statement of the 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 attended school until 1890; was in 3rd yr. High School when 1st class before entering highschool - found work there more difficult. Had severe attack whooping cough at 7 yrs. Pronounced of marmoreum especially prominent on left side about 5th rib. Left shoulder higher + shorter than right. Spine slightly curved to R. Had abscess on buttock 5 or 6 yrs ago. Manner timid. Speech slow + hesitating + expresses herself with difficulty - Is decidedly feeble minded +

Personal and Medical History of Gertrude A. Doran.

1899.

This patient was brought here by Sheriff's deputy F.E. Thompson attended by Mrs. Thompson in his physical condition, with the following history:- No consanguinity: History of heredity unknown: No intemperance in patient nor in parents: First symptoms of insanity manifested three yrs. ago and patient was here from Dec. 24 96 to Nov. 16 97 when she was discharged unimproved - under Peterson law - (Rec Vol. 50. Fol. 73 No. 4623) Disease appears increasing: Not variable: Derangement manifested on all subjects: Not disposed to injure anyone: No filthy habits, breaks windows: No peculiarities previously manifested: No severe diseases nor injuries to head. No confinement nor restraint employed: On personal examination admits need of treatment but refuses to take it. On admission put upon Infirmary W. On admission put upon Infirmary W. (Gen. Rpt Complexion fair: hair red: eyes gray: skin in normal condition: No marks, scars nor bruises noted: Tongue has 13 upper + 11 lower teeth: behavior quiet: Talks intelligently but stammers.)

Dec 20 to Jan 2 Summary 14 da record. by Dr. Beebe. Dec. 20 - Jan 2. Temp. + resp. about normal Pulse 76-108 appetite fair. bowels constipated requires frequent laxatives. Sleeps well Very quiet + agreeable: assists some with work in dining room. Also reads a great deal: Takes out door exercise: Converses quite willingly + sensibly but it is a great effort for her to express herself Stammers + muscles of face twitch when she talks: Is quite talkative.

March 15 1900 Neat in habits + appearance: Genually pleasant but at times quite disagreable. Talks sensibly: Laughs to herself. General health good. Takes occasional cathartics bowels quite constipated: Very fault finding Does no work + is inclined to be indolent + induce others not to work. June 11 Refused to have clothes sent to laundry + When nurse insisted attacked her + pulled her hair. Wt. 116# Jan 19, 1901 Wt. 110# Vaccinated July 21 Vaccinated July 31 Vacc. B+. Nod ++ No. change. Wt 114#. Feb 22. Wt. 103#. General health good: Disagreable at times. Mar. to June 1901 Shows no change in either mental or physical condition. May 22d. Wt. 100#.

June to Sept. Remains unchanged in general condition Aug. 27 Wt. 101#.

Sept. to Dec. General health good, neat in habits and appearance, is silly in manner, at times is obstinate, menstruates regularly, takes regular out of door exercise, is unoccupied, Nov. 30 Wt. 101#.

Dec. to Feb. 1903 No change. Wt. about 103#. July 6-1902 Came in from a stay in camp at Aronoco.

Personal and Medical History of

Personal and Medical History of Olena Christianson.

Whole No. 5473
Residence, Adolphus Tp. Minn.
Date Admission, December 21 1899.
Admitted by Dr. R. A. Bibb. hour, 7 PM.
How Sent, A. A. Washburn & of P. Mower Co.
Sex, female Age, 18 yrs.
Civil Condition, single.
Children, —
Age Youngest Child, -
Occupation, Domestic (father a farmer.)
Degree Education, Common school.
Profession, Religion, Lutheran.
Habits, Not intemperate.
Nativity, Mower Co. Minn. (Parents born in Norway.)
Physicians Committing, A. J. Pierson & F. E. Daigneau M.D.
Correspondents, Mr. Ole. Christianson (father) Blooming Prairie Minn. Box 331.
Telephone to Mr. O. A. Wroblen & he will send word.

No. of Year, 103
Insane Relatives, Brother & maternal uncle.
Cause Exciting, Menstrual derangement.
Cause Predisposing, Heredity.
Form, Melancholia with delusions.
Accompanying Bodily Disorder, Menstrual trouble.
Suicidal or not, not.
Date of this Attack, 10 days ago.
Duration, 10 days
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 18 yrs.
Time of Leaving, May. 22. 1900
Time in Hospital, 3 m. 1 d
Result, Discharged Sept. 22, 1900 Rec.

EXAMINATION ON ADMISSION BY DR. Bibb *Date of* 12/21/99.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, } Impaired Special Subjects,
Recent Events, }

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

REASONING POWER, Ordinary Subjects, }
Special Subjects, } Impaired.
Own Mental State, }

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

DELUSIONS, Systematized, Transitory, Special Subjects, Fairly Thinks food is poisoned - refuses to eat. Thinks she is taken for someone else & keeps saying that she is Olena Christianson. Thinks also that she was brought here to take her brothers place (he was here years ago).

HALLUCINATIONS, Expresses none.

ILLUSIONS, Yes
Some of attention impaired.
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, About 2 weeks.
ONSET, Gradual or Sudden, Sudden.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, living well.
Paternal Relatives, Father's mother living 99 yrs. old.
Mother, living - well.
Maternal Relatives, mother's father & mother lived to be nearly 100 yrs. old.
4 Brothers and 5 Sisters, all well. 1 brother was here is now at home & quite well.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No serious illness
HABITS, Drinking and Smoking, no.
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches
OCCUPATION, Healthy or not, Sewing since attended school until 14 yrs. age.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Slept well until a few nights before admission. Very restless since. Appetite also poor refused food for several days before admission

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 PRESENT WEIGHT, 97 lbs USUAL WEIGHT, NUTRITION, Somewhat emaciated
WOUNDS, Abnormalities and condition of Skin, Skin cool & dry Circulation poor - hands & feet blue & cold.
TONGUE, Coatings or Promptness of Movement, Heavily coated - breath foul.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size slightly dilated responses 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, slight of tongue.
PATELLAR REFLEX, diminished Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Slurred
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, Size, Excitable
Apex Beat, Regularity, regular - rapid



Jan. 1900.

ARTERIES,
Pulse Weak.

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expans. fair - more limited on R. side
B. Sounds shallow over R. side ant.

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,

12/23/99 EXAMINATION URINE, Quantity, Sp. g. 1037 Reaction, acid Color and Appearance, Yellow - cloudy Heavy pink deposit
Albumen, Moderate acute by all tests Sugar,
Casts and Crystals, Amor urates - several oxalate of lime crystals - a few pus corpuscles & all kinds of epith. cells.
GYNECOLOGICAL EXAMINATION, External genitals normal - Hymen intact. uterus normal position. Urethral orifice much inflamed.
MENSTRUATION, Established about 1 yr. ago - has now been suppressed for at least 3 mos.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, restless.
BOWELS, Present Condition, Constipated

Give condensed statement of the 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). Learned quite well in school - Always quiet & reserved. Onset of this attack quite sudden - had chill & fever one evening & during night became very much disturbed mentally - Is now depressed - Constantly begs for something in a distressed voice. Whenever asked to do anything says "Wait a Minute" & walks restlessly about. Is very reticent - Remarks incoherent & hesitating.

Personal and Medical History of Olina Christianson.

1899

This patient was brought here by sheriff's deputy Burnett Christianson attended by Mrs Jerdet in fairly good physical condition with the following history:- No consanguinity: Maternal uncle + brother: First symptoms of insanity manifested ten days ago: Refuses food and drink: objects to being dressed + first took dislike to a baby at home + wanted to throw it out of doors: Disease appears increasing: Not variable: Derangement now manifested by refusing treatment, food + drink - talks incoherently or not at all. Not suicidal: Refuses to bathe herself: No previous peculiarities manifested: Father intemperate: No confinement nor restraint employed. Has refused treatment: On personal examination stares at examiners without answering questions: utters a few words bearing on the questions asked sometime afterward. Menstrual flow stopped for sometime, is restless, remains standing. On admission put upon Infirmary (G.H.N.Pat. Complexion dark: hair brown: eyes gray: No marks, scars nor bruises. So dirty: Has sixteen upper and 15 lower teeth: Desired being bathed: Incoherent in speech.

Dec 31 to Jan 3 Summary 14 da Record by Dr. Bebb. Dec 31 when received on ward was very restless, depressed + agitated: had taken no nourishment for several days + refused her supper. Thought food was poisoned: Was fed by tube at 10:5 PM Dec 31 - Jan 3 Temp. 98⅘. - 101⅔. Pulse 96 - 134. Resp. 22 - 32. Fed mechanically during first week. After second day took some nourishment. After 1st week ate fairly well, principally liquid diet. Bowels quite constipated, required laxatives frequently. Slept quite well. First few days very restless + out of bed often also noisy at times - put in restraint - Circulation poor: hands + feet always cold. Up on ward after Dec. 28. Very much disturbed at times especially in afternoon: is resistive: Seems to be afraid she will be harmed. Has morbid ideas; a distressed expression - Dec 30-31 Visited by sister - was quieter with her. Lavage of stomach - Contents very greenish + sour. Tongue heavily coated: breath very offensive. Jan. 6 Wt. 90# Jan 5 Visited by brother

Mch 1 - 99. Rather restless. Wanders aimlessly about. Does no work. Usually answers when spoken to. Fairly neat. Seems very languid + inactive. Appetite good. Sleeps well. Bowels regular. Mch 22 Taken home by brother

Discharged

Letter from father July 25, 1900 states that patient is "all well".

Personal and Medical History of

Personal and Medical History of Rosa Kautes. (Kalter)

Whole No. 5479

Residence, St. Paul, Minn.

Date Admission, January 4th 1900

Admitted by Dr O C. Hyerdale hour, 7 P.M.

How Sent, E.W. Bazille Sup't Ramsey Co.

Sex, female Age, 26.

Civil Condition, Single.

Children, —

Age Youngest Child, —

Occupation, Servant.

Degree Education, none.

Profession, Religion, Catholic.

Habits, no knowledge.

Nativity, Germany (Parents also born there)

Physicians Committing, E.J. Abbott + H.P. O'Brien.

Correspondents, Father - Albert Kalter Bayern, Germany

No. of Year, 109.

Insane Relatives, unknown.

Cause Exciting, unknown.

Cause Predisposing, unknown.

Form, Adolescent Ins. Mfg. Chronicity + with delusions of persecution

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, Not.

Date of this Attack, a week or two ago.

Duration, 1 - 2 mo.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 26 yrs.

Time of Leaving, Mar. 15. 1900

Time in Hospital, 2 m. 11 d.

Result, Discharged Sept. 22, 1900 Recovered

EXAMINATION ON ADMISSION BY DR. R.A. Boss *Date of* 1/7/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Somewhat confused - sluggish.

MEMORY, Past Events, Impaired.

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, of persecution
Thinks food is poisoned. So suspicious - thinks people will injure her. Is afraid to be touched.

HALLUCINATIONS,

ILLUSIONS,

Power of attention impaired.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 - drinks some -

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, Says drank some a long time ago.

HEADACHES, VERTIGO, OR CONVULSIONS, Says - no headaches

OCCUPATION, Healthy or not, Domestic.

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

Sleep, Appetite, and Bowels,
Has refused food for several days.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. PRESENT WEIGHT, 115 Lbs. USUAL WEIGHT, NUTRITION, Fair.

WOUNDS, Abnormalities and condition of Skin, Warts on hands - Small scratch on each little finger. Skin rough + dry

TONGUE, Coatings or Promptness of Movement, Slight coating protruded slowly + reluctantly -

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - slightly dilated - responses about normal.

SIGHT, Says good

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

HEARING, Says good -

COORDINATION, Arms, Too obstinate to try test Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Slight of tongue.

PATELLAR REFLEX, About normal. (Exists) Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Hesitates some to collect thoughts then talks quite freely.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, N Murmurs, Strength, Sounds, N Size, N

Apex Beat, N Regularity, Regular

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical
Expansion normal
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, 3 XXXIV Sp. g. 1025 Reaction, Acid. Color and Appearance, Yellow-clear

Albumen, None Sugar, None.

Casts and Crystals, a few epith. cells.

2/6/1900

GYNECOLOGICAL EXAMINATION, External genitals normal except for hyperaemia of urethral + vaginal orifices. Hymen intact. Uterus inclined slightly to left + ~~retroflexed~~. otherwise normal.

MENSTRUATION, Menstruation regular + usually free from pain

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps well. slept most of night + a great deal today

BOWELS, Present Condition, Constipated.

Give condensed statement of the 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). Full of delusions of persecution - When asked to put out tongue we wish to cut it off - when taking pulse - eye - hurt her arm etc. whenever asked to do anything acts suspicious + asks "Why" &c. Is irritable, obstinate + resistive - probably on account of her delusions of persecution. Also rather slow of comprehension.
Physical condition fair - no special disease apparent, but is pale + general nutrition is somewhat impaired.

Personal and Medical History of Rosa Xantes.

1900

This patient was brought here by Sheriffs deputy A Hanson, attended by Mary Wenisch in fair physical condition, with the following history:- No history of consanguinity nor of heredity given: Patient has been peculiar for past four years but first definite symptoms of insanity manifested in latter part of December 1899. Disease appears increasing: Derangement manifested by religious impressions: Patient has shown no disposition to injure anyone: Not disposed to be filthy or destructive in habits unless frightened: No history of intemperance in patient nor in parents nor of severe injuries or disease: Patient has been in St Josephs Hospital: Has been in restraint & has been given narcotics. On personal examination no further particulars noted. On admission put upon Infirmary (Gen. Rpt. Complexion dark: Hair brown: eyes gray: skin hot & dry: Little fingers of both hands bruised: So dirty. Has 32 Teeth. Behavior quiet. Refused to talk.

Jan 4/1900 to Jan 19/1900 Summary 14 da. Record by Dr Bebb. On admission expressed many delusions & was very resistive: Pulse & resp. normal: Temp. slightly elevated at times: At first refused food & fed once mechanically, after that took nourishment & appetite improved gradually: Bowels constipated & given laxatives & enemata as needed. Slept well: Usually quiet but when disturbed resistive: Expression anxious & appeared in constant fear of impending danger: On Jan. 9th some mental improvement noted: Conversed quite readily & on Jan 10 Commenced to assist with work. From this time on mental improvement more decided: Quiet & cheerful in manner: no delusions noted: always willing to assist with work: Frequently takes outdoor exercise. Jan 5 Wt. 100½#.

Mch 15, 1900 Patient quiet: assists with work: General health good: Converses pleasantly. Mch 15 Allowed to go home.

Discharged.

Letter from Sister Benigna at St Josephs Hospital-St Paul. July 21, 1900. States that patient had always been a little peculiar & defective but since return had appeared just as well as she ever was.

Personal and Medical History of

Personal and Medical History of Mrs Annie Lindeen.

Whole No. 5484

Residence, St. Paul, Minnesota

Date Admission, January 8' 1900.

Admitted by Dr E.J. Marcoux hour, 7 PM.

How Sent, Ewd. Bazille & of P. Ramsey Co.

Sex, Female Age, 26

Civil Condition, married

Children, one.

Age Youngest Child, 7 years.

Occupation, Housewife

Degree Education, Common school.

Profession, Religion, Roman catholic.

Habits, Not intemperate

Nativity, Wisconsin (Parents Ireland)

Physicians Committing, A.R. Merrick & J.A. Amicus

Correspondents, Chas Lindeen 20 W 4th St, St. Paul, c/o Fred Schroeder

No. of Year, 114

Insane Relatives, Mother.

Cause Exciting, Unknown

Cause Predisposing, Heredity.

Form, Acute Melancholia with Delusions.

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Not.

Date of this Attack, 4 days ago

Duration, 4 days.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 26 yrs.

Time of Leaving, June 7. 1900

Time in Hospital, 5 mo.

Result, Dis. Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Bass Date of Jan 9' 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Confused - Quick.

MEMORY, Past Events, Impaired

Recent Events, " Special Subjects, After much thought seems statements which seem reliable.

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Alert but illusive.

REASONING POWER, Ordinary Subjects, Imp.

Special Subjects, ds.

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Depression with confusion & agitation.

DELUSIONS, Not Systematized, Many Transitory, Special Subjects,

HALLUCINATIONS, Apparently listens for sounds but expresses none now.

ILLUSIONS, Thinks she sees snakes

Power of attention impaired.

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).

Can secure no reliable information from her.

Father, Says dead. Says had abscess in side

Paternal Relatives,

Mother, Died insane - About 14 yrs. ago.

Maternal Relatives,

2 Brothers and 7 Sisters, 1 Child

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

Statements unreliable - Contradicts herself.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches often Vertigo sometimes

OCCUPATION, Healthy or not, Housekeeper.

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

Says First attack.

Sleep, Appetite, and Bowels,

Says slep somewhat disturbed. Appetite not good

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6½ PRESENT WEIGHT, 135 lbs USUAL WEIGHT, NUTRITION, Quite good.

WOUNDS, Abnormalities and condition of Skin, has a number of small scratches on R hand. Hands moist & warm - rest of skin dry.

TONGUE, Coatings or Promptness of Movement, prompt - dry & coated. breath offensive.

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

SIGHT, says good

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

HEARING, says good

COORDINATION, Arms, To disturbed to make tests Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Slight of tongue.

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,

1/19/1900 EXAMINATION URINE, Quantity, Sp. g. 1014 Reaction, acid Color and Appearance, Yellow - cloudy

Albumen, None Sugar, None.

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

GYNECOLOGICAL EXAMINATION, Slight laceration of perinium: external genitals otherwise normal. hyperaemia of cervix & erosion of os. Uterus slightly retroflexed & adherent to left.

MENSTRUATION, History cannot be obtained

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Much disturbed -

BOWELS, Present Condition, Constipated.

Give condensed statement of the 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). Keeps saying 'Take What St Patrick took' Most of time is very restless & will not remain in bed. Talks rapidly in an excited manner & remarks being characterized by incoherence & confusion of thought. At times lies quietly with eyes closed but at least sound starts up frightened & trembling as tho in fear of impending danger. Has various transitory delusions & illusions. Listens for voices & may have auditory hallucinations (does not express any) sees snakes & cats. By great effort seems able to collect thoughts & answer some questions intelligently but her mind soon wanders & she becomes incoherent. Physical condition fair. Has moderate fever & Anorexia. Takes little nourishment but often refuses food. Very restless & noisy during night.

Personal and Medical History of Mrs. Anna Linden

1900

This patient was brought here by Sheriff-deputy Hansen, attended by husband, in fair physical condition, with the following history:- No consanguinity: mother insane: No history of intemperance in patient nor parents: First symptoms of insanity manifested four days ago by delusions of persecution: Disease appears increasing: Not variable: Delangement now manifested by delusions of persecution + of desertion by friends: Not disposed to injure anyone: No filthy nor destructive habits: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued. On personal examination talks irrationally. shows loss of memory of recent events.

On admission put upon Infirmary Mot. Gen. Rpt. Hair brown: eyes blue: Skin in normal condition: Several cuts on right hand says she cut it breaking glass in window: Is clean: Has 16 upper and 15 lower teeth: Is rather maniacal: Has delusions + illusions)

Jan 8/1900 to Jan 22/1900 Summary Nurses 14 da. Record by Dr Bess. On admission restless + restless: Out of bed often during night + extremely noisy: After third night slept well. Temp. shows constant slight elevation: Pules. 90-120. + one day 164. Resp. about normal: Took fair amount of liquid nourishment: Requires frequent laxatives + enemata: Mild hypnotics given as needed. Very excited + noisy first two days + on third day put in restraint after this became much quieter. Jan. 14 Menstruating.

Jan 22/1900. Kept in bed: moans some but sleeps quite well: occasionally restless: Jan 30 Very restless, slept only a few hours: Jan 31. Very restless In restraint during night: out of bed frequently when not in restraint. Given liquid diet for some time. Bowels constipated: Stupid: Will not talk

Apr 2/ Quiet + depressed: Neat: Has improved some: Takes an interest in her surroundings: May 6. Visited by husband. May 30 Improved rapidly Takes out door exercise. June 4. Visited by friends: Is nearly well. Talks readily + intelligently: Has delusions: Assists on ward: Sleeps well: Takes out door exercise General health good: June 6 Sent home

Discharged

Visited by friend Has delusions about food.

Personal and Medical History of

Personal and Medical History of Mary J. Boynton.

Whole No. 5485

Residence, Austin, Mower Co, Minn.
Resident of State or since 1860.

Date Admission, January 10' 1900.

Admitted by Dr. O. C. Heyerdale hour, 5 P.M.

How Sent, C. Washburn Sup't Mower Co.

Sex, female Age, 55.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, None.

Degree Education, Common school.

Profession, Religion, Not a church member.

Habits, Not intemperate.

Nativity, New Hampshire (Father N. Mother U. S.)

Physicians Committing, Asst. Allen & E. H. Washburn.

Correspondents, Family physician Dr. Emma Washburn. Austin.

No. of Year, 115

Insane Relatives, Paternal also maternal aunt.

Cause Exciting, Uterine trouble.

Cause Predisposing, heredity.

Form, Hysteria (Dem. Melancholia)

Accompanying Bodily Disorder, Uterine trouble - Nose strong.

Suicidal or not, Not.

Date of this Attack, about 2 mos. ago.

Duration, About 2 mos.

No. of Attack, Many during past 18 years.

No. of Admission, 1st

Age First Attack, about 37 yrs.

Time of Leaving, May 21-1900

Time in Hospital, 4 mo. 11 d.

Result, Died - Oedema of lungs

EXAMINATION ON ADMISSION BY DR. Bess. Date of Jan 15' 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Apparently not much confused - Talks quite promptly when she speaks.

MEMORY, Past Events, Cannot determine - will not converse.

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, Fair -

Special Subjects, do

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Hysterical -

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks everything about her has an offensive odor.

Power of attention impaired.

HALLUCINATIONS,

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, of long duration.

ONSET, Gradual or Sudden, 35 - 40 yrs.

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
None.

Father, d- old age

Paternal Relatives,

Mother, d- abscess of womb.

Maternal Relatives,

Brothers and Sisters, living well.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None.

HABITS, Drinking and Smoking, No

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

Detail Date, Duration, and Character of Previous Attack, if any,
Has been an invalid & confined to bed for over 30 yrs. Unable to walk.

Sleep, Appetite, and Bowels,

1

To the Physician Attendant or Nurse of the Ward in Which Mary Boynton is located.

Feeling it My duty to write you a few lines which might aid you for a few days until you became acquainted with her case will say that she cannot walk, by urging and moving her slightly have had her get on chair at side of bed night & morning. Her prevailing mania for some time past has been that her clothes & bed clothes did not smell right, and tonight as I write she has no garments on and has been so for two days. It takes two strong women to put her garments on, perhaps they do not sew them on as thorough as they should, in the a short time after left alone her garments lay on the floor.

...TERISTICS.

...AL WEIGHT, NUTRITION, Much impaired

...avoist - Circulation poor - Extremities quite poor.

...mist of teeth - Fill not protrude.

...ils normal - Response to light fair - Sclerae?

...ired Grasp,

...limp - Facial Muscles - left side - twitch.

...ther 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,

1/1900 EXAMINATION URINE, Quantity, ~~XXIV~~ Sp. g. 1022 Reaction, acid Color and Appearance, Clear-yellow

Albumen, None Sugar, None.

Casts and Crystals, Amor. urates - a few uric acid crystals & epith. cells a few fat globs.

GYNECOLOGICAL EXAMINATION, External genitals excoriated otherwise normal. Hymen lax: Cervix long & movable: small projection of mucous membrane extends from above at, falling down & covering same: portion of uterus retroflexed. very constipated - not examined

MENSTRUATION, Cannot obtain history.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Quite good.

BOWELS, Present Condition, Constipated - Kept regular by laxatives.

Give condensed statement of the 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). Always nervous - Weakness of spine causing inability to walk. Hysterical - Keeps eyes closed & refuses efforts to open them. Makes grimaces with muscles of upper side of face: Seldom speaks. Talks quite rationally when she does - Only answers questions briefly or asks for what she wants. Moans & shrieks at times - Never shed tears when she cries.

Personal and Medical Histor

Whole No. 5485

Residence, Austin, Mo

Date Admission, Jan 13 1900

Admitted by Dr. O

How Sent, C W

Sex, fema

Civil Condition, Sin

Children, –

Age Youngest Child, –

Occupation, None.

Degree Education, Common

Profession, Religion, not a chur

Habits, not intemperate

Nativity, New Hampshire (Father N.

Physicians Committing, Asst. Allen + E. H. Wa

Correspondents, Family physician Dr. Emma Cockburn

ars.

o.

21-1900

nn. U S.

c. Oedema of lungs

EXAMINATION ON ADMISSION BY DR. Bras *Date of* Jan 13 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Apparently not much confused - Talks quite promptly when she speaks.

MEMORY, Past Events, Cannot determine - will not converse

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

dull -

REASONING POWER, Ordinary Subjects, Fair -

Special Subjects, do

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Hysterical -

DELUSIONS, Systematized, Transitory, Special Subjects,

Thinks everything about her has an effensive odor.

Power of attention impaired.

HALLUCINATIONS,

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, of long duration.

ONSET, Gradual or Sudden, 35 - 40 yrs.

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

None.

Father, d. old age

Paternal Relatives,

Mother, d. abscess of womb.

Maternal Relatives,

Brothers and Sisters, living well.

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

None.

HABITS, Drinking and Smoking, No

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

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

Has been an invalid + confined to bed for over 30 yrs. Unable to walk

Sleep, Appetite, and Bowels,

2

In regard to her eating we have to feed her as a little child laying in bed will often reject her meals but usually eats one or two a day - Her drink is lemonade and either taken or rejected

Ollive Crane one of your patients there if her mind is not shadowed too much would know her as her Parents were our nearest neighbors

Should be pleased to hear from her whenever you think it advisable.

Address Mrs M Litchfield

Austin

Miss

(P O Box 346)

Tel.

CTERISTICS.

AL WEIGHT, NUTRITION, Much impaired

moist - Circulation poor - Extremities quite poor.

mit of teeth - Jaw not protrude.

ils normal - Response to light fair - Sacrum?

ired Grasp,

limp - Facial muscles - left side - twitch.

ther 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,

7/1900 EXAMINATION URINE, Quantity, ~~XXIV~~ 3 Sp. g. 1022 Reaction, acid Color and Appearance, Clear - yellow

Albumen, None Sugar, None -

Casts and Crystals, Amor. urates - a few uric acid crystals + epith. cells a few fat globs.

GYNECOLOGICAL EXAMINATION, External genitals excoriated otherwise normal - Hymen lax: Cervix long + movable: small projection of mucous membrane extends from above at, falling down + covering same: position of uterus retroflexed: very constipated - rectum examined.

MENSTRUATION, Cannot obtain history.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Quite good.

BOWELS, Present Condition, Constipated - Kept regular by laxatives.

Give condensed statement of the 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). Always nervous - Weakness of spine causing inability to walk. Hysterical - Keeps eyes closed + resists efforts to open them. Makes grimaces with muscles of upper part of face: Seldom speaks. Talks quite sensibly when she does - Only answers questions briefly or asks for what she wants. Moans + shrieks at times - Never shows tears. When she cries.

Personal and Medical Histor

Whole No. 5485

Residence, Austin, Mo

Resident of State [illegible]

Date Admission, Jan[illegible]

Admitted by Dr. O

How Sent, C. M

Sex, fema

Civil Condition, [illegible]

Children, —

Age Youngest Child, —

Occupation, None.

Degree Education, Common

Profession, Religion, not a chu

Habits, not intemperate

Nativity, New Hampshire (Father N.

Physicians Committing, Asa Allen & E. H. Wa

Correspondents, Family physician Dr. Emma Washbu

no.

21-1900

n. H.

Oedema of lungs

EXAMINATION ON ADMISSION BY DR. Bro... *Date of* Jan 13 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Apparently not much confused - Talks quite promptly when she speaks.

MEMORY, Past Events, Cannot determine - will not converse

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

dull -

REASONING POWER, Ordinary Subjects, Fair -

Special Subjects, do

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Hysterical -

DELUSIONS, Systematized, Transitory, Special Subjects,

Thinks everything about her has an offensive odor.

Power of attention impaired.

HALLUCINATIONS,

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, of long duration.

ONSET, Gradual or Sudden, 35 - 40 yrs.

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

None.

Father, d- old age

Paternal Relatives,

Mother, d- abscess of womb.

Maternal Relatives,

Brothers and Sisters, living well.

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

None.

HABITS, Drinking and Smoking, No

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

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

Has been an invalid & confined to bed for over 30 yrs. Unable to walk

Sleep, Appetite, and Bowels,

sonal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, ——— PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION, Much impaired

WOUNDS, Abnormalities and condition of Skin, None - Skin cool & moist - Circulation poor - Extremities quite poor.

TONGUE, Coatings or Promptness of Movement, Clear - flabby - imprint of teeth - Tries not protrude.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - Eye normal - Response to light fair - Saccad[illegible]

SIGHT, normal

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

HEARING, Normal.

COORDINATION, Arms, will not test - Legs, impaired Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Limbs fair limp - Facial muscles - left side - twitch -

PATELLAR REFLEX, diminished especially in left - Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, About normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, hyperaesthesia -

HEART, No Murmurs, Strength, Sounds, N. Size,

Apex Beat, N. Regularity, Regular but rapid

ARTERIES,

Pulse weak - rapid.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest Asymmetrical -

Expansion variable - usually fair -

Resp. Variable - at times obstructed

at other times also slow & rapid.

1/1/900 EXAMINATION URINE, Quantity, ~~XXIV~~ Sp. g. 1022 Reaction, acid Color and Appearance, Clear - yellow

Albumen, None Sugar, None -

Casts and Crystals, Amor. urates - a few uric acid crystals & epith. cells a few fat globs.

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 excoriated otherwise normal - Hymen lax: Cervix long & movable: small projection of mucous membrane extends from above it, falling down & covering same: Position of uterus retroflexed - very constipated - not examined

MENSTRUATION, Cannot obtain history.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Quite good.

BOWELS, Present Condition, Constipated - Kept regular by laxatives.

Give condensed statement of the 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). Always nervous - Weakness of spine causing inability to walk. Hysterical - Keeps eyes closed & resists efforts to open them. Makes grimaces with muscles of left side of face. Seldom speaks. Talks quite rapidly when she does - Only answers questions briefly or asks for what she wants. Moans & shrieks at times - Never sheds tears when she cries.

Personal and Medical History of Mary J. Boynton.

1900

This patient was brought here by Sheriffs deputy Edson Bassett attended by Mrs. Wright in fair physical condition, with the following history:- No consanguinity known: maternal & paternal aunt insane: No history of intemperance in family: Patient has shown symptoms of insanity at intervals for past 18 years: Has been an invalid for 35 or 40 yrs. gradually becoming worse, until last month or two has refused to be dressed & refuses food for quite long periods: Disease appears increasing: So variable Will sometimes appear quite rational but for past 3 years has said very little: Derangement now manifested by refusing to converse or to be clothed, remains in bed all the time & refuses food part of time: Not disposed to injure anyone: No filthy nor destructive habits: No previous peculiarities excepting that she may have had delusions in regard to her health: Has never been strong since childhood, supposed cause uterine trouble. Has several times been treated without benefit. On personal examination will not allow examination without force - lies with eyes closed & will not reply when addressed. On admission put upon Ward's (Gen Rpt) Complexion fair: hair brown part gray: eyes blue: Condition of skin normal: a few bruises on wrists: So clean: 7 upper & 9 lowers teeth, all in poor condition: So noisy at times: Refused food & would not speak.

Nov 10/00 to Jan 24/01 Summary of 14 da. record by Dr. Bibb. Patient received on ward, given bath & put to bed, also fed mechanically as she had not been taking her nourishment well at home. She slept about 5 hours & during remainder of night was noisy & restless & moaned a great deal. During first week had a slight fever not above 99⅘. Pulse 76-120. Resp. normal. Second week temp: Pulse & Resp. normal. Took meals regularly after second day: Occasional laxatives given for bowels: Has slept well since first night & has gradually become quieter.

March - May 21. 1900 Patient quiet & stupid: Does not speak but occasionally screams: Appetite poor: Kept in bed: Sleeps fairly well: Appr No change. Taken up each day for a short time for exercise. Gen massage 3 × week.

May 16. Sick in bed: very weak. May 19. Gradually failing: Appetite very poor: May 21 - Died at 8 AM.

Died

Personal and Medical History of

Personal and Medical History of Kate Degroo. as Kate D. Gros.

Whole No. 5487
Residence, St. Paul, Minn.
Date Admission, January 12 1900.
Admitted by R. A Bebb M.D. hour, 7 P.M.
How Sent, E.W. Bazille J. of P. Ramsey Co.
Sex, Female Age, 17 yrs.
Civil Condition, single.
Children, none.
Age Youngest Child, –
Occupation, domestic.
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, not known.
Nativity, Minnesota (Parents also born there)
Physicians Committing, J.C. Brimhall & A.W. Miller.
Correspondents,

No. of Year, 117
Insane Relatives, No knowledge.
Cause Exciting, Unknown.
Cause Predisposing,
Form, Adolescent - (Hysterical mania)
Accompanying Bodily Disorder, Twitching of muscles - Rolling of eyeballs.
Suicidal or not, Not.
Date of this Attack, About 1 wk. ago.
Duration, 1 week.
No. of Attack, 1st so far as known.
No. of Admission, 1st
Age First Attack, 17 yrs.
Time of Leaving, ~~Dec~~ Feb 27 ~~Ft~~. 1900
Time in Hospital, 1 mo. 15 d.
Result, Discharged Apr. 30. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Bebb *Date of* Jan. 13 1900

MENTAL CHARACTERISTICS.

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Thought that he painted her entire body when she came to the hospital.
HALLUCINATIONS, Cannot determine.
ILLUSIONS, " "

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

HISTORICAL.

LENGTH INVASION, About a week.
ONSET, Gradual or Sudden, Onset quite sudden.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, living.
Paternal Relatives,
Mother, dead - has step-mother.
Maternal Relatives,
3 Brothers and 3 Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Week before admission fell down stairs & struck head. Head & eyes swollen & bruised - dizzy & troubled with headache after fall.
HABITS, Drinking and Smoking, no.
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches since fall.
OCCUPATION, Healthy or not, Servant.
Detail Date, Duration, and Character of Previous Attack, if any,
first attack
Sleep, Appetite, and Bowels, Good Regular

GIRL'S INSANITY.

Seized With Violent Fits and Had to Be Cared for in Jail.

Katie D. Gros is the name of a 16-year-old girl insane at the county jail. The girl is so violent that she has been handcuffed.

During spells of momentary sanity she says that her home is St. Cloud. At other times she says that she lives at Rush City and Pleasant Lake. The authorities have thus far been unable to find her relatives.

The girl has been employed in the home of Lincoln Good, 724 East Third street, for the past three months. The insanity gradually grew upon her, until yesterday afternoon she became violent and had to be taken to the county jail.

This afternoon the girl was in the probate court, and was examined by Dr. Brimhall and Dr. Miller. Judge Bazille committed her to the insane asylum at Rochester.

The patient is a stout, healthy-looking girl. She would not talk, but insisted on playing the ancient game of slapping hands and pounded the table until her hands were sore.

She took a fancy to Hanson, deputy sheriff, and politely sat on his knee.

Medical History of Kate Degroo.

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 131 # USUAL WEIGHT, NUTRITION, Good.
nd condition of Skin, Small scar on left wrist. Skin dry & warm.
uptness of Movement, Prompt. slight coating.
sponse to Light, and Accommodation, Equal - dilated. responses normal.
utly good.
Arcus Senilis, or other troubles,
HEARING, Apparently good.
COORDINATION, Arms, normal Legs, normal. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, slight of tongue.
PATELLAR REFLEX, diminished Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, dull.
HEART, No Murmurs, Strength, Sounds, Size,
Apex Beat, No Regularity, Regular
ARTERIES,
Normal.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion normal.
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,

1/20/1900 EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, Neutral Color and Appearance, Yellow - cloudy. Creamy flaky deposit
Albumen, None Sugar, None
Casts and Crystals, Excessive amt. amor. urates. a few pus Corpuscles. Excessive amt. all kinds of Epith. cells.
1/24/1900. GYNECOLOGICAL EXAMINATION, Labia minora hypertrophied: Hymen lax, erosion of os. mucopurulent discharge fatulous. 2nd Exam. made Feb. 19. 1st exam. verified. probably 2-2½ mos. pregnant.
MENSTRUATION, Regular until last time. Has missed one period. During past months. During past month has been troubled with nausea & emesis much of time especially in morning.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleeps well.
BOWELS, Present Condition, Usually regular

Give condensed statement of the 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 good. Is probably about 6 mos pregnant. Previous mental grade probably below average - uneducated. of fair degree of intelligence - At present extremely restless & excited. Rather hysterical in manner. Cries one minute & laughs the next. But on whole is more apt to be melancholy. Conversation incoherent & irrelevant with occasional comparatively lucid intervals when she talks fairly sensibly but statements are not very reliable.

Personal and Medical History of Kate Degroo. or Kate D. Goo.

Whole No. 5487
Residence, St. Paul, Minn.
Date Admission, January 12 1900.
Admitted by R. A Bibb M.D. hour, 7 P.M.
How Sent, E.W. Bazille J. of P. Ramsey Co.
Sex, Female Age, 17 yrs.
Civil Condition, single.
Children, none.
Age Youngest Child, –
Occupation, Domestic.
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, not known.
Nativity, Minnesota (Parents also born there)
Physicians Committing, J.B. Brimhall & A.W. Miller.
Correspondents,

No. of Year, 117
Insane Relatives, No knowledge.
Cause Exciting, Unknown.
Cause Predisposing, "
Form, Adolescent - (Hysterical mania)
Accompanying Bodily Disorder, Twitching of muscles - Rolling of eyeballs.
Suicidal or not, Not.
Date of this Attack, About 1 wk. ago.
Duration, 1 week.
No. of Attack, 1st so far as known.
No. of Admission, 1st.
Age First Attack, 17 yrs.
Time of Leaving, ~~Dec.~~ Feb 27 ~~Ja~~. 1900
Time in Hospital, 1 m. 15 d.
Result, Discharged Apr. 30. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Bibb Date of Jan. 13 1900.

MENTAL CHARACTERISTICS.

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Thought that pt painted her entire body when she came to the hospital.
HALLUCINATIONS, Cannot determine.
ILLUSIONS, " "
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, About a week.
ONSET, Gradual or Sudden, Onset quite sudden.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, living.
Paternal Relatives,
Mother, dead - has step-mother.
Maternal Relatives,
3 Brothers and 3 Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had before admission fell down stairs & struck head. Head & eyes swollen & bruised - dizzy & troubled with headache after fall.
HABITS, Drinking and Smoking, no.
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches since fall.
OCCUPATION, Healthy or not, Servant.
Detail Date, Duration, and Character of Previous Attack, if any,
First attack
Sleep, Appetite, and Bowels, Regular

Personal [illegible] History of Kate Degroo.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 4 PRESENT WEIGHT, 131 # USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, Small scar on left wrist. Skin dry & warm.
TONGUE, Coatings or Promptness of Movement, Prompt. slight coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - dilated. responds normal.
SIGHT, Apparently good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Apparently good.
COORDINATION, Arms, normal Legs, normal. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight of tongue.
PATELLAR REFLEX, diminished Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, dull.
HEART, No Murmurs, Strength, Sounds, Size,
Apex Beat, W. Regularity, Regular
ARTERIES,
Normal.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion normal.
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,

1/20/1900 EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, Neutral Color and Appearance, Yellow - cloudy Heavy flaky deposit
Albumen, None Sugar, None
Casts and Crystals, Excessive amt. amorphous urates. a few pus Corpuscles. Excessive amt. all kinds of Epith. cells.
1/14/1900. GYNECOLOGICAL EXAMINATION, Labia minora hypertrophied: Hymen torn, erosion of os: mucopurulent discharge. uterus normal position: Vaginal walls fatulous. 2nd Exam - made Feb. 19. 1st exam. verified. probably 2-2½ mos. pregnant.
MENSTRUATION, Regular until last time. Has missed one period. During past months. During past month has been troubled with nausea & emesis much of time especially in morning.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleeps well.
BOWELS, Present Condition, Usually regular.

Give condensed statement of the 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 good. Is probably about 6 mos pregnant. Previous mental grade probably below average - uneducated. of fair degree of intelligence - At present extremely restless & excited. Rather hysterical in manner. Cries one minute & laughs the next. but on whole is more apt to be melancholy. Conversation incoherent & irrelevant with occasional comparatively lucid intervals when she talks fairly sensibly but statements are not very reliable.

Personal and Medical History of Kate Deegros.

1900

This patient was brought here by Sheriffs deputy A Hansen attended by Mrs. A.L. Phillips & Mr. Wyman. is apparently good physical condition, with the following history: No consanguinity nor heredity so far as known: First symptoms of insanity manifested about one week ago- became melancholy: Disease appears increasing: Not variable: Derangement now manifested by hysterical mania & violent motions. No disposition to injure anyone: No filthy nor destructive habits: Has been melancholy for some time: No history concerning intemperance, severe diseases nor injuries to head. No confinement nor restraint employed, no treatment pursued: On personal examination shows twitching of facial muscles, rolling of eyeballs, violent motions.
On admission put upon Infirmary Diet. (Std. Rpt. Complexion dark: hair brown: eyes blue: eruption on back & upper part of legs: Small bruise on left side of back: So dirty: Behavior quiet. Refuses to talk.)

Jan 31/1900 to Jan 31/1900 Summary 14 da: Record by Dr Bebb. Temp. first week. 99-100° Pulse 79-110 Resp. normal. Appetite good: Requires occasional laxatives: after second night slept well: First two days much disturbed, restless, tossing about room & bruising herself on wall & furniture, & conversation rambling & incoherent: was hysterical & agitated & cried & wrung hands but if attention was diverted would laugh & become quiet & several times talked quite sensibly to nurse. Feb. 15 became much quieter & talked more sensibly & from this time continued to improve: Feb. 19 Trans. to B3. Quiet for a few days & then became boisterous & talkative & rather talkative: Occasionally is slightly depressed: She has only expressed one delusion; that when she came she was "painted all over". Feb 27. Sent home on trial. Quiet & agreeable: Conversation rational Behavior somewhat changeable.

Discharged.

Personal and Medical History of

Personal and Medical History of Elizabeth Steimer.

Whole No. 5488
Residence, St. Paul, Minn.
Date Admission, January 15 1900.
Admitted by Dr R A. Bass. hour, 7 P.M.
How Sent, Exp Bazille Dept Ramsey Co
Sex, female Age, 21
Civil Condition, single.
Children, none
Age Youngest Child, -
Occupation, domestic
Degree Education, Common school
Profession, Religion, Not a church member
Habits, Not intemperate
Nativity, Germany - (Parents also born there)
Physicians Committing, Asst. Medical Officer
Correspondents, Mrs Kate Steimer sister or Mrs. Bertha Wedemann (cousin) 690 Forest ave. St. Paul, Minn.
Ind. to Ernest Cairns c/o John Stahel - Cor. 3rd & Minn. St. St. Paul - (wife is a cousin.)

No. of Year, 118
Insane Relatives, None
Cause Exciting, Disappointment in love.
Cause Predisposing, unknown.
Form, Melancholia - Much agitation at first now not
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not attempted - but is suspected
Date of this Attack, Oct. '99
Duration, About 3 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 21 yrs.
Time of Leaving, May 17. 1900
Time in Hospital, 4 mo. 2 d.
Result, Disc. Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Bass *Date of* Jan 16 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - 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, Impaired.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed & agitated.

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks world is coming to an end & that she herself is already dead & only her spirit is now living.
HALLUCINATIONS, Not now - but at onset of attack. Did not hear voices.
ILLUSIONS, no.

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

HISTORICAL.

LENGTH INVASION, About 3 mos ago
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Living - Well.
Paternal Relatives,
Mother, Living
Maternal Relatives,
Brothers and Sisters, 6
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No serious illness
HABITS, Drinking and Smoking, no
HEADACHES, VERTIGO, OR CONVULSIONS, No. formerly had dizzy spells
OCCUPATION, Healthy or not, Laundress.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels,

Personal and Medical History of

BLIGHTED HOPES DETHRONE REASON

Elizabeth Steimer was examined in the probate court of Ramsey yesterday, and being found insane was committed to the hospital at Rochester.
She is a German girl, and her sanity is supposed to be the result of a disappointment in love. She claims that voices constantly tell her to drown herself, and thus bring the world to an end and save others from much unnecessary trouble.
She must be restrained constantly to keep her from killing herself.

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, USUAL WEIGHT, NUTRITION, Good.
and condition of Skin, dry & warm.
omptness of Movement, Slight coating - prompt.
esponse to Light, and Accommodation, Equal - size dilated. responses normal.

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 & tongue - occasional twitching of facial muscles.
PATELLAR REFLEX, Exaggerated. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Hesitating & slow.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, normal.
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal - regular
ARTERIES,
Rad. Pulse weak but regular.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair
B. Sounds normal



January — 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,

1/9/1900 EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, Acid. Color and Appearance, Yellow. Cloudy, flaky dep.
Albumen, None Sugar, None -
Casts and Crystals, Amor. urates, several epith cells. a few pus corpuscles & oxalate of lime crystals.
GYNECOLOGICAL EXAMINATION, External genitals normal - cervix small & club shaped: slight leucorrheal discharge: uterus normal position
MENSTRUATION, estab. at 15. says always regular until she came here. free from pain
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Quite good.
BOWELS, Present Condition, Require occasional laxatives

Give condensed statement of the 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 went to school until 14 yrs old. then went to work. Says she learned easily. Rather silly & dull of comprehension - Says there is something on her mind which worries her day & night. Will not state what it is.

Personal and Medical History of Elizabeth Steiner.

Whole No. 5488

Residence, St. Paul, Minn.

Date Admission, January 15 1900.

Admitted by Dr R A. Best. hour, 7 PM

How Sent, Ex Bazille Dept. Ramsey Co

Sex, Female Age, 21

Civil Condition, single.

Children, none

Age Youngest Child, -

Occupation, domestic

Degree Education, Common school

Profession, Religion, Not a church member

Habits, Not intemperate

Nativity, Germany - (Parents also born there)

Physicians Committing, Asst. Medical Board.

Correspondents, Miss Kate Steiner sister or Mrs. Julia Wedemann (cousin) 690 Forest ave. St. Paul, Minn.
Tel. to Swiss Consul c/o John Stahel - Cor. 3rd & Minn. St. St. Paul. (wife is a cousin.)

No. of Year, 118

Insane Relatives, None

Cause Exciting, Disappointment

Cause Predisposing, unknown

Form, Mel. Melancholia - Mute

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Not attempted - but is suspected

Date of this Attack, Oct. '99

Duration, About 3 mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 21 yrs.

Time of Leaving, May 17. 1900

Time in Hospital, 4 mo. 2 d.

Result, Dis. Nov. 6. 1900 Recovered


PRODUCE.

Revised and corrected up to noon Jan. 15.

BUTTER EGGS AND CHEESE.

The butter market shows a decidedly strong one with a rise in price. A scarcity of current receipts is noticed as well as the abnormal strength of Eastern markets, which, together, is responsible for the advance. A somewhat weaker tone pervades the egg market. The supply is large and is taken by most classes of trade in preference to fresh. The cheese market is quiet. The demand is

...ay 7,000; strong; native steers, $4@6; Texas ...ers, $3@5; cows and heifers, $2.50@4.40; ste...rs and bulls, $3.25@4.85.
Hogs—Receipts, 8,000 head; strong, active. ...ulk of sales, $4.55@4.65; heavy, $4.55@4.7... ...ixed, $4.47½@4.62½; light, $4.45@4.62½; pigs, ...@4.40.
Sheep—Receipts, 2,000 head; steady; lambs, ...@6.25; wethers, $4.25@5.

Relatives, Sister Mrs. Julia Wedemann (cousin) 690 Forest ave. St. Paul, Minn. Tel. to Swiss Consul c/o John Stahel - Cor. 3rd & Minn. St. St. Paul. (wife is a cousin.)

EXAMINATION ON ADMISSION BY DR. Best Date of Jan. 16 1900

MENTAL CHARACTERISTICS.

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

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks world is coming to an end & that she herself is already dead & only her spirit is now living.

HALLUCINATIONS, Not now - but at onset of attack. Did not hear voices.

ILLUSIONS, no.

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

HISTORICAL.

LENGTH INVASION, About 3 mos ago

ONSET, Gradual or Sudden, Gradual.

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

Father, Living - Well.

Paternal Relatives,

Mother, Living

Maternal Relatives,

Brothers and Sisters, 6

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No serious illness

HABITS, Drinking and Smoking, no

HEADACHES, VERTIGO, OR CONVULSIONS, No. formerly had Epilepsy, spells

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, ——— PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, dry & warm.

TONGUE, Coatings or Promptness of Movement, Slight coating - prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size dilated - responses 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 & tongue - occasional twitching of facial muscles.

PATELLAR REFLEX, Exaggerated. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, hesitating & slow.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, Normal.

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal - regular

ARTERIES,
R. Pulse weak but regular.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion fair
R. Rounds normal


January — 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,

1/19/1900

EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, acid. Color and Appearance, Yellow. Cloudy, flaky, dep.

Albumen, None Sugar, None -

Casts and Crystals, Amor. urates, several epith cells. a few pus corpuscles & oxalate of lime crystals.

GYNECOLOGICAL EXAMINATION, External genitals normal - cervix small & club shaped: slight leucorrhoeal discharge: uterus normal position.

MENSTRUATION, estab. at 15. says always regular until she came here. free from pain

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Quite good.

BOWELS, Present Condition, Regular occasional laxatives

Give condensed statement of the 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 went to school until 14 years old then went to work. Says she learned easily. Rather silly & dull of comprehension - Says there is something on her mind which worries her day & night. Will not state what it is.

Personal and Medical History of Elizabeth Steiner.

1900

This patient was brought here by Sheriff's deputy H Hanson attended by Mrs. Widmann in fair physical condition, with the following history:-
No history of consanguinity heredity nor intemperance given: First symptoms of insanity manifested in October 1899 - Hears voices: Disease appears increasing: not variable Derangement now manifested by "hearing voices which tell her to drown herself, so in that way the world will come to an end". Not disposed to injure anyone: Has never attempted suicide but has been watched at home for fear she would drown herself: No filthy nor destructive habits: No peculiarities previously known: No severe diseases nor injuries to head: Has been watched at home but has received no treatment
On personal examination, difficult to get her to talk.
On admission put upon Infirmary ward (Gitt. Apt Complexion fair: hair red: eyes blue: Skin in normal condition: slight eruption over chest & arms: So clean: has 15 upper & 15 lower teeth: Persisted when being taken to ward: Talks intelligently.)

Jan 15 1900 to Jan 29 1900 Summary 14 da. record by Dr Bibb. On admission quite excitable & resistive but soon became quiet on ward: Temp. slightly elevated, especially in afternoon, during first ten days- Pulse & Resp. about normal. Appetite fair: Requires laxatives Sleep good: During first few days expressed delusions but in a mild indifferent way as tho she rather doubted them. She remained very quiet improved mentally and soon ceased to express the delusions.
Neat in habits: Took out door exercise: Assisted with work.
Jan 29 Trans. to B3. Her appetite has improved, also her mental condition but she talks to herself at times. Has hallucination that someone is calling her - often answers "yes" & laughs- Very absent minded
Mch - May 17. Very agreeable on ward: Assists with work: Quite absent minded At times much depressed: Converses quite readily Expresses hallucinations of hearing: Takes out door exercise: Trans. to A3. Mch 16 Improving rapidly. General health good: Menstruates regularly: Apt 4. 2 teeth extracted.
May 17 In good health. Sent home.

July 23 1900 Letter from Cousin states that patient has entirely recovered & is doing housework.

Discharged.

Personal and Medical History of

Personal and Medical History of Alvina Morgenstein.

Whole No. 5490.

Residence, Saint Paul, Minn.
Resident of State 14 years. Co. since Dec 1899

Date Admission, January 15th 1900.

Admitted by Dr. R. A. Bebb. hour, 7 P.M.

How Sent, E. W. Bazille. Co. of P. Ramsey Co.

Sex, female Age, 44.

Civil Condition, married.

Children, 4

Age Youngest Child, Six months.

Occupation, Housewife.

Degree Education, Fair

Profession, Religion, Lutheran

Habits, Not intemperate.

Nativity, Germany. (Parents also born there.)

Physicians Committing, E.W. Buckley. H.R. Merrick.

Correspondents, Aug. Morgenstein (Husband) Cor E 3rd & Hoffman Av. St Paul.

No. of Year, 12.

Insane Relatives, Mother, in mild form

Cause Exciting, Unknown.

Cause Predisposing,

Form, Ac. Del. Mania. or Mel. ag.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, Jan. 15. 1900.

Duration, 3 days.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 44 yrs.

Time of Leaving, Mar. 30. 1900

Time in Hospital, 2 mo. 7d

Result, Discharged Aug 8. 1900 Improved

EXAMINATION ON ADMISSION BY DR. Bebb *Date of* Jan 19 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - & quick.

MEMORY, Past Events, Impaired.

Recent Events, Fair Special Subjects,

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

REASONING POWER, Ordinary Subjects, Impaired.

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed - but very agitated.

DELUSIONS, Systematized, Transitory, Special Subjects,
of persecution. Thinks people will poison or kill her

HALLUCINATIONS, Auditory - Hears children crying.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 when quite old - does not know cause

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

Brothers and Sisters, -
6 children - 4 living youngest 6 mos.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None.

HABITS, Drinking and Smoking, Some - moderate.

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches & dizzy spells

OCCUPATION, Healthy or not, Housekeeping.

Detail Date, Duration, and Character of Previous Attack, if any,
First attack.

Sleep, Appetite, and Bowels,
Sleep much disturbed for 3 nights before admission

Alvina Morgenstein.

Patient very much agitated. Extremely restless and noisy; has delusions of persecution; thinks food is poisoned and that people wish to kill her; talks incoherently in a frightened voice. Breasts hard, and have considerable milk in them. Has chronic kidney trouble. Excessive albumen; numerous granular and fatty casts; has decided gastriris; craves food, but stomach is disturbed; emesis frequently, vomited material, greenish, offensive; has endometritis with profuse offensive leucorrhoea. Formal mental condition probably fair; present mental condition acute delirious mania, caused by toxaemia from kidney and stomach, kidneys especially; probably uraemic.

Husband states that week before admission to the Hospital she had a cold from Friday until Wednesday; was chilly all the time and perspired freely. Did not cough. Wednesday morning talked as sensibly as usual. Wednesday noon husband was telephoned to come home, his wife had been taken to jail. Says that Wednesday morning she went out to the back yard, and when going back to house talked to two men. They sent for patrol wagon and took her to station. Remained in jail until Thursday. Thursday morning expressed delusions freely; thought she was being poisoned and that people wanted to kill her.

MENSTRUATION, says regular & free from pain previous to last pregnancy.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, much disturbed

BOWELS, Present Condition, Regular

Give condensed statement of the 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 slip attached.

1900

Physic.

Corresponde. Aug 8. 1900 - Improved

Paul.

EXAMINATION ON ADMISSION BY DR. Date of Jan 19 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused - quick

MEMORY, Past Events, Impaired

Recent Events, Fair Special Subj

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Alert - illusion

REASONING POWER, Ordinary Subjects, Impaired.

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Depressed - but very agitated.

DELUSIONS, Systematized, Transitory, Special Subjects,

of persecution. Thinks people will poison or kill her

HALLUCINATIONS, Auditory - Hears children crying.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 when quite old - does not know cause

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

Brothers and Sisters, 7

6 Children - 4 living youngest 6 mos.

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

None.

HABITS, Drinking and Smoking, Some - moderate.

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches + dizzy spells

OCCUPATION, Healthy or not, Housekeeping.

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

First attack.

Sleep, Appetite, and Bowels,

Sleep much disturbed for 3 nights before admission

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken PRESENT WEIGHT, not taken. USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, Skin dry + warm.

TONGUE, Coatings or Promptness of Movement, dry - cracked - heavy brown coat - prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - dilated -

SIGHT, Says eyesight is not very good. - Wears glasses.

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

HEARING, Quite good.

COORDINATION, Arms, Too disturbed to test. Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, of hands + tongue.

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Rapid - distinct - without hesitation.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Feeble

Apex Beat, Regularity, regular. Normal position

ARTERIES,

Pulse full.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical

Expansion good.

B. Sounds rapid + labored.



CRANIAL MEASUREMENTS.

Circumference Horizontal, 2nd Gynaecological Exam.

Circumference Verto-Mental, Feb. 20/1900.

Naso-Occipital Arc, Has been receiving antiseptic

Binauricular Arc, douches - bichloride 1-3000.

Ant-Post Diameter, followed by sterilized water

Transverse Diameter, Local pelvic inflammation

Binauricular Diameter, much reduced. Leucor-

Facial Length, hoea scanty + mild in

Length-Breadth Index, Character.

Volume,

Peculiarities in Shape,

EXAMINATION URINE, Quantity, (1) Yellow (2) Reddish-yellow Sp. g. (1) 1034 (2) 1024 Reaction, acid. Color and Appearance, (1) clear (2) cloudy, heavy sediment.

Albumen, (1) Trace by Tests. (2) Excess. Ante all tests.

Sugar, none none

Casts and Crystals, (1) Amorphous urates, a few fat globules + pus corpuscles - a few epith. cells + normal granular casts (3)

(2) " " " many overlapping epith. cells.

1/22/1900
2/7/1900

See under cranial measurements for 2nd exam

GYNECOLOGICAL EXAMINATION, Extensive laceration of perineum + lateral laceration of cervix. Profuse offensive chocolate colored leucorrheal discharge. general inflammation of vagina. Vaginal walls fistulous, especially posterior to uterus. Uterus slightly retroflexed.

MENSTRUATION, Says regular + free from pain previous to last pregnancy.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, much disturbed

BOWELS, Present Condition, Regular

Give condensed statement of the 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 slip attached.

Personal and Medical History of Alvina Morgenstein.

1900

This patient was brought here by Sheriff's deputy H. Hanson, attended by Dr. Jacobsonde & Mrs. Reisal, in poor physical condition, with the following history: No consanguinity; Mother insane, in a mild form. No history of intemperance in patient nor parents. First symptoms of insanity manifested January 15 1900, by active delirium. Disease appears increasing. Not variable. Derangement now manifested by imagining she has been poisoned, & disposed to harm others. No filthy nor destructive habits. No peculiarities previously manifested. No severe diseases nor injuries to head sustained. No confinement nor restraint employed. No treatment pursued. On personal examination talks irrationally & is violent at times. On admission put upon Infirmary Mrst.

1/14/1900 Gen'l Rpt Complexion dark: hair brown: eyes grayish blue. Small scar on neck. Is dirty. Both breasts caked. Has 3 upper & 6 lower teeth & several roots. Is very maniacal, incoherent & has delusions.

Jan 18 1900 to Feb 7 1900 Summary 14 da record by Dr Bibb. On admission extremely restless & apron bath put into protection sheet to keep her in bed & prevent her hurting herself. Her breasts very hard & full of milk & attended to at once & liniment applied & pumped daily. First night slept one hour, & very noisy when awake. During two weeks temp. almost constantly elevated - 99° - 104°. Pulse 90-100. Kept on liquid diet, took nourishment fairly well, acted she feared poison in food. Bowels required laxatives. Sedatives & tonics given also baths & cold compresses to head. Rest much disturbed & slept only for short intervals at a time. Much of time extremely noisy, & restless when taken out of restraint. Jan 22 Glands on left side of neck swollen, probably due to secondary infection. Hot Compresses applied & swelling reduced in a few days. Lavage of stomach - contents very offensive, greenish & contained mucous. After Jan 25 out of restraint much of time but very active & necessary to hold her a great deal. Up to Jan 29 expressed many delusions principally of persecution & poison in food & medicine. Also feared someone would kill her. For a time auditory hallucinations also, thought she heard her children calling. Was untidy in habits & indifferent to surroundings. Conversation incoherent. During first week extremely restless & noisy most of time but delirium broken by occasional comparatively lucid intervals. After Jan 26. Considerable improvement noted & on 29th talked quite rationally: has not been delirious since. Jan 26. Small bed sores appeared - dressed daily; Lavage & vaginal douches continued. Jan 29 Visited by husband who remained with her much of time after this. Jan 30-31 Repeated emesis. After this much quieter, depressed & rather irritable: often complaining & fault-finding, her principal complaint being that she does not receive sufficient food: she asks especially for potatoes she has been receiving abundant liquid nourishment but we have thought best to give her but little solid food as yet.

Feb 1-7 1900. Temp. ranged from 101-105. Pulse 105-140 Resp. 22-42. Medicine given regularly in form of whiskey, hypodermics of strychnia also

Personal and Medical History of

medicine for Kidneys: Bowels regular. Gives douches daily: Patient very weak. Nurse in Constant attendance. Expectorates some: Sleeps quite well. Sept 8-16. Temp. 100-104 8 Pulse 104-135. Resp 22-42. Takes nourishment very well in form of milk, Gruel &c. Bowels constipated: Had discharge from ear: Feb 28. Little change: Same treatment pursued. Takes nourishment (light diet) quite well. Bowels regular. Rests quite well at night. Seems weak. Coughs some: Sponge baths & Vaginal douches given: During past four weeks has been visited daily by husband.

Mch 5. Improving some: Cough less: Douches still given daily: Takes light diet: Sponge baths given frequently: Temp. 100 - 103. Gives stimulants every four hours: Bowels moved Regularly: Seems quite weak: Ear still washed several times daily with boric acid solution Still discharges slightly. Mch 15. Improving quite rapidly: Talks sensibly. Same treatment Continued. Now sitting up in chair: Temp. subsiding: appetite good: Bowels regular: Mch 20 Improving Must leave today with husband.

Letter received from husband Apr. 27 1900 Stating that patient has some fever all the time but aside from that is as well as could be expected.

Discharged.

Personal and Medical History of Emma Love.

Whole No. 5491

No. of Year, 121.

Residence, Winnebago City, Minn.
Became resident of State Co. in October 1884.

Date Admission, January 19, 1900.

Admitted by Dr. O.C. Heyerdale hour, 10:30 A.M.

How Sent, N.L. Bullis S. of P. Faribault Co.

Sex, female Age, 24 yrs.

Civil Condition, single.

Children, —

Age Youngest Child, —

Occupation, None.

Degree Education, Common school.

Profession, Religion, Not a church member.

Habits, not intemperate.

Nativity, Wisconsin (Parents born in Ohio.)

Physicians Committing, Jos. E. Cooper & F. N. Hunt.

Correspondents, Mrs Mary Love, Winnebago City, Minn.

Insane Relatives, None.

Cause Exciting, Unknown

Cause Predisposing, Unknown

Form, Adolescent 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, 22 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Dr. Bebb. *Date of* 1/21/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Some confusion of thought - rather slow.

MEMORY, Past Events, Fair.

Recent Events, Special Subjects, poor.

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Rather dull - fairly correct.

REASONING POWER, Ordinary Subjects, Fair

Special Subjects, Impaired.

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks food is poisoned. Thinks Miss Peterson is her sister.

HALLUCINATIONS, Rather dull & slow.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Living. Has dyspepsia &

Paternal Relatives,

Mother, Living. Has liver & kidney trouble. Is extremely nervous.

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had cholera infantum - recently. Catarrh last few yrs.

HABITS, Drinking and Smoking, no.

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, None during last two years.

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

Sleep, Appetite, and Bowels, Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, Scars from boils. Skin dry & cool.

TONGUE, Coatings or Promptness of Movement, Prompt. yellow coating.

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

SIGHT, Quite good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Rather mask. - apparently normal otherwise.

HEARING, Quite good

COORDINATION, Arms, Quite good. Legs, Fair. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands & tongue.

PATELLAR REFLEX, about normal. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, somewhat slurred. rather hesitating & slow.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Apex beat rather weak & rapid
Apex Beat, Regularity, Rhythm very irregular.

ARTERIES,



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, Chest symmetrical. Expansion fair

Breath Sounds, B. sounds normal.

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal. hymen intact. very close & firm. shape of cervix irregular - prominent anteriorly. posterior lip short & blends into posterior vaginal wall.

MENSTRUATION, Scanty & painful - quite regular.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Quite good.

BOWELS, Present Condition, Inclined to be constipated - requires occasional laxatives.

Give condensed statement of the 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). At times very obstinate & resistive. Is quite silly at times. At times answers direct questions sensibly at others remarks are irrelevant & silly. is also suspicious of people. Whispers a great deal in a confidential, mysterious manner. says does it because it saves talking. Physical condition impaired - Appetite poor - is anaemic.

Personal and Medical History of Emma Love.

1900

This patient was brought here by Sheriff L. McDonald, attended by Mrs Mary Love, mother, in fair physical condition, with the following history:-
No consanguinity, heredity nor intemperance in patient nor in parents. First symptoms of insanity manifested ten years ago: had pain in head and began to lose interest in things. Disease appears increasing. So variable. Derangement now manifested by wishing to be alone: takes no interest in affairs: so slack in habits + morose. Not disposed to injure anyone: often breaks dishes + throws things through the window lights. Before accession of disease was quick-tempered. No severe diseases nor injuries to head. Has had to be watched closely for two years. Has received no particular treatment.
On personal examination is listless, will not converse readily: keeps her face covered with a thick veil which she will not remove.
1/19/1900 On admission put upon Infirmary Mat (G.H.N.Pt). Complexion dark: hair brown: eyes gray: child in normal condition: Very large scars on both legs. So dirty. Very obstinate: talks very little but intelligently.)
Jan 19 to Feb 3 Summary 14 da. Record by Dr. Bell. On admission obstinate + resistive: slept only 3 hrs. first night + refused food. Temp. slightly elevated first two weeks especially afternoons. P. 88-125 R. normal. Appetite impaired + some days fed mechanically. Requires frequent laxatives: Sleep quite good after second night. When undisturbed very quiet but when cared for or disturbed in any way often irritable + resistive: Seems to fear being harmed. Jan. 30 Eyes much inflamed. Also has aphthous stomatis, her lips, also gums + tongue affected. Hot boracic acid compresses applied to eyes + mouth washed out frequently: medicine given + local treatment of stomatitis. During this time sullen, sarcastic + obstinate. Occasionally answered questions sensibly but more often conversation incoherent + irrelevant.
Feb. 3-14 1900 Temp. lower tho still slightly elevated: Pulse 90-108. Resp. normal. Takes nourishment fairly well, on light diet. Bowels more regular but still requires occasional laxatives. Treatment of mouth + eyes continued + condition gradually improving: Feb 12 Able to be up + dressed. So now more agreable but inclined to be silly. Often answers questions sensibly but conversation childish + frequently incoherent. Feb 28. Quiet: rather irritable, indifferent + untidy. at times answers questions: attempts to get out when doors are opened. Appetite fair: bowels moved by laxatives: expectorates on wall. May 30. No change: Takes outdoor exercise. July 1. Vaccinated: Given regular electrical treatments: Sept 7. No change. Went home with mother. Mar. to June 1901 Mar. 6 patient admitted on Infirmary West bathed and put to bed, quiet in behavior. Apr. 4 Trans. to B.3 West. May 29 Wt. 95#.

Personal and Medical History of Emma Love

June to Sept. 1901. Patient in good general health, takes out door exercise, is unoccupied, frequently asks for medicine, at times tries to get out of door, has some trouble with her eyes for which she receives treatment June 26 Wt. 93#.
Sept. to Dec. Rather untidy in habits and appearance, general health good, very obstinate at times, requires assistance in dressing and undressing, receives gynecological treatment, Nov. 30 Wt. 99#.
Dec. to Feb. 1903. No change. Wt. about 100#. Patient rather incorrigible, is at times silly and rather childish: at other times stubborn and resistive sometimes violent. Nov 24th Bit nurse on the head. Was secluded for 2 hours. At times she converses and answers questions sensibly rarely sensibly. at other times says nothing + does no work. Not inclined to exertion unless forced to. Gen'l health good: sleeps well: appetite fair: bowels regular: is neat and clean in habits and appearance. Very delusional.
Dec. 12th Wt 96#

Personal and Medical History of Julia Connell. (Conley)

Whole No. 5496
Residence, St. Paul, Minnesota.
Date Admission, January 23rd 1900.
Admitted by Dr. R. A. Babb hour, 7 P.M.
How Sent, E.W. Bazille & of P. Ramsey Co.
Sex, female Age, 35 6/12 yrs. (age given as 34 in 1899.)
Civil Condition, single.
Children, one.
Age Youngest Child, 13 yrs. (girl - in orphans home St. Paul)
Occupation, domestic.
Degree Education, common school.
Profession, Religion, Roman catholic.
Habits, unknown.
Nativity, Ireland (Parents also born there)
Physicians Committing, A.P. Wirick & Talbot Jones.
Correspondents, Correspondents unknown.

No. of Year, 126
Insane Relatives, unknown.
Cause Exciting, unknown.
Cause Predisposing, Previous attacks.
Form, Chr. Mania with Dementia
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, not.
Date of this Attack, January 19' 1900.
Duration, 4 days.
No. of Attack, 2nd
No. of Admission, 2nd
Age First Attack, 26 yrs. old.
Time of Leaving,
Time in Hospital,
Result,

Former history gives Step sister. Mrs. Ann Coleman. Rice St. near bridge. St. Paul. Minn.
Bro. Richd Connell Clonoughs. Ireland.

Medicine R. Johnson (Auditor Ramsey Co) Guardian for Julia Connell (or Conley) 5/20/1900 5496

EXAMINATION ON ADMISSION BY DR. Babb *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
not quick - fairly clear.
MEMORY, Past Events, Good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
dull. fairly correct.
REASONING POWER, Ordinary Subjects, Quite good.
Special Subjects, do.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent or slightly depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none at this time.

HALLUCINATIONS, no.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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,
Paternal Relatives,
Mother, died 53 yrs ago, during confinement
Maternal Relatives,
Brothers and Sisters, 3 living & well. Brothers drink but not to excess
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
none
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, Occasional headache.
OCCUPATION, Healthy or not, housework on farm
Detail Date, Duration, and Character of Previous Attack, if any,
see previous history
Sleep, good Appetite, good and Bowels, regular.

...RISTICS.

...WEIGHT, NUTRITION, fair.
... fell off steps when a child. R. thumb and injured ... promptly.
... - Rt. eye injured by twig when 13 yrs. old ... see dimly.
... right eye -

COORDINATION, Arms, Fair Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, marked of tongue -
PATELLAR REFLEX, diminished. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, rather slow & indistinct but otherwise normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, normal.
HEART, Murmurs, Strength, Sounds, Size, Apex Beat, Regularity, reg.



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,
Pulse weak but regular.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical. Expansion normal. Sounds were shallow at R. side.
2/26/1900 EXAMINATION URINE, Quantity, Sp. g. 1010 Reaction, Acid Color and Appearance, Yellow - clear
Albumen, none Sugar, Trace by Bismuth.
Casts and Crystals, Amor. urates. a few fat globules & several epith cells. Many overlapping.
GYNECOLOGICAL EXAMINATION, Laceration of perineum: hypertrophy of urethral orifice: external genitals otherwise normal. uterus hypertrophied & retroverted & adherent to left. numerous adhesions posteriorly & to left. Endometritis: abundant offensive yellowish leucorrhoeal discharge.
MENSTRUATION, Regular & free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleeps well.
BOWELS, Present Condition, Regular needs occasional laxatives

Give condensed statement of the 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 fairly good Probably always defective mentally. Answers questions sensibly but always rather listless & stupid. Had words with some man & claims he slandered her. Her story is somewhat confused & probably not entirely reliable.

Personal and Medical History of Julia Connell. (C...

Whole No. 5496

Residence, St. Paul, Minnesota.

Date Admission, January 23rd 1900.

Admitted by Dr. R. A. Babb hour, 7 P.M.

How Sent, C.W. Bazille & of R. Ramsey Co.

Sex, female Age, 35 yrs. (age given as 34 in 1899.)

Civil Condition, single.

Children, one.

Age Youngest Child, 13 yrs. (girl- in Orphans home St Paul)

Occupation, domestic.

Degree Education, Common school.

Profession, Religion, Roman catholic.

Habits, unknown.

Nativity, Ireland (Parents also born there)

Physicians Committing, R.P. Wurick & Talbot Jones.

Correspondents, Correspondents unknown.

Former history gives Step sister. Mrs. Ann Coleman. Rice St. near Bridge. St. Paul. Minn.
Bro. Thos Connell Clonoughs. Ireland.

No. of Year, 126

Insane Relatives, unknown

Cause Exciting, unknown.

Cause Predisposing, Previous ...

Form, Chr. Mania with Dementia

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, not.

Date of this Attack, January 19' 1900.

Duration, 4 days.

No. of Attack, 2nd

No. of Admission, 2nd

Age First Attack, 26 yrs. old.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Babb. Date of

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
not quick - fairly clear.

MEMORY, Past Events, Good.

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
dull. fairly correct.

REASONING POWER, Ordinary Subjects, Quite good.

Special Subjects, do.

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent or slightly depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses none at this time.

HALLUCINATIONS, no.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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,

Paternal Relatives,

Mother, died 53 yrs ago, during confinement

Maternal Relatives,

3 Brothers and Sisters, (live) living + well. Brothers drink but not to excess.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
none

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Occasional Headaches

OCCUPATION, Healthy or not, housework on farm

Detail Date, Duration, and Character of Previous Attack, if any,
see previous history

Sleep, good Appetite, good and Bowels, regular.

...sonal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 in. PRESENT WEIGHT, 129 lbs USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, Linear scar over right eye. Fell off steps when a child. Rt. thumb nail injured

TONGUE, Coatings or Promptness of Movement, Skin coal + dry. clear. protruded promptly.

PUPILS, Equality, Size, Response to Light, and Accommodation, Unequal - Rt. eye injured by twig when 13 yrs old

SIGHT, Left eye fair - Rt very defective but can see dimly.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Cataract on right eye.

HEARING, Quite good.

COORDINATION, Arms, Fair Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, marked of tongue -

PATELLAR REFLEX, diminished. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, rather slow + indistinct but otherwise normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, normal.

HEART, No Murmurs, Strength, Sounds, Size, Nc.

Apex Beat, Regularity, Reg.

ARTERIES,
Pulse weak but regular.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical. Expansion normal. Sounds more shallow on R. side.



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,

2/26/900 EXAMINATION URINE, Quantity, Sp. g. 1010 Reaction, Acid Color and Appearance, Yellow - clear

Albumen, none Sugar, Trace by Bismuth

Casts and Crystals, Amor. urates. a few fat globules + several epith cells. Many overlapping.

GYNECOLOGICAL EXAMINATION, Laceration of perineum: hypertrophied of urethral orifice: external genitals otherwise normal. uterus hypertrophied + retroverted + adherent to left. numerous adhesions posteriorly + to left. Endometritis. abundant offensive yellowish leucorrhoeal discharge.

MENSTRUATION, regular + free from pain.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps well.

BOWELS, Present Condition, Regular needs occasional laxatives

Give condensed statement of the 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 fairly good Probably always defective mentally. Answers questions sensibly but always rather listless + stupid. Had words with some man + claims he slandered her. Her story is somewhat confused + probably not entirely reliable.

Personal and Medical History of Julia Connell. (Conley)

1900

This patient was brought here by Sheriff's deputy H. Hanson, attended by Dr. Kelly, in fair physical condition, with the following history: Very little information given concerning patient beyond fact that she was in this (Rochester) hospital from Dec. 31' 89 to June 19' 94 (See Vol. 13. Fol. 88. No. 2248) Suffered from Acute Mania at that time - discharged recovered: On Jan. 19' 1900 was found with delusions of persecution by an Italian: Nothing known concerning her history: On personal examination is mentally obtuse + has active delusions as stated above.

On admission put upon Infirmary. (Gen. Rpt. Complexion dark: Hair brown: eyes gray: Skin in normal condition: Small scar on upper part of back: Is dirty: Cataract on right eye: Has an upper plate ~~for~~ 11 teeth in lower jaw: Behavior quiet: Talks intelligently.)

Summary Nurses 14 da. Record by Dr. Bebb. Temp. + Resp. normal. Pulse 60 - 90. Appetite
Jan 23 to Feb 6 good: Bowels constipated: usually slept well. Physical condition good upon ward - quiet + stupid. Assists with work. Talks quite sensibly but in extended conversation showed slight confusion of thought + reasoning faculty slightly impaired. Mch 1 - Aug 31, 1900 (Dr. Linton) Quiet + fairly cheerful. Converses readily: Neat in habits + appearance: Often talks to herself: During April was very irritable + depressed + cried + scolded a great deal: At times unstable: Appetite is good: Bowels regular. Sleeps well: Assists with ward work: Takes daily exercise: July 20 Vaccinated: Res. ✕. Rather depressed: Assists daily with work: Talks readily: appetite good: bowels regular: sleeps well. Apr. 15 No change: June 30' 1900. Irritable + scolds at times: Refuses to help with work: Tidy: Takes outdoor exercise: Appetite good. July 21. Vaccinated Aug 30 Quite agreeable. Assists on ward. General health good: Nov 30. No change, Dec 21 Trans. to D[3] Jan 7. to A[3]. Assists in Steward's Kitchen. Frost Mr. 156#. General health good. Mar. to June 1901 May 30 No change in general condition Wt. 165#.

June to Sept. No change in mental or physical condition Aug. 30 Wt. 150#.

Sept. to Dec. General health good, neat in habits and appearance, takes regular out door exercise, assists regularly with ward work, is very agreeable when not in spell, when in spell is very irritable and expresses many delusions Nov. 27 Wt. 149#.

Dec to Feb 1903 No change. Wt. about 126#.

Personal and Medical History of

Personal and Medical History of Bertha Rupp.

Whole No. 5497

Residence, Osratonna, Minn.

Date Admission, January 24 1900.

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

How Sent, W.A. Eggleston J of P. Steele

Sex, female Age, 36 yrs.

Civil Condition, single.

Children, —

Age Youngest Child, —

Occupation, housewife.

Degree Education, Common school.

Profession, Religion, German Reformed.

Habits, Not intemperate.

Nativity, Wis. (Parents born in Germany)

Physicians Committing, E.E. Bigelow + J.H. Adair.

Correspondents, Mrs. Mary Silden (Sister) Los Angeles Cal-
Mrs Elizabeth Rupp. Osratonna, Minn.

No. for Year, 127

Insane Relatives, No history.

Cause Exciting, Religious mania.

Cause Predisposing, unknown

Form, Melancholia simp

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, not.

Date of this Attack, about 1 wk ago

Duration, about one week.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 36 yrs.

Time of Leaving, February 3rd.

Time in Hospital, 10 days.

Result, Died.

EXAMINATION ON ADMISSION BY DR. Bell. Date of 1/25/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quick. Some confusion with comparatively lucid intervals.

MEMORY, Past Events, Quite good during lucid intervals-probably impaired most of time-usually refuses to speak.

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,

Variable - often excited. Usually indifferent + remains with eyes closed.

DELUSIONS, Systematized, Transitory, Special Subjects, Religious delusions - also of persecution - Believed in dreams + witchcraft. Feared she would be poisoned + harmed.

HALLUCINATIONS, Heard men about her at night who tried to put her in her coffin.

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, Probably of long duration - acute exacerbation about 3 mos. ago.

ONSET, Gradual or Sudden, gradual -

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

Father, dead. Temper. was dissipated, peculiar + had a trouble. Possibly an abscess. Death caused by some brain disease. His last illness was very brief accompanied by emesis + great suffering. Autopsy refused.

Paternal Relatives,

Mother, living. 62 yrs. feeble - Suspicious + believes in dreams + witchcraft.

Maternal Relatives,

Brothers and Sisters, 2 bros. + 2 sisters are dead.

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

Malarial fever when 15 yrs. old. Fell + struck face when about 15 yrs. Recd no serious injury.

HABITS, Drinking and Smoking, No.

HEADACHES, VERTIGO, OR CONVULSIONS, Subject to severe headaches. Several times had convulsions when she would scream + fall unconscious. Then become stiff + cold - This condition would last an hour.

OCCUPATION, Healthy or not,

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

People thought her "peculiar" - This was first attack known

Sleep, Appetite, and Bowels, Poor Much disturbed Good

Copy of Notice of Hearing Petition of Wilhelmina Ziegler for appointment of guardian for Bertha Rupp. served upon Dr Kilbourne - February 1st 1900.

Papers returned to Judge Eggleston.

ERISTICS.

WEIGHT, NUTRITION, Good.

ry.

Gums inflamed - Lips dry + chapped Teeth covered with sord.

mal Reflexes Responses Fair

bismo -

COORDINATION, Arms, Fair Legs, Fair. Grasp,

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

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, Diminished

HEART, Murmurs, Strength, Sounds, Size, No Weak + dilated

Apex Beat, Regularity, Regular

ARTERIES, Normal

Pulse Regular but weak

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical
Expansion normal
B. 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. 1040 Reaction, Acid Color and Appearance, Yellow. Cloudy + ropy deposit 1/26/1900

Albumen, Trace by Tanrets Sugar, Trace by Bismuth

Casts and Crystals, Excessive amount amor. urates several mucus bands + a few epith. cells.

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen lax - uterus normal position tenderness in left ovarian region.

MENSTRUATION, For 10 yrs. more or less disturbed at menstrual periods. Much better during last two yrs however -

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Much disturbed - refuses to eat.

BOWELS, Present Condition, Constipated.

Give condensed statement of the 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 ability probably below average + present condition an acute exacerbation developing in a chronic case. A marked hereditary element is present + at this time an hysterical element manifested. Was always superstitious + previous to this illness melancholy over religious subjects. + worried over unjust rumors of scandal about herself.

Personal and Medical History of Bertha

Whole No. 5497

Residence, Owatonna, Minn.

Date Admission, January 24 / 1900.

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

How Sent, W.A. Eggleston J of P. Steele

Sex, female Age, 36 yrs.

Civil Condition, single.

Children, —

Age Youngest Child, —

Occupation, housewife.

Degree Education, Common school.

Profession, Religion, German Reformed.

Habits, Not intemperate.

Nativity, Wis. (Parents born in Germany)

Physicians Committing, E.E. Bagelow + J.H. Adair.

Correspondents, Mrs. Mary Sieden (sister) Los Angeles Cal-
Mrs Elizabeth Rupp. Owatonna, Minn.

No. of Year, 1[illegible]

Insane Relatives, No

Cause Exciting, Religious

Cause Predisposing, [illegible]

Form, Melancholia

Accompanying Bodily Disorder, none [illegible]

Suicidal or not, not

Date of this Attack, about 1 wk ago

Duration, about one week.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 36 yrs.

Time of Leaving, February 3rd.

Time in Hospital, 10 days.

Result, Died.

EXAMINATION ON ADMISSION BY DR. Bell. *Date of* 1/25/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quick. Some confusion with comparatively lucid intervals.

MEMORY, Past Events, Quite good during lucid intervals - probably impaired most of time - usually refuses to speak.

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,

Variable - often excited. Usually indifferent + remains with eyes closed

DELUSIONS, Systematized, Transitory, Special Subjects, Religious

Delusions - also of persecution - Believed in dreams + witchcraft

Feared she would be poisoned + harmed.

HALLUCINATIONS, Heard men about her at night who tried to put her in her coffin.

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION Probably of long duration - Acute exacerbation about 3 wks. ago.

ONSET, Gradual or Sudden, gradual -

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

Father, dead. Was dissipated, peculiar + had a violent temper. Death caused by some brain trouble, possibly an abscess. His last illness was very long + accompanied by much + great suffering. Autopsy refused.

Paternal Relatives,

Mother, living. 69 yrs. feeble - Suspicious + believes in dreams + witchcraft.

Maternal Relatives,

Brothers and Sisters, 2 bros. + 2 sisters are dead -

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

Malarial fever when 15 yrs. old. Fell + struck face when about 15 yrs. Said no serious injury.

HABITS, Drinking and Smoking, No.

HEADACHES, VERTIGO, OR CONVULSIONS Subject to severe headaches. Several times had convulsions where she would scream + fall unconscious. Then became stiff + cold - This condition would last several hours.

OCCUPATION, Healthy or not,

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

People thought her peculiar - This was first attack known

Sleep, Appetite, and Bowels, much disturbed poor good

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

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

WOUNDS, Abnormalities and condition of Skin, Skin - warm + dry.

TONGUE, Coatings or Promptness of Movement, dry - brownish coating. Gums inflamed - Lips dry + chapped Teeth covered with sordes.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal size Responds fair

SIGHT, Quite good.

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

HEARING, Quite good.

COORDINATION, Arms, Fair Legs, Fair. Grasp,

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

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, Diminished

HEART, Murmurs, Strength, Sounds, Size Weak diminished

Apex Beat, Regularity, Regular

ARTERIES, Normal

Pulse regular but weak

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical
Expansion normal
B. 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. 1040 Reaction, Acid Color and Appearance, Yellow, cloudy + ropy deposit 1/26/1900

Albumen, Trace by Tanrets Sugar, Trace by Bismuth

Casts and Crystals, Excessive amount amor. urates several granular casts + a few Epith. cells.

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen lax - uterus normal position tenderness in left ovarian region.

MENSTRUATION, For 10 yrs. more or less disturbed at menstrual periods. Much better during last two yrs. normal -

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Much disturbed - refuses to eat.

BOWELS, Present Condition, Constipated.

Give condensed statement of the 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 ability probably below average + present condition an acute exacerbation developing in a chronic case. A marked hereditary element is present + at this time an hysterical element manifested. Was always superstitious + previous to this illness melancholy over religious subjects. + worried over unjust rumors of scandal about herself.

Personal and Medical History of Bertha Rupp.

1900

This patient was brought here by sheriff H.F. Warren attended by Mrs Zeiger + Frank Bekora, in fair physical condition, with the following history:- No history concerning consanguinity or heredity. No intemperance in patient nor her parents. First symptoms of insanity manifested within the past week. Disease appears increasing, not variable. Derangement now manifested by religious delusions. No disposition shown to injure anyone. Habits filthy + destructive. From history given patient probably manifested previous peculiarities. No history of nerve disease nor injuries to head. No confinement nor restraint employed. No treatment pursued. On personal examination suddenly became maniacal + required restraint. On admission put upon Infirmary (Gitt. Rpt. Complexion dark. Hair black part gray. Eyes brown. Skin in normal condition. No marks, scars nor bruises noticed. Is rather dirty. Left eye slightly crossed. Behavior hysterical, refused to walk. Talks at times intelligently but has delusions.)

Summary 14 da record - From Jan 25 - Feb. 3rd 1900. By Dr Bebb. On admission hands + feet were tied because she had strenuously resisted the sheriff. She refused to speak at first but resisted some when being carried to Infirmary. She received bath + was put to bed, drank one glass of milk. At this time she talked quite intelligently told Miss Gleeson she came from Osratonna + had lived there alone with her mother, that she had been brought here against her will. When asked if she had always been pretty well she said yes except that she was subject to fainting spells, claimed that they were not convulsions, she only became weak + fell. She expressed some delusions but her mind remained fairly clear + she was quiet for several hours. She then became extremely restless + noisy, removed bedding + clothing + refused to eat or take her medicine also resisted so it was impossible to take temperature From this time on there was more or less confusion of thought + incoherence of speech with a few brief comparatively lucid intervals. She continued extremely noisy all the first night + would not remain in bed so was put in restraint the next morning (Jan. 26) She persisted in her refusal of food + medicine + was fed mechanically. She was untidy in her habits + violent + destructive at times. She would occasionally answer questions rationally or make a sensible remark, most of time was very obstinate + her actions manifested a decidedly hysterical element. She would often lie quietly with eyes closed for hours during the day but was extremely noisy at times + almost invariably so at night, her rest being very much disturbed. She usually became more disturbed when anyone entered her room.

Personal and Medical History of Bertha Rupp.

POST MORTEM EXAMINATION OF MISS BERTHA RUPP.
FEBRUARY 3rd, 1900.

Made by Dr. F. R. Mosse, Coroner, Drs. Wanous, Chapple, Bebb, and Heyerdale.

Body well developed. Post mortem lividity observed on back and hips. On lips were noticeable sores from the herpetic eruption which had been present. Face looked rather haggard. Lungs normal, rather small in size. Serous covering of lungs normal; smooth. Pleural cavities normal; very little fluid; no adhesions. Pleura smooth. Heart very small in size; very flabby; no clots present. Pericardium normal, smooth and glistening. Examination of valves revealed no lesions. Spleen very small in size, apparently normal. Kidneys very small, apparently normal, although examination revealed albumen. Liver seemed somewhat enlarged. Stomach walls were thin and vey flabby. Presence of grayish liquid, remains of last meal of milk. Intestines somewhat congested.in walls of duodenum. Examination of intestinal mucosa revealed no lesion. Appendix small and normal. Pelvic organs:- Uterus very small, normal position. Fallopian tubes normal; fimbriated ends. Ovaries both rather enlarged; white, sclerotic. Surfaces rough. Left ovary cystic. Servix small and normal. Hymen quite relaxed. Perineum quite relaxed.

Brain and cord not examined.

Personal and Medical History of

1900

This patient was brought to the Infirmary by Dr. Beebe and Sheriff Frank Pekora, in the forenoon of Jan. 25, 1900.

No history coming consciously from patient.

Has parents living.

Disease appears to have originated by religious delusions. No definite history of previous mental disturbance.

Habits: From history given by sheriff, intemperate & destructive.

Peculiarities: No history of epilepsy.

No confinement nor restraint required previous to admission. On personal examination, patient was found in restraint. On admission, patient was put in bath. Hair black part gray; eyes brown; complexion dark. No marks, scars nor bruises noted. Is slightly crossed: Behavior hysterical, refused to walk. Talks intelligently, but has delusions.

Summary 14 day record. From Jan 25 - Feb. 3 1900. By Dr Beebe. On admission hands & feet were tied because she had strenuously resisted the sheriff. She refused to speak at first but insisted some when being carried to Infirmary. She received bath & was put to bed, drank one glass of milk. At this time she talked quite intelligently told Miss Gleason she came from Owatonna & had lived there alone with her mother, that she had been brought here against her will. When asked if she had always been pretty well she said yes except that she was subject to fainting spells; claimed that they were not convulsions, she only became weak & fell. She expressed some delusions but her mind remained fairly clear & she was quiet for several hours. She then became extremely restless & noisy; removed bedding & clothing & refused to eat or take her medicine also resisted so it was impossible to take temperature. From this time on there was more or less confusion of thought & incoherence of speech with a few brief comparatively lucid intervals. She continued extremely noisy all the first night & would not remain in bed, so was put in restraint the next morning (Jan. 25) She persisted in her refusal of food & medicine & was fed mechanically. She was untidy in her habits & violent & destructive at times. She would occasionally answer questions rationally or make a sensible remark, most of time was very obstinate & her actions manifested a decidedly hysterical element. She would often lie quietly with eyes closed for hours during the day but was extremely noisy at times & almost invariably so at night, her rest being very much disturbed. She usually became more disturbed when anyone entered her room.

Personal and Medical History of Bertha Rupp.

Slept only about 3 hrs. extremely noisy 5 hrs. Jan 26 Temp. 102°-103°. In restraint was quiet during afternoon & slept until 1 A.M. extremely noisy remainder of night. Jan 27 T. 101°3 A.M. Took light diet. Sat up about 1½ hrs., seemed weak & was put to bed. Very noisy all day, slept 4 hrs. during night. Temp. Pls. 103 T. 102. P. 84 R. W. Took a little nourishment also fed mechanically. Calls to grimace & bowels moved 5 times. Noisy & resistive & attacked nurses. Slept 2½ hrs. Jan 29 Temp. 101°4. Fed mechanically, was noisy & resistive, slept about 5 hrs. Jan 30 T. 99°? Temps. to C. No change. During above period mouth washed out frequently & movement of bowels secured daily by laxatives. Jan. 31 T. 100°9 P. 74. R. 27. Was restless & fought nurses: when taken out of bed she attempted to creep under it, was afraid of the rubber sheet & called it a "black devil" - very talkative, & incoherent. Believed that evil spirits were about her. Has herpes of lips which is spreading rapidly. Mouth cleaned frequently & ointment applied. Is growing weaker & bed sores developed which are dressed daily. Feb 1 Temp. 100°. Pulse 74. Resp. 27. Fed by tube: awake greater part of night: Language is obscene at times. Feb 2 Temp. 102° P. 140 R. 65. Is fed mechanically, speech very incoherent. Is failing rapidly, appears very weak. Latter part of afternoon & evening seemed to be suffering. After 8:30 P.M. a rapid failure noted. Pulse became weak & irregular & stimulants given: Summary Cont. by Dr Reynolds. Feb. 3 Sank into condition resembling shock; Body became cold & clammy, Temp. 102°. Toward morning became pseudo, Temp. subnormal: 97 P. 100. R. 50. Pulse very rapid & heart beat furiously: From this condition she did not rally. but continued thus until 11:05 A.M. When she died.

Note on previous history as given by Mrs. Zieger of Owatonna, a friend.

The onset of Miss Rupp's present mental disturbance was probably gradual but noticed just 3 wks ago. Some of neighbors thought she had always been peculiar. Her mother & she lived alone & neighbors knew very little about them. She was always industrious & very kind to aged mother, especially so during the lucid intervals of recent weeks. Last Christmas Miss Rupp received a dress & $1.00 from Mrs. Zieger. She thought dress was bewitched & would not wear it & threw it out doors with some other articles. Later she commenced to throw money out - her idea being that in order to serve God rightly & go to heaven she must deprive herself of everything. When urged not to throw money out she burned it instead. During day she seemed quite rational except when spoken to on religious subjects or about her own peculiar conduct. At these times she became restless & would laugh nervously, told her mother that she realized that she acted strangely at night. As night approached she always became very uneasy, pounding wall & imagining that people were trying to kill her & that she was being put in a coffin. One morning between 6 & 7 A.M. she went down town waited until store opened & bought bibles & testaments to amount of $4.50 paying for them with $10.00 bill & refusing change. She distributed the bibles & testaments. The attention of neighbors being attracted to her strange conduct they reported case to the authorities who made an investigation & fearing that she might set fire to the house or injure her mother they sent her to the hospital.

Died.

Personal and Medical History of Ema Isaacson.

Whole No. 5498
Residence, St. Paul, Minn.
Date Admission, January 27. 1900.
Admitted by Dr. R. A. Bibb. hour, 7 P.M.
How Sent, E.W. Bazille & Co. Ramsey Co.
Sex, female Age, 54
Civil Condition, single
Children, none
Age Youngest Child, -
Occupation, machine operator.
Degree Education, Common school.
Profession, Religion, Not a church member.
Habits, Not intemperate.
Nativity, Sweden - (Parents also born there)
Physicians Committing, H.R. Mirick & C.J. Woolway.
Correspondents, brother Hans Nelson, Belgrade Minn. — (Card fr by relative) By P.of C.
Patient lived with Mrs Jorgenson at 379 E 8th St. & may have furniture & personal effects.

No. for Year, 128
Insane Relatives, None
Cause Exciting, Unknown.
Cause Predisposing,
Form, Paranoia (Original Dementia)
Accompanying Bodily Disorder, none mentioned
Suicidal or not, Not.
Date of this Attack, 4 mos. ago.
Duration, 4 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 54 yrs.
Time of Leaving, May 17 - 1900
Time in Hospital, 4 yrs 3 Mos 20 days
Result, Improved. Discharged Nov 8/02

EXAMINATION ON ADMISSION BY DR. Bibb *Date of* 1/30/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Apparently quite clear & not sluggish.
MEMORY, Past Events, Quite good.
Recent Events, do Special Subjects, do.
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,
normal.

DELUSIONS, Systematized, Transitory, Special Subjects,
Probably of persecution - Thinks people talk about her.
HALLUCINATIONS, Hears neighbors & people in shop call after her.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, D. 13 yrs. ago. (66 yrs) died suddenly while crossing ocean.
Paternal Relatives,
Mother, D. 10-11 yrs ago (over 70) nursing - paralyzed a year before death - died of apoplexy.
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Small pox when 19 yrs. Says takes cold easily.
HABITS, Drinking and Smoking, No.
HEADACHES, VERTIGO, OR CONVULSIONS, Occasionally dizzy.
OCCUPATION, Healthy or not, Dressmaker
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Quit Appetite, Good and Bowels, Reg

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2. PRESENT WEIGHT, 98# USUAL WEIGHT, NUTRITION, Quite good.
WOUNDS, Abnormalities and condition of Skin, Scars from small pox. Small scar on L. side neck. Skin warm & moist.
TONGUE, Coatings or Promptness of Movement, Prompt. slight coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal. Responses fair
SIGHT, fair.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Left eye weak - uses glasses for close work.
HEARING, fairly good.
COORDINATION, Arms, good Legs, good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, slight of hands & tongue & of muscles on R. side of face.
PATELLAR REFLEX, normal. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Slightly slurred - prompt.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, normal.
HEART, No. Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity, Regular
ARTERIES,
Pulse weak but regular.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair.
More tubular & inspirations slightly roughened 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,

1/30/1900 EXAMINATION URINE, Quantity, Sp. g. 1008 Reaction, Acid. Color and Appearance, Yellow cloudy
Albumen, None Sugar, None
Casts and Crystals, Amor. urates - a few Epith cells & uric acid crystals.

GYNECOLOGICAL EXAMINATION, External genitals normal. hymen lax. uterus bound posteriorly & to left by many adhesions. hyperaemia of cervix & vagina.
MENSTRUATION, Menopause past 3 yrs ago. Has had hot & cold flashes for 4 yrs. " was sometimes painful in Rt. ovarian region - & still complains in this position. Says she has suffered from it for 16 yrs.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleeps well.
BOWELS, Present Condition, Normal

Give condensed statement of the 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 fair. When she has hot & cold flashes is very restless. Probably of fair degree of intelligence - talks quite sensibly on general subjects. 3-4 mos. ago began to be annoyed by people hollering at her & talking about her. Probably has delusions of persecution. Has depression at back of head with elevation just beginning - says when a baby has "something there which discharged bad matter"

Personal and Medical History of Elna Isaacson.

1900

This patient was brought here by Sheriff's deputy H Hanson attended by Mr A.D. Peterson in fair physical condition, with the following history:
No history of consanguinity, heredity nor intemperance in patient nor her parents: gives first symptoms of insanity manifested about four months ago, by delusions disease appears increasing: Not variable: Derangement now manifested by imagining that people are talking about her: Not disposed to injure anyone: No filthy nor destructive habits: No history of previous penitentiries, nor of severe diseases or injuries to head: No confinement nor restraint employed: No Treatment pursued: On personal examination talks irrationally & has delusions of persecution.
On admission put upon Infirmary Ward (Gen'l Rpt. Complexion dark: hair brown & gray: eyes blue: Skin in normal condition: Small scar on right ear: Is clean: Has four upper & 8 lower teeth & a partial upper & lower plate: Behavior quiet. Talks intelligently.)
January 5 Feb 10/1900 Summary 14 da. Record by Dr. Bess. On admission complained of pain in side: Circulation impaired & temp. usually subnormal (97°-98°) Pulse 60-75 R. 15-19. Physical condition fairly good: Appetite good. Bowels constipated, requires occasional laxatives. Is up on ward, quiet, agreeable & converses quite sensibly on ordinary subjects: Has delusions of persecution in regard to people in St Paul but does not express them freely unless closely questioned Jan 31 Trans. to A[x]. Feb 10 No change since above note. Feb 26. Neat: Appetite good: Sleeps well. Bowels regular: Takes out door exercise: Assists some with work. Has many delusions in regard to nurses: Mch 20 No change:
Apr 28 1900. Very cross & disagreeable: Insists upon having her own way— Trans. to B[3]. July 4. More agreeable. Trans. to A[3]. July 19 Vaccinated- Very disagreeable at times. Refuses to assist with work: Menstruation regular. General health good; Aug 25 Visited by friends. About the same. Does some sewing & knitting- Nov 16. Somewhat more agreeable of late: General health good. Coughs a good deal at times. Wt. 109#
Dec 1- Feb 28 1901. General health good: Has delusions about nurses: Thinks they do not treat her right. Mar. to June 1901 Does not show any change in either mental or physical condition. May 30 Wt. 115#.
June to Sept. Patient sick in bed with a cold, medicines given, at times is quite hysterical, neat and clean, reads and sews for herself but does no ward work, takes out door exercise, Aug. 31 Wt. 108#. Sept. to Dec. Nov. 30 Wt. 107½#.
Dec 1st to May 17, 1902. Patient is agreeable on the ward: neat in habits and appearance: converses readily: appetite good: Gen'l health good takes regular outdoor exercise: Occupies her time reading and sewing.

Personal and Medical History of Elna Isaacson.

April 8 visited by a friend May 17th Taken home by friend.

Personal and Medical History of Jennie M. Kripp.

Whole No. 550 x

Residence, St. Paul, Minn.

Date Admission, February 1 1900.

Admitted by Dr. E. G. Iverson. hour, 7 P.M.

How Sent, Ex. Bazille Dept. Ramsey Co.

Sex, Female Age, 30 yrs.

Civil Condition, married.

Children, None

Age Youngest Child, ——

Occupation, Housewife (husband a laborer)

Degree Education, Common school.

Profession, Religion, Roman catholic

Habits, not intemperate.

Nativity, France (Parents born in Luxemburg.

Physicians Committing, A. Schroyer. & Parks Ritchie

Correspondents, Jos. Kripp. (husband.) 763 Decatur St. St. Paul, Minn.

No. of Year, 132.

Insane Relatives, Mother insane at menopause (mania)

Cause Exciting, Unknown.

Cause Predisposing,

Form, Melancholia (Mild) with delusions

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, Last May.

Duration, 9 mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 29 yrs.

Time of Leaving, Apr. 7. 1900

Time in Hospital, 2 mo. 6 d

Result, Disc. Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Bibb. Date of Feb. 3/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Rather confused - not sluggish.

MEMORY, Past Events, Quite good.

Recent Events, " Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Not dull.

REASONING POWER, Ordinary Subjects, Fairly good.

Special Subjects, " "

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Variable - slight depression.

DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any now.

HALLUCINATIONS, None apparently now - Before
ILLUSIONS, admission "heard voices" & saw angels

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 7 yrs. Had been insane 6 mos.

Maternal Relatives,

Brothers and Sisters, four half & one half sister.

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

HABITS, Drinking and Smoking, Takes whiskey sometimes.

HEADACHES, VERTIGO, OR CONVULSIONS, Constant. Had convulsion probably last mo.

OCCUPATION, Healthy or not, Housekeeper.

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

Sleep, Appetite, and Bowels, Try

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2½ in. PRESENT WEIGHT, 146 lbs USUAL WEIGHT, NUTRITION, Good

WOUNDS, Abnormalities and condition of Skin, Skin dry.

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

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

SIGHT, good.

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

HEARING, Good.

COORDINATION, Arms, O. good Legs, do. Grasp,

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

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, No Murmurs, Strength, Sounds, Size,
Sounds normal at apex - weak at base.
Apex Beat, Regularity, Regular.

ARTERIES,
Rad. receding pulse.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion normal.
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,

7/2/900 EXAMINATION URINE, Quantity, Sp. g. 1034 Reaction, Acid Color and Appearance, yellow - cloudy with mucus & flaky deposit

Albumen, None Sugar, None.

Casts and Crystals, # Ammonium + Amor. urates + oxalate lime crystals - Epith. Cells. + normal mucine bodies.

GYNECOLOGICAL EXAMINATION, External genitals normal - Uterus normal position. Hyperaemia of cervix. White milky leucorrhoeal discharge.

MENSTRUATION, Established at 18-19 yrs - always regular + free from pain

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, not very good.

BOWELS, Present Condition, Const. ipated.

Give condensed statement of the 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 apparently good. but complains frequently of various aches + pains. Is nervous + easily frightened - Appears suspicious of people. Did not express delusions freely at this examination

Personal and Medical History of Jennie M. Kriips.

1900

This patient was brought here by Sheriff's deputy Hanson attended by Dr. Jos. Kriips in apparently good physical condition, with the following history: No consanguinity: Mother insane at menapause: No history of intemperance in patient nor parents: First symptoms of insanity manifested last year by spells of laughing & crying & despondence. Disease appears increasing; not variable: Derangement now manifested by hallucinations, hears voices, sees angels, prays almost continually cries easily: Complains of severe pain in left side & of fear of being killed. Suffers from insomnia: Not disposed to injure anyone: No filthy nor destructive habits. Before accession of disease was strongly religious. No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued: On personal examination no further facts noted: has hallucinations & fears personal injury. On admission put upon Dr. Primary Ward (Girls Dept.) Complexion dark: Hair & eyes brown: Skin in normal condition: Is clean: has the upper & four lower teeth: Behavior quiet. Talks intelligently.

Feb 1 to Feb 14/1900 Summary 14 da. record. By Dr. Bass. Temp. pulse & Resp. about normal: Sleep disturbed first week, better the 2nd wk. Appetite good: Bowels constipated: requires laxatives: Complains of pain in left arm & back but general physical condition good. Upon ward usually quiet but inclined to be irritable & very exacting in her demands. During 2nd week more agreable, said she felt very well & wished to assist with ward work. Attended dance & chapel services: Talked quite rationally: no longer faultfinding.

Feb 28. Neat; quiet: usually cheerful: At times irritable & fault finding: Usually occupied with some work: reads: Appetite good: Bowels regular: Somewhat hypochondriacal: Complains of various pains & aches.

March 7. Quiet & agreeable. Laughs to herself at times. Sent home today.

Letter from husband Apr. 9, 1900 States that patient is very well.

Discharged

Personal and Medical History of

Personal and Medical History of Fredericka Piks.

Whole No. 5504

Residence, Winona Co. Minnesota.

Date Admission, February 7th 1900.

Admitted by Dr. O.C. Heydale hour, 4th P.M.

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

Sex, female Age, 76.

Civil Condition, widowed.

Children, 9.

Age Youngest Child, 28 yrs.

Occupation, Housewife.

Degree Education, Can read & write.

Profession, Religion, Lutheran.

Habits, Not intemperate.

Nativity, Prussia. (Parents also born there.)

Physicians Committing, E.S. Muir - W.F.C. Heise.

Correspondents, Son Fred Piks. Cor. Olmsted & Sanborn Sts. Winona, Minn.

No. of Year, 134.

Insane Relatives, None.

Cause Exciting, Senility

Cause Predisposing, Unknown.

Form, Senile Dem.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Talks of it.

Date of this Attack, 2 yrs. ago.

Duration, 2 yrs.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 76 yrs.

Time of Leaving, Oct. 24. 1900

Time in Hospital, 8 m. 17 d.

Result, Died. Dysentery

EXAMINATION ON ADMISSION BY DR. Bell *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Hears talks acutely - Confused & quick.

MEMORY, Past Events, Failing - poor.

Recent Events, poor Special Subjects, do.

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,
Excited restless & talkative

DELUSIONS, Systematized, Transitory, Special Subjects,
Probably has many but does not express connected ideas.

HALLUCINATIONS, ?

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Died

Paternal Relatives,

Mother, Died

Maternal Relatives,

Brothers and Sisters,
7 children living & dead. 2 not well.

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

HABITS, Drinking and Smoking, none

HEADACHES, VERTIGO, OR CONVULSIONS, none.

OCCUPATION, Healthy or not,

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

Sleep, Appetite, and Bowels, Good Excellent regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, ——— PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION, Impaired.

WOUNDS, Abnormalities and condition of Skin, Skin dry & wrinkled.

TONGUE, Coatings or Promptness of Movement, Protrudes slowly - slight coating - Breath offensive.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - responses only fair.

SIGHT, Quite good

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

HEARING, Quite good

COORDINATION, Arms, fair Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, of hands & tongue

PATELLAR REFLEX, Exaggerated. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Talks constantly & rapidly.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, diminished

HEART, Murmurs, Strength, Sounds, Size,
1st sound at apex roughened. Sounds feeble.

Apex Beat, Regularity, regular.

ARTERIES,
Sclerotic.
Pulse 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,

2/6/1900 EXAMINATION URINE, Quantity, 3XI Sp. g. — Reaction, acid Color and Appearance, Clear - yellow

Albumen, + by all tests Sugar, + Bismuth Test by Haines.

Casts and Crystals, Amor. urates. a few Epith. cells. + oxalate of lime crystals

GYNECOLOGICAL EXAMINATION, has haemorrhoids. External genitals normal except laceration of perineum - Granul. vaginal hyperaemia. Rectocele, numerous adhesions on all sides of uterus almost concealing cervix - uterus & cervix atrophied.

MENSTRUATION, History not obtainable.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Quite good.

BOWELS, Present Condition,

Give condensed statement of the 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). Daughter-in-law came with her & could give little history. Is nervous - talkative - good natured - mischievous - Extremely restless & noisy at times. Mental condition probably due to senile changes.

Personal and Medical History of Fredericka Pihs.

1900

This patient was brought here by sheriff A. W. Fuhrmann attended by Dr. F. Pihs. in fair physical condition, with the following history:- No history of consanginity, heredity nor intemperance in patient nor parents. First symptoms of insanity manifested two years ago: took off clothes & cut them with hatchet: Disease appears increasing: Not variable: Derangement now manifested on all subjects: exposes her person: Threatens injury to grandchildren: destroys clothing: Is disposed to injure others: Habits filthy & destructive: Has always been quick tempered: No severe diseases nor injuries to head: Has been kept at home to prevent running away: No treatment pursued: On personal examination is quiet; incoherent. On admission put upon Infirmary West / Ward Dept. Complexion dark: hair gray: eyes gray: Skin in normal condition: Is rather dirty: Has 3 lower & 4 upper teeth: Resisted being bathed: Does not talk English.

Feb 7 1900. Admitted on Infirmary, bathed & put to bed.: restless & noisy during night: incoherent. Feb 13 Has been restless excited & noisy at times conversation irrational: Condition one of senile dementia. Appetite quite good. Bowels constipated: Sleeps poorly: Has been kept in restraint at night. Trans. to B'. Feb 28 Kept in bed most of day: Eats & sleeps well: frequently out of bed: noisy & pounds on door: Incoherent: has many delusions: Thinks nurses are her relatives: Takes out door exercise: Appetite quite good. Mch 1. Aug 31 Dirty & untidy: Noisy & very restless much of time: Seems to worry a good deal & often cries: Is gradually failing: Sometimes destroys clothing. Has chronic diarrhoea. Put on boiled milk diet. Out of bed much at night: Takes out door exercise: July 16 Vaccinated Sept 1- Oct 25 1900. Oct 16. Very dirty in habits. Hands kept in mitts part of each day: Very demented: Sings & talks loudly: Takes out door exercise daily. Troubled a great deal with diarrhoea. Speaks only german: Oct 17 Trans. to Infirmary. Oct 21. Remains in bed. Failing some. Bowels very loose: Oct 25 Continued to fail. Died at 1 P.M.

Died

Personal and Medical History of

Personal and Medical History of Mrs. Carrie Stewart.

Whole No. 5506

Residence, St. Paul. Minn.

Date Admission, February 9. 1900.

Admitted by Dr. E. J. Hawkins. hour, 7 P.M.

How Sent, E.W. Bazille & of P. Ramsey Co.

Sex, female Age, 36.

Civil Condition, married

Children, four.

Age Youngest Child, six months.

Occupation, housewife.

Degree Education, High School.

Profession, Religion, Episcopal.

Habits, Not intemperate.

Nativity, Illinois. (Father Ireland, Mother N.Y.)

Physicians Committing, E. J. Hawkins & R.S. Bole.

Correspondents, Augusta Stewart. 407 Drewry Ave, Merriam Park, Minn. (Husband)

Telephone during day. Prior 13. Minneapolis - at night Prior 22. Call 5. St. Paul. Minn.

No. for Year, 136

Insane Relatives, One sister.

Cause Exciting, Followed confinement.

Cause Predisposing, Possibly heredity.

Form, Puerperal Melancholia Ac.

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, Sept. 8'99 -

Duration, About 5 months.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 36 yrs.

Time of Leaving, Left ~~Nov~~ Dec 10'1900.

Time in Hospital, 10 mos 1 da.

Result, Discharged Recovered Apr. 30'1901

EXAMINATION ON ADMISSION BY DR. Bubs. Date of 2/8, 23/1900.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Will not converse - Says only a few words in answer to questions.
Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, Impaired.
Special Subjects, "
Own Mental State,

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

DELUSIONS, ~~Not~~ Systematized, Transitory, Special Subjects,

HALLUCINATIONS, None determined.
ILLUSIONS, " "

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

HISTORICAL.

LENGTH INVASION, About 9 mos.

ONSET, Gradual or Sudden, Gradual.

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

Father, living & well. Very nervous & suspicious

Paternal Relatives, -

Mother, living & well. Subject to Rheumatism.

Maternal Relatives,

2 Brothers and Sisters, Sister dead - delirious 10 wks. Had Typhoid. Brothers well.

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

Typhoid at 15 yrs. & at 19 yrs (very severe) Also had Scarlet Fever

HABITS, Drinking and Smoking, Subject to headaches.

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, housekeeper.

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

Sleep, Appetite, and Bowels, Until a week ago slept rate quite well. since then poorly.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3 in. PRESENT WEIGHT, 115# USUAL WEIGHT, NUTRITION, Impaired

~~WOUNDS~~, ~~Abnormalities~~ and condition of Skin, Anaemic, dry & warm.

TONGUE, Coatings or Promptness of Movement, White coating - protruded reluctantly.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - response to accom. slow.

SIGHT, Good.

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, No trouble -

HEARING, good.

COORDINATION, Arms, Will not test Legs, do. Grasp,

TREMORS, Hands, Tongue, ~~Facial Muscles~~, General,

PATELLAR REFLEX, unequal. Right diminished Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Very hesitating & slow.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Anaemic murmur over pulmonary area. Murmurs, Strength, Sounds, Size,
Strength Sounds normal
Apex Beat, Regularity, regular.

ARTERIES, Normal
Pulse Weak, rapid, regular

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion limited
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,

2/9/1900

EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, acid. Color and Appearance, Yellow-clear-hazy pink dep.

Albumen, Trace by all tests Sugar, Trace by Haines & Bismuth.

Casts and Crystals, Amor & sodium urates - a few Epith. cells & fat droplets several uric acid crystals.

GYNECOLOGICAL EXAMINATION, Has haemorrhoids - Slight laceration of perineum - External genitals otherwise normal - lateral laceration of cervix - cervix small - uterus normal position.

MENSTRUATION, history not obtainable

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, disturbed.

BOWELS, Present Condition, Constipated.

Give condensed statement of the 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 very sensible lively & amiable. At present will occasionally answer a question correctly but rarely speaks. Sometimes commences to say something & stops before finishing, apparently forgetting to complete statement. She is apparently much depressed & had delusions at home, has not expressed them here. She read newspapers a great deal & received wrong impressions from them. Moves very reluctantly & sometimes is obstinate & resistive - Appears ill attention. Physical condition impaired - Anaemic.

Personal and Medical History of Mrs. Carrie Stewart.

1900

This patient was brought here by sheriffs deputy Hanson, attended by Angus Stewart in fair physical condition with the following history:- No history of consanguinity, one sister insane: No intemperance in patient nor parents: First symptoms of insanity manifested September 8' 1899, by acute mania: Disease appears increasing: Not variable: Derangement now manifested by melancholia, - no rational intervals: Patient not disposed to injure anyone: No filthy nor destructive habits noted: No peculiarities previously manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: Has had constant medical attendance: On personal examination refuses to talk: Was confined

2/9/900 Aug 8th 1899. On admission put upon Infirmary (Gen. Dpt. Complexion dark: hair auburn: eyes hazel: skin hot + dry: Eruption on upper part of back: small blister on left heel + several scratches on legs: Chin + both eyes slightly bruised, right eye + nose inflamed: So clean: Teeth- has an entire upper plate. has eight lower ~~plate~~ teeth + a few roots: Behavior quiet but resisted being taken to hall + being bathed. Refused to talk.

Feb 9 to Feb 15 Summary 14 da. Record by Dr. Heyerdahl) Admitted an Infirmary - slept quite well. During first week. Temp. 99°- 101.6. Pulse 98 - 111. Resp. 22 - 25. Appetite fair: occasional cathartics required: bowels move daily. Given occasional hypnotics. Feb 10 Did not pass urine. Hot compresses applied: eyes inflamed. Out of bed often. Slept one hour. Feb 11 In restraint Slept 5 hours: Restless all day: Compresses on eyes. Feb 12 no change- Did not sleep any- sat up in bed all night. 13 Slept quite well. 14 Slept 8 hours- Compress still on eyes: 15 In restraint: violent when bed was being changed. Did not sleep any. Second week. Temp. 99.6 - 101. Pulse 99 - 120 Resp. 18 - 28: Appetite poor Feb 16 - 19. Fed by tube 20th - 22nd. Occasional cathartics given, bowels moved daily. In restraint from 16 - 19th Slept poorly. Hot compresses kept on eyes. Out of bed most of time, during night Feb 20 up + dressed - quiet. Slept 8 hrs. Feb 21 Fed by tube. Slept 4 hrs. quiet when awake Feb 22. Restless, wanders about in a confused manner, seldom speaks + resists everything: untidy in habits: indifferent to surroundings: Sleeps poorly. Bowels moved by laxatives. Mch. 14 Restless; refuses to stay in bed. kept in restraint untidy + indifferent. Seems bewildered: Seldom speaks very resistive: Fed by tube. Bowels moved by laxatives: Sleeps poorly: 20th Out of restraint today. in at night: Seems quite mad. Sepid sponge baths given to reduce temp. which for past few days has averaged as high as 104.6. Bladder irrigated + douche of distilled water given: 27 Has been sleeping fairly well at night Temp. 100 - 104. Very restless during day. Fed by tube. Enemata given frequently. + bladder irrigated: also given cathartics + hypnotics

Personal and Medical History of Mrs. Carrie Stewart.

In restraint part of time. Examination of urine shows condition of acute kidney trouble which cause of present condition + temperature. Hot packs to relieve system by perspiration. Odour from urine very offensive. Apr. 3. During past week same treatment pursued: Hot packs, irrigation of bladder, douches of hot water: hypnotics, cathartics + enemas, alcohol rubs: Has taken nourishment by glass: Temp. from normal to 100,

Apr 16. no change in treatment. Patient has improved, temp. practically normal: Kidney inflammation reduced. Apr 29 untidy, dull, does not converse: Still seems bewildered: Appetite poor. May 23 - 24. Visited by husband. May 30 Fed by nurse: June 12 - 13 Visited by husband + daughter

June 25. Given electrical treatment + massage 3 times a week July 2nd Visited by husband: Taken for a drive: Aug 30 No change: Very untidy: Kept in bed most of time on account of habits. Sept 5 - 8 Visited by husband + daughters + taken driving. Oct 25. Has improved somewhat. Complains of severe earache in left ear: poultice applied. Oct 30 Talks a little at times: Still untidy: Taken out for exercise: Fed on tray.

Nov 3. Visited by mother + daughter. Nov 16 Wt 114½ lbs. Nov 28 Quite resistive when taken out but has improved slightly. Dec 10 Visited by husband + taken home. Had improved very much: conversed pleasantly + freely: Increased in weight + expression normal. At times still a little bewildered + resistive.

Letter from husband Feb 4 1901. States that for about ten days after returning home patient was quiet + morose - Then began to improve + at time of writing she seemed as well as ever except for a slight timidity about going out into public.

Discharged

Personal and Medical History of Thora M. Nilson.

Whole No. 5508
Residence, St. Paul. Minnesota.
Date Admission, February 13' 1900.
Admitted by Dr. C. E. Evanson hour, 7 P.M.
How Sent, Ex. Bazille & Apt. Ramsey Co.
Sex, female Age, 36.
Civil Condition, married.
Children, Four.
Age Youngest Child, Two years.
Occupation, housewife
Degree Education, Common school.
Profession, Religion, Not a ch. member.
Habits, Not intemperate
Nativity, Denmark - Parents also born there
Physicians Committing, C. T. Miller M.D. F. H. Oldmakl.
Correspondents, Hans A Nilson 689 Wabasha St. St. Paul Minn.

No. of Year, 138
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing,
Form, Acute Melancholia ag.
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, One week ago
Duration, one week.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 36 yrs.
Time of Leaving, Sept. VI' 1900
Time in Hospital, 7 mo. 8 da.
Result, Discharged. Recovered Feb 5' 1901

EXAMINATION ON ADMISSION BY DR. Bell *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused - Quick.
MEMORY, Past Events, Impaired.
Recent Events, " Special Subjects, do.
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert. illusive.
REASONING POWER, Ordinary Subjects, Impaired.
Special Subjects,
Own Mental State, delirious.
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Extremely restless & rather depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Cannot determine. talks incoherently

HALLUCINATIONS, Cannot determine
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, Brief
ONSET, Gradual or Sudden, One week.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father,
Paternal Relatives, Can secure no information from Ler.
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, Housewife.
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, Impaired.
WOUNDS, Abnormalities and condition of Skin, Many bruises on body. Bruised knee 1st night of admission. Throws bed about room.
Skin cool & dry.
TONGUE, Coatings or Promptness of Movement, Will not protrude. dry & scaly.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Eye dilated responds readily.
SIGHT, Apparently good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, No apparent trouble. eyes sunken with heavy dark circles around them.
HEARING, Apparently good.
COORDINATION, Arms, fair Legs, Fair - Cannot test much Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Frequent moving & twitching of muscles.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Indistinct. usually refuses to talk.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, Forcible at apex base Sounds, Size, Normal
Apex Beat, N Regularity, Regular.



ARTERIES,
Pulse - weak & thready.

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion variable
B sounds rapid & 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,

2/9/1900 EXAMINATION URINE, Quantity, Sp. g. 1030 Reaction, acid Color and Appearance, yellow, cloudy.
Albumen, + by all tests Sugar, + by Bismuth.
Casts and Crystals, Amor. urates. a few epith. cells. pus corpuscles & renal granular casts.

GYNECOLOGICAL EXAMINATION, External genitals normal. lateral laceration of cervix: erosion of os uteri normal position. has hemorrhoids.
MENSTRUATION, Says regular & free from pain.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Very much disturbed.
BOWELS, Present Condition, Constipated.

Give condensed statement of the 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). Typical case of delirium - extremely restless most of time shaking head - moving arms restlessly - picking at clothing & other objects. Muttering incoherently to herself. Conversation always incoherent & words indistinct - no lucid intervals. Even when lying quietly if spoken to becomes extremely nervous - mutters in sing song manner & tosses arms about. Physical condition much impaired

Personal and Medical History of Flora M. Nelson

1900

This patient was brought here by Sheriffs deputy John A. Noah, attended by Hans A. Nelson, in poor physical condition, with the following history:- No history of consanguinity, heredity or intemperance given: First symptoms of insanity manifested one week ago by same emotional & exalted: Disease appears increasing: Not variable: Not disposed to injure anyone: No filthy nor destructive habits noted: No peculiarities previously manifested: No severe diseases nor injuries to head: Has been confined in house during past four days: Promises given with out any effect. On personal examination refuses to talk, sings constantly, is exalted, moves arms in circular manner.

2/13/1900 On admission put on Infirmary West (G.H.R. Rpt. Complexion fair hair dark brown: eyes blue-gray: Skin in normal condition: Small red spot on right arm: small scar on R. little finger: Is clean: Has 11 upper & 10 lower teeth: Is noisy.)

Feb 13 to Feb 7 (Summary by Dr. Reynolds of da record) Received on Infirmary, given bath & put to bed: Slept from 8:30 to 11. Then barred door & turned bed up on end. Noisy & violent Bruised herself a good deal: Temp. WNL Temp. 98-103. Pulse 104-128. Resp. 20-30. Appetite poor on 17, 18 & 19th. fed by tube: Enemata & cathartics given: Bowels moved daily: Hypnotics given. Feb 14 Noisy & out of bed at times during day. Put in restraint: Noisy at times during night. 15th & 16th In restraint: Noisy at times Stomach washed: Sponge baths given: Appeared to sleep a great deal 17th In Restraint: Seemed weaker: 18th & 19th do. Second week. Temp. 98°-100. Pulse 80-90 Resp. about 20. Took nourishment fairly well. Given hypo. strych. also enemata & cathartics Feb 20 Out of restraint: out of bed several times during night Feb 21 Out of restraint. Seems stronger: Is incoherent & expresses delusions Feb 23 In restraint: Very restless: Somewhat noisy: Slept well Feb 24 Still in restraint: Noisy & restless but slept fairly well at night. Mch 18 Taken out of restraint & allowed on hall. Has a great many delusions of having done wrong: Temp. pulse & resp. above normal at times. Cathartics & tonics given. 18th Continues to improve but still somewhat agitated & melancholy: Has red spots on face: Is menstruating. Mch 28 Improving somewhat: Appetite fair: hypnotics & occasional cathartics required: Tidy & well behaved: Very despondent: In restraint at night Sleeps somewhat better.

Mch- Sept 21, 1900. Mch 29 Attempted to choke herself, tying sheet around neck
Mch 30 Very restless at times becomes quite excited: most of time agitated & cries. Thinks she has done some great wrong. Has attempted suicide several times. Kept in restraint at night. Appetite poor: Bowels constipated: Sleeps fairly well:
Apr 28. Quiet & depressed: Takes no interest in surroundings

Personal and Medical History of

May 30 1900 Patient improving slightly: Occasionally does a little work on ward Appetite good: Bowels constipated. Sleeps well. June 7. 5 teeth extracted June 30 Conversation sensible: Quiet: assists with work: July 21 Vaccinated Aug 30 Continues to improve altho becomes melancholy & cries at times Expresses desire to die. At present is quite stupid, has to be dressed & undressed & taken to dining room. Sept 10. Visited by friends.
Sept 21. very much improved: Talks sensibly: Is cheerful & happy: Assists with work: Converses readily. Takes outdoor exercise. Attends amusements also does fancywork. General health good.
Sept 21 1900 Went home today.

Discharged.

Personal and Medical History of Anbjor O. Braaten

Whole No. 5514
Residence, Holden Tp. Goodhue Co.
Date Admission, February 22 1900.
Admitted by Dr. O.C. Heyerdale hour, 7 P.M.
How Sent, Apl Hallen P.O. Goodhue Co.
Sex, female Age, 27.
Civil Condition, single
Children, none.
Age Youngest Child, —
Occupation, Housework.
Degree Education, Common school.
Profession, Religion, Lutheran.
Habits, Temperate.
Nativity, Holden. (Parents born in Norway)
Physicians Committing, Aa. Jones & G.C. Wellmer.
Correspondents, Mrs. Inga Braaten (mother)

No. of Year, 144
Insane Relatives, None. Father intemperate.
Cause Exciting, Probably masturbation a factor.
Cause Predisposing, Unknown.
Form, Melancholia
Accompanying Bodily Disorder, None mentioned
Suicidal or not, not.
Date of this Attack, October 1899.
Duration, 4 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 27 yrs.
Time of Leaving, Febry 15 — 1902
Time in Hospital, 1 yr 11 mos 25 ds
Result, Died: February Tuberculosis

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Feb. 5/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear. quick.
MEMORY, Past Events, Very fair.
Recent Events, fair Special Subjects, do.
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert. fairly correct.
REASONING POWER, Ordinary Subjects, fair.
Special Subjects, do.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Quite indifferent.

DELUSIONS, Systematized, Transitory, Special Subjects,
Hears voices in left ear which tell her many strange things especially that people are talking about her.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.
LENGTH INVASION, Oct. 1898.
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, living. paralyzed. began with convulsion. drank hard.
Paternal Relatives, Father's mother crazy. Father a hard drinker.
Mother, Healthy
Maternal Relatives, Mother's father dead. mother healthy. 70 yrs.
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking, Fond of stimulants
Began to use liquor 10 yrs. ago.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework. Never a good worker
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Has stomach trouble

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5 in. PRESENT WEIGHT, 127# USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, None.
TONGUE, Coatings or Promptness of Movement, slight White coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal — normal.
SIGHT, Quite good. uses glasses for reading.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good in right. fair in left.
COORDINATION, Arms, good Legs, good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, hands slightly unsteady. slight tremors of tongue.
PATELLAR REFLEX, Exaggerated. Other Reflexes, Elbow reflex present.
ARTICULATION, Slurred, Hesitating, Slow, Good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, Seems diminished on left side.
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal.
ARTERIES,



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,
Normal.

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

GYNECOLOGICAL EXAMINATION,

MENSTRUATION, began rather late. hard time at first. irregular. usually lasted 4 days to a week.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, poor.
BOWELS, Present Condition, Regular

Give condensed statement of the 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). Began to be queer 10 yrs ago at puberty. Has great appetite for stimulants. says for several years has noted that sensation is diminished on left side & strength was greater on right. Wanders away from home for days at a time.

Personal and Medical History of Anbjor O. Braaten.

1900

This patient was brought here by sheriff's deputy S.S. Lundquist attended by Mrs. Inga Braaten (mother) in good physical condition, with the following history: No history of consanguinity & heredity: Father very intemperate. First symptoms of insanity manifested in October 1899, wandered away from house & slept in outhouses: Disease appears increasing: Is variable but with no rational intervals, is worse during menstrual periods: Derangement now manifested concerning family troubles and religion: No disposition shown to injure anyone unless provoked: No filthy nor destructive habits. Before accession of disease became very irritable & irregular in temper: No severe diseases nor injuries to head: No confinement nor restraint employed: Very little treatment received: no result. On personal examination is excitable, melancholic, hysterical & self accusing.

2/22/1900 On admission put upon Infirmary (Gen. Rpt. Complexion dark: hair light brown: eyes blue: Skin in normal condition: No marks, scars nor bruises: Is rather dirty: Has 12 upper & 11 lower teeth. Behavior quiet: Talks intelligently at times & says she knows her mind is not right & that she is growing worse.)

Feb 27 to Mch 8 Summary 14 days record by Dr. Heyerdale. Temp. pulse & resp. about normal: Appetite fair during first week: Cathartics given occasionally: Slept well after first night. When she was awake four hours. Expressed some delusions: quiet in behavior: Does some work on ward: During second week little change expressed delusions of persecution: went out daily for exercise: Talked quite lucidly: appetite fair slept well.

Mch 7 & 8 Visited by sister: Mch 30 untidy; restless. Converses readily. Assists with work: appetite good. Bowels moved by laxatives. Sleeps well: works some in Laundry. June 6 Trans. A3. No change.

May 30 July 1 1900 Becoming very untidy. Takes meals on tray: works in laundry occasionally. 17 Vaccinated unsuccessfully. Aug 12 lower incisor tooth extracted. Trans. to D'. July 21 Assists with ward work. No change. Oct 29, Violent at times & rather disagreeable: Trans. to B'. Nov 16 Wt. 173# Nov 24 Very violent at times; attacks patients & nurses. Attacked Mc Simmons & pulled her hair also tied sheet about Anna Anderson's neck. Put in restraint for a few days. Dec 1 - Feb 28 1901 General health good. Does no work. Takes outdoor exercise: Talks incoherently. Seldom answers questions: sings & laughs to herself. Often says "don't work" Walks rapidly around hall: Has attempted to run away several times when out working. Mch 1 Wt. 110#

Apr 7. Patient pushed Pauline Lund down, also fought & scratched Julia McClung. Has many delusions: Thinks spirits talk to her. At times quite disturbed moving from place to place in an aim-

Personal and Medical History of

less manner: Is resistive & inclined to be violent: Does no work: Physical health good: Bowels regular: Apr 18 Visited by mother & taken home altho she did not seemed to be pleased about going

Mar 1 - June 1 - 1901 Patient returned to hospital May 13. seemed nervous and disturbed; a bruise on right leg noticed. Appetite seemed good: pulse regular: sleeps well. Transfered to D3 from Infirmary. Patient poured pitcher of coffee down her neck; did no injury to her. Very disagreeable: habits regular. May 31 Wt 110#. June to Sept Patient violent and very disagreeable does no work, takes out door exercise, is careless and dirty, is losing physically, Sept. 2 Wt. 98#. Sept. to Dec. Nov. 14 visited by friends; Nov. 23 Wt. 98#. During next quarter lost very much physically began to expectorate, has running temperature, Jan. 21 trans. to Infirmary and secluded. Feb. 5 & 6 visited by mother, sputum and urine both tubercular, Feb. 15 09 died at 6:45 A. M.

Died

Personal and Medical History of Mary Wanous.

Whole No. 5-5-2-3

Residence, Steele Co., Minn.

Date Admission, March 9th, 1900

Admitted by Dr. O. C. Heyendale hour, 8¹⁵ pm.

How Sent, W. A. Eggleston. J. & P. Steele Co.

Sex, Female Age, 27

Civil Condition, married

Children, Seven

Age Youngest Child, six weeks

Occupation, House work - Husband Farmer.

Degree Education, Common School.

Profession, Religion, Catholic.

Habits, Not intemperate.

Nativity, Bohemia - Parents also.

Physicians Committing, F. M. Dimmick & B. M. J. Conklin

Correspondents, Anton Wanous - Owatonna (lives on farm 6½ m. South west of town)

No. of Year, 153

Insane Relatives, None

Cause Exciting, Supposed loss of children + excessive child bearing.

Cause Predisposing,

Form, Melancholia - Puerperal

Accompanying Bodily Disorder,

Suicidal or not, Not

Date of this Attack, Mar. 7th

Duration,

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 27

Time of Leaving,

Time in Hospital,

Result,

Stephen Albert Kasper - merchant.

EXAMINATION ON ADMISSION BY DR. Heyendale Date of 3/13/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Sluggish.

MEMORY, Past Events,

Recent Events, Fair. Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Dull.

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

Religious delusions - prays constantly but can be aroused from this condition at times when talks intelligently.

Has had fashion of sitting down + thinking in a melancholy way for 2 yrs past.

HALLUCINATIONS, Saw Holy Family - Saw Jesus Crucified.

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, Began Mch. 7th 1900

ONSET, Gradual or Sudden,

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

Father, Died Phthisis - 59 yrs.

Paternal Relatives, don't know

Mother, living - healthy.

Maternal Relatives, don't. know.

2 Brothers and 5 Sisters,

Children 5 living - 2 dead.

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

Diphtheria at ten yrs. Has had no doctor for 11 yrs.

HABITS, Drinking and Smoking, drank considerable coffee.

HEADACHES, VERTIGO, OR CONVULSIONS, no.

OCCUPATION, Healthy or not, housework.

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

Sleep, Appetite, and Bowels,

Good

Personal and Medical History of Mary Wanous

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ PRESENT WEIGHT, 135# USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, Skin clear - healthy.

TONGUE, Coatings or Promptness of Movement, Clear - prompt.

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

SIGHT, Good - (says)

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

HEARING, Says good.

COORDINATION, Arms, Legs, Grasp,

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

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Slow.

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Slight laceration of perineum; quite deep laceration of cervix uteri normal position + size: Mucous membrane of vagina slightly inflamed.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Has slept very poorly recently.

BOWELS, Present Condition,

Give condensed statement of the 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). Husband says day before admission prayed from 11-2 o'clock, also cried. Held baby tightly + more busily cried more tightly she held him. Voice seems hoarse. Disposition always quiet. Was jealous + would scold husband. Always very mild. Children healthy. Married at age of 25. Has been in good physical condition. Has been thinning in body until admission. Very much depressed + very quiet. Prays constantly. Can at times be aroused from this stupid condition + will then talk quite intelligently but very slowly.

Personal and Medical History of Mary Wanous.

1900

This patient was brought here by Sheriffs Deputy F. P. Ley Kora attended by Anton Wanous (husband) in good physical condition, with the following history:- No history of consanguinity or heredity or intemperance in parents or self. First symptoms of insanity manifested Mar. 7th 1900. by "melancholy + praying" Disease appears to be increasing: Is not variable: no rational intervals. Derangement now manifested by constant prayer If disturbed is violent. Has shown disposition to injure others by hugging babe. Not suicidal. filthy and destructive. No treatment confinement nor restraint has been employed. No severe disease nor injury to head. On personal examination no further facts obtained.

Mch 9 On admission put upon Infirmary West (Gen. W. Rpt. Complexion fair: eyes blue: hair light: skin in normal condition: No marks, scars nor bruises noticed: Is dirty: Has twelve teeth in either jaw + a few roots. Behavior quiet. Answers questions intelligently.)

Mch 9 to Mch 23 Summary 14 da. record by Dr. Heydale. Behavior good, talked quite readily: During first week Temp. normal pulse + resp. somewhat accelerated: Appetite fair: Took cathartics occasionally. Very quiet in behavior: Slept quite well. Prayed a good deal talked very little: Milk pumped from breasts as long as necessary: Mch 13 Visited by husband. During second week Temp. pulse + resp. about normal. Appetite good but somewhat capricious: occasionally refused food: Bowels regular: Slept quite well at night altho somewhat restless at times: Given douches daily: Still prays: Taken home by husband on March 20.

May 1st Patient returned - Husband + brother (Otto Black) accompanied her: Husband stated that during stay at home patient was not so much mentally: Most of time took nourishment but on some days a very small quantity: Manifests a great many delusions, religious + jealous in regard to husband + other members of family: Slept very poorly talked a great deal at night. Bowels constipated. Did not menstruate while at home. July 28 Very dirty: July 30 Clean in habits: quiet. Talks very little but answers questions readily: Takes out door exercise: Sleeps well. Aug 20 Visited by husband + taken home.

Dec 7 Returned - Feb 16 1901. Very much depressed: cries a great deal:

Feb 16 1901. Vaccinated: Feb 28 wt. 115#. Sits quietly about ward: Does no work: much depressed. Mar. to June 1901 Apr. 18. tran. to Infirmary West on account of becoming somewhat violent, Apr. 30 tran. to A. 3 West. May 15 tran. to C. 3 West. May 29 Wt. 123#. June to Sept. In good physical health, untidy in habits and appearance, is generally quiet and melancholy, has many delusions and at times is governed by them, at times is inclined to be violent strikes patients and is frequently disagreeable in many ways. Aug. 30 Wt. 128#.

Personal and Medical History of Mary Wanous.

Sept. to Dec. Patient tran. to C. 2. patient failing both mentally and physically frequently becomes violent, breaks chairs and stands and attacks those who interfer. has to be watched very closely. Nov. 23 Wt. 121½ #.

Dec. to Feb. 1903 No change. Wt about 137#.

Personal and Medical History of Mrs. Julia Pride.

Whole No. 5525
Residence, Owatonna, Minnesota.
Date Admission, March 12' 1900.
Admitted by Dr. C. L. Chapple hour, 7 PM
How Sent, M.A. Eggleston Sup. P. Steele Co.
Sex, female. Age, 58
Civil Condition, widow
Children, 5
Age Youngest Child, 26
Occupation, Washing
Degree Education, Very little - can read.
Profession, Religion, Not a ch. member
Habits, Not intemperate.
Nativity, Germany - (Parents also born there.)
Physicians Committing, F.C. Bacon + W.C. Eustis.
Correspondents, Son. Wm. Wabshall. Waseca, Minn.

No. of Year, 1st
Insane Relatives, none.
Cause Exciting, "living alone".
Cause Predisposing,
Form, Senile Dementia
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, 58 yrs.
Time of Leaving, Apr. 11. 1900
Time in Hospital, 30 d.
Result, Discharged Nov. 7. 1900
Improved

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* 3/17/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick.
MEMORY, Past Events, Good
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Clear
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Fairly Normal
DELUSIONS, Systematized, Transitory, Special Subjects,
Evidently delusions of persecution.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, Probably gradual.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Can get no history.
Father, Died - 72. Had Salt Rheum on foot.
Paternal Relatives, Father's father a hard drinker + abusive. Uncle Wipe with club + cut skull.
Mother, Died - old age.
Maternal Relatives,
Brothers and Sisters, Well.
Children 3 boys - 1 girl. Also 3 dead + 3 miscarriages.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking, Good.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework + washing.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Says sleep disturbed by neighbors boys.

Personal and Medical History of

5525

M Julia Pride.

Copy of Order for Hearing Petition of Mr. Geo E Wabshall. for appointment of said petitioner as guardian for Julia Pride insane; served and service admitted April 17' 1900

(Papers filed with commitment papers.)

ACTERISTICS.

SUAL WEIGHT, NUTRITION, good.
ant. Skin healthy.
ept.
- normal.

COORDINATION, Arms, good Legs, good Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, marked by hands.
PATELLAR REFLEX, present. Other Reflexes, present.
ARTICULATION, Slurred, Hesitating, Slow, Clear.
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,

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

GYNECOLOGICAL EXAMINATION, Laceration of perineum: cervix normal: uterus small. Says she has "falling of womb" but parts seem to be normal.
MENSTRUATION, Began at 12 - stopped at 41.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition, Somewhat constipated.

Give condensed statement of the 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 married twice - lived with first husband 12 yrs. Then separated from him. He abused her + tried to shoot her. often whipped her. 6 yrs after separation married a negro at Owatonna + lived with him 21 yrs. He drank heavily + abused her. All children by first husband. In good physical condition. Has delusions of persecution. Says people are against her: that she had tubs trumped + miscarry washing they have exchanged for others + she found things in them which were not hers. Has done washing for a living for 28 yrs. + since death of husband 6 yrs ago has lived alone. Talks very freely: memory good. Says she has never been addicted to intemperance but her talk + history would indicate more or less dissipation.

Personal and Medical History of Mrs. Julia Pride

Whole No. 5525
Residence, Owatonna, Minnesota.
Date Admission, March 12th 1900.
Admitted by Dr. C. L. Chapple hour, 7 PM
How Sent, M.A. Eggleston & P. Steele Co.
Sex, female. Age, 58
Civil Condition, widow
Children, 5
Age Youngest Child, 26.
Occupation, Washing
Degree Education, Very little - can read.
Profession, Religion, Not a ch. member
Habits, Not intemperate.
Nativity, Germany - (Parents also born there.)
Physicians Committing, C.L. Barin & W.C. Custer.
Correspondents, Son. Wm. Wabshall. Mascca, Minn.

No. of Year, 155
Insane Relatives, none.
Cause Exciting, "living alone".
Cause Predisposing,
Form, Senile Dementia
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, 58 yrs.
Time of Leaving, Apr. 11. 1900
Time in Hospital, 30 d.
Result, Discharged Nov. 7. 1900 Improved

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* 3/17/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick
MEMORY, Past Events, Good
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Clear
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Fairly Normal
DELUSIONS, Systematized, Transitory, Special Subjects,
Evidently delusions of persecution.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, Probably gradual.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Can get no history
Father, Dead - 72 - Had Salt Rheum on foot. Father's father a hard drinker & killed a man. Struck wife with club & cut skull.
Paternal Relatives,
Mother, Died - old age.
Maternal Relatives,
Brothers and Sisters, Well.
Children 3 boys - 1 girl. Also 3 dead & 3 miscarriages
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking, Good.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework & washing.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Good. Good. Regular. Says sleep disturbed by neighbors boys.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, Not Taken PRESENT WEIGHT, Not Taken. USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, Scar on R. Breast. Skin healthy.
TONGUE, Coatings or Promptness of Movement, Clear & prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal.
SIGHT, Quite good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, normal
COORDINATION, Arms, good Legs, good, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, marked of hands.
PATELLAR REFLEX, present. Other Reflexes, present.
ARTICULATION, Slurred, Hesitating, Slow, Clear.
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,

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

GYNECOLOGICAL EXAMINATION, Laceration of perineum: cervix normal: uterus retrod: says she has falling of womb but parts seem to be normal.
MENSTRUATION, began at 12 - stopped at 41.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition, somewhat constipated.

Give condensed statement of the 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 married twice. lived with first husband 12 yrs. then separated from him. He abused her & tried to shoot her. often whipped her. 6 yrs after separation married a negro at Owatonna & lived with him 21 yrs. He drank heavily & abused her. All children by first husband. In good physical condition. Has delusions of persecution. Says people are against her: that she had tube trumps & Mice away washing they were exchanged for others & she found things in them which were not hers. Has done washing for a living for 28 yrs. & since death of husband 6 yrs ago has lived alone. Talks very freely: memory good. Says she has never been addicted to intemperance but her talk & history would indicate more or less dissipation.

Personal and Medical History of Mrs. Julia Pride.

1900

This patient was brought here by Sheriff's deputy J.R. Neykora, attended by Mrs. M. Degar, in fair physical condition, with the following history: No history of consanguinity; no heredity so far as known: No intemperance in patient nor parents: First symptoms of insanity manifested about six months ago. Thought people treated her strangely: Disease appears increasing: So variable. Derangement now manifested by imagining that various people are annoying and abusing her: that poison is in food & that holes are bored & tacks driven in her house & property: Not disposed to injure anyone: No filthy nor destructive habits noted: No previous peculiarities manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued. On personal examination no further facts noted.

Mch 14 On admission put upon Infirmary (G.H.R. Rpt. Complexion fair: eyes blue hair brown: skin in fair condition: No marks, scars, nor bruises noted: So clean: Mo upper & seven lower teeth found - all very poor: Behavior quiet: Has delusions & thinks neighbors are tormenting her.)

Mch 14 to Mch 26 Summary 14 da. record by Dr. Heydale. Patient talked quite sensibly: Slept about 6 hours quiet when awake: Temp. pulse & resp. about normal: appetite fair: occasional cathartics given: Slept well until night of 16 when she was restless & complained of pain in stomach: Awake often nights of 17th & 18th. Expressed many delusions. Second week Temp. pulse & resp. normal: Appetite fair: bowels regular with an occasional cathartic Slept well: Did some work: quiet & agreeable: Out of doors daily: expressed many delusions of persecution. April 11

April 11. Cheerful: Converses readily: neat in habits & appearance: Assists with work: Appetite good: bowels regular: sleeps well: Taken home by son today.

Discharged.

Letter from son July 28 1900 States patient is very well.

Personal and Medical History of

Personal and Medical History of Anna G. Carlson.

Whole No. 5528
Residence, Redwing, Minn.
Date Admission, March 14. 1900
Admitted by Dr. O. C. Heyerdale hour, 7 P.M.
How Sent, Ard Keller Jay P. Goodhue Co.
Sex, Female Age, 33 yrs.
Civil Condition, married.
Children, Seven
Age Youngest Child, Eight weeks.
Occupation, Housekeeper (Husband a shoemaker)
Degree Education, Common school.
Profession, Religion, Not a church member.
Habits, Not intemperate.
Nativity, Sweden - (Parents also born there)
Physicians Committing, Dr Thoreson & J. V. Anderson.
Correspondents, Husband. Samuel Carlson 227 E. Third St. Redwing, Minn.

No. of Year, 158
Insane Relatives, Mother.
Cause Exciting, Puerperium.
Cause Predisposing, Heredity.
Form, Acute Melancholia.
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, not
Date of this Attack, About six weeks ago.
Duration, 6 weeks.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 33 yrs.
Time of Leaving, May 4. 1900
Time in Hospital, 1 mo. 20 d.
Result, Dis. Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* 3/16/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear.
MEMORY, Past Events, good
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Quite alert.
REASONING POWER, Ordinary Subjects, Good.
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Slightly depressed.
DELUSIONS, Systematized, Transitory, Special Subjects,
believes she is going to die.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, About 7 wks. - 10 days after birth of last child - Bad hard, long labor - 36 hrs.
ONSET, Gradual or Sudden, Sudden
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, living - well - 70 yrs.
Paternal Relatives, Father's Father died young - cause unknown / Mother " of old age
Mother, died insane (about 52 yrs.)
Maternal Relatives, Mother's Father died at 85. Had drunken abusive wife / Mother died suddenly - quite young.
Brothers ~~and Sisters~~, living - All hard drinkers
7 children 6 living. oldest 11 yrs. - all well
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Labrippe 10 yrs. ago.
HABITS, Drinking and Smoking,
HEADACHES, VERGIGO, OR CONVULSIONS, Troubled with headaches for about 10 yrs.
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels,
Poor, Appetite good. afraid of dying while asleep

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, Not Taken PRESENT WEIGHT, Not Taken. USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, Small scar on upper part of R. leg. Skin clear + healthy.
TONGUE, Coatings or Promptness of Movement, Slight coating. prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal - responses normal
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Left eye shows a slight strabismus.
HEARING, good.
COORDINATION, Arms, Good Legs, good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight of tongue.
PATELLAR REFLEX, present. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
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,

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

GYNECOLOGICAL EXAMINATION, Perineum extensively lacerated: Uterus + cervix rather large + somewhat boggy, due to incomplete involution after pregnancy. Some discharge from uterus.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition, Constipated

Give condensed statement of the 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). Husband says had a quiet disposition somewhat inclined to be jealous. Slept disturbed for several years since married. Husband is a hard drinker, + is inclined to be abusive at home etc. Patient rather poorly nourished, has been sick since last child was born - Patient answers questions intelligently + quickly.

Personal and Medical History of Anna G. Carlson.

1900.

This patient was brought here by Sheriffs deputy S. S. Lundquist attended by her husband, in fair physical condition, with the following history:- No history of consanguinity, Mother insane: First symptoms of insanity manifested about six weeks ago: Disease appears stationary + not variable: Derangement now manifested by spells when she believes she is dying: hears her friends plotting against her, says they put poison in her food: 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: In Redwing hospital one week for treatment. On personal examination face flushed + congested, Temp. 99⅕ wants to remain in bed, says she is not strong enough to get up: Refuses medicine, thinks it + her food contains poison.

Mch 14 On admission put upon Infirmary W. (Gt. W. Apt. Complexion fair: hair + eyes brown: Skin moist + cold: Small scar on upper part of right leg: Is clean: Left eye crossed: Has 15 upper + 12 lower teeth: Is quiet but refused to walk: Talks intelligently.)

Mch 14 to Mch 18 Summary 14 da. Record by Dr. Heyerdale. On admission talked quite sensibly: behavior quiet awake often during night. During first week Temp. pulse + resp. about normal. Appetite fair bowels regular with occasional cathartics: Hyperotics given: Talked very sensibly + has evidently had delusions in regard to dying which seem to have disappeared: Seemed rather weak given douches: Slept quite well at night: sat up in chair on 18th.

During second week Temp. pulse + resp. about normal: appetite fair: hypnotics + cathartics given: bowels quite regular: Patient dressed + on ward daily: very quiet in behavior: Slept well at night very agreeable + pleasant altho quiet + somewhat retiring.

Mch 30 Quiet + depressed: Answers questions readily when spoken to: Is inactive: Neat in appearance: Appetite fair bowels moved by cathartics: April 9. Visited by husband: Apr 29 More cheerful: Assists with ward work: Sleeps well: Is given massage + electrical treatment twice a week: May 4 Temp. to Ax. May 4 Remains in same - Sent home.

Discharged.

Letter from husband July 26 1900, states that patient is well mentally but quite weak physically.

Personal and Medical History of

Personal and Medical History of Margaret E. Catlin.

Whole No. 5529
Residence, Town of Lura.
Date Admission, March 20 1900.
Admitted by Dr. A. J. Kilbourne hour, 8th P.M.
How Sent, F. L. Bullis J. of P. Fairbault Co.
Sex, female Age, 26.
Civil Condition, married
Children, two.
Age Youngest Child, 15 mos.
Occupation, Housewife (husband a farmer)
Degree Education, Common school.
Profession, Religion, Not a church member.
Habits, Not intemperate.
Nativity, Blue Earth Co. Minn. (Parents born in Canada)
Physicians Committing, W. S. Fullerton & Wm. Caprow
Correspondents, Address communications to Wm. Catlin Easter, Minn.
Father Geo. H. Waddell, Minnesota Lake, Minn.

No. for Year, 159
Insane Relatives, Mother
Cause Exciting, Death of child by accident. Injury on occiput top of 15 mos.
Cause Predisposing, Heredity
Form, Chronic Melancholia (with)
Accompanying Bodily Disorder, not mentioned.
Suicidal or not, Not.
Date of this Attack, two yrs. ago.
Duration, 2 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 24 yrs.
Time of Leaving, Oct. 23 1900
Time in Hospital, 7 mos, 3 Days
Result, Discharged - Unimproved, May 1/1901

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Mch. 24/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick.
MEMORY, Past Events, good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert. correct
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 Dulness, 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, does not know much about them.
Mother, living - not very well.
Maternal Relatives, does not know about them.
Brothers and Sisters, 3 all well - married age 19 1894 - married born April 25 - 2nd June 19 97 - died accident. One child - living & well - 1st born 99.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking, No.
HEADACHES, VERTIGO, OR CONVULSIONS, Bad headaches when mind blanks from death & also at menstrual period
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 1 in. PRESENT WEIGHT, 127# USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, Small scar across back of R. middle finger. Scar on R. thigh. Skin normal - healthy.
TONGUE, Coatings or Promptness of Movement, Clear. prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal.
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, of other troubles,
HEARING, good.
COORDINATION, Arms, good Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, good.
PATELLAR REFLEX, present Other Reflexes, present.
ARTICULATION, Slurred, Hesitating, Slow, Somewhat slow - nasal speech
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,

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

GYNECOLOGICAL EXAMINATION, External genitals normal - Perineum lacerated. Cervix large. no inflamed uterus large & boggy - position normal. has some endometritis - Says she has been troubled with Haemorrhoids.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 as a girl was not strong. Says has been sick & come here to State Hospital for 5 yrs. but says it was to be treated for female trouble. Looks quite well; is very quiet & talks very sensibly.

Personal and Medical History of Margaret E. Catlin.

1900.

This patient was brought here by sheriff Dandy MacDonald attended by Mrs. D McDonald & father, Geo Waddell. Patient in good physical condition; history given as follows: No history of consanguinity, nor of intemperance in patient nor parents: Mother was insane. First symptoms of insanity manifested two years ago by melancholia following death of child by accident: Disease appears increasing: Is variable: Derangment now manifested by communications with imaginary persons: Not disposed to injure anyone: Is very neglectful about appearance of herself & children. was formerly the opposite: No peculiarities previously manifested: No severe diseases nor injuries to head: No confinement nor restraint employed, no treatment pursued: On personal examination appears profoundly abstracted & careless of surroundings: Is timid in melancholy expression vacant. On admission put upon Infirmary Rest. (Gen. N. Rpt. Complexion dark hair black: eyes brown: Skin in normal condition: Small scars on left leg & ear & on right fingers: Is dirty: Has 15 upper & 11 lower teeth: Behavior quiet: Has delusions.)

Note History related by father. Mother had sunstroke about 8 yrs. ago. Never was insane. Patient has been acting queerly since death of 2½ yr. old child, a great shock. Husband has not used her well. Drinks & neglects her. 2 children youngest 1½ yrs. Does her work but neglects it. Sleeps a good deal. Dances & sings whole alone. Talks to herself. Satisfied to come here. A great worker but lives in a rather shiftless manner — was very ambitious & husband was shiftless. Laughed to herself on way here.

March 30 to Apr 13 Summary 14 da. Rec'd by D. Weygandt. On admission very quiet in behavior. During first week temp. pulse & resp. about normal. Relished nourishment the first evening & breakfast the next morning: after that appetite fair. Hypnotics & cathartics given: bowels regular. Very quiet in behavior. Talked very little: seemed very intelligent but had delusions of grandeur. Second week Temp. pulse & resp. about normal. Appetite fair: occasional hypnotics & cathartics required. Continues very quiet in behavior altho somewhat more active than when admitted. Sits quietly about ward. Somewhat restless at night. Spoke only when spoken to. Apr. 20 Trans. to A2.

May 10 1900 Still rather weak & failing in general health. Trans to Infirmary May 18. Much improved. Takes outdoor exercise. Trans. to A2.

July 7. Vaccinated: unsuccessfully. July 7. Does some work. More tidy in appearance. Menstruates regularly. Given electrical treatment thrice a week. Expresses desire to go home. Aug 31 Visited by father. Oct 20 Visited by father & went home with him on Oct. 23rd.

Discharged

Personal and Medical History of

Letter from father Apr. 14 1901. States that patients bodily health is good. She is quiet & does some work about house - but never speaks unless spoken to & never mentions husband or children

Personal and Medical History of Ida Phillips.

Whole No. 5530
Residence, Brush Creek Tp. Faribault Co. Minn.
Date Admission, March 20th 1900.
Admitted by Arthur F Kilbourne hour, 8:30 P.M.
How Sent, H. L. Bullis Jap. Faribault Co.
Sex, Female Age, 20.
Civil Condition, Single
Children, None
Age Youngest Child, -
Occupation, Housework.
Degree Education, Common school
Profession, Religion, Catholic Church.
Habits, not intemperate.
Nativity, Faribault Co. Minn. (Father Ky. Mother Germany)
Physicians Committing, N. Jacoby & Mrs. Leland.
Correspondents, Father Louis Phillips, Wells, Minn.

No. of Year, 1st
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, Unknown.
Form, Melancholia Simp.
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, Not.
Date of this Attack, 1897.
Duration, 3 yrs.
No. of Attack, 1st Continuous
No. of Admission, 2nd
Age First Attack, 17 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Heyerdahl *Date of* March 24th 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear - sluggish.
MEMORY, Past Events, Good
Recent Events, Good Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Correct.
REASONING POWER, Ordinary Subjects, Good.
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent
DELUSIONS, Systematized, Transitory, Special Subjects,
HALLUCINATIONS, Of hearing.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Good Good Normal Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, Not Taken PRESENT WEIGHT, Not Taken USUAL WEIGHT, NUTRITION, Good.
WOUNDS, Abnormalities and condition of Skin, small scar on left knee. Skin in good condition
TONGUE, Coatings or Promptness of Movement, quite clear.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal.
SIGHT, good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, do. Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None.
PATELLAR REFLEX, present. Other Reflexes, Elbow. present.
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal. regular - slow.
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,
Color and Appearance,

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

GYNECOLOGICAL EXAMINATION, External genitals normal - hymen very much relaxed Cervix normal. uterus retroverted & seems rather large. A thin white milky discharge present.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Not good just before coming.
BOWELS, Present Condition, Constipated

Give condensed statement of the 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). In good physical condition. Is sluggish in actions. Areolae & nipples are deeply pigmented also brown pigmented line on abdomen

Personal and Medical History of Ida Phillips.

1900

This patient was brought here by Sheriffs Dep. Lt. Taylor, attended by Mrs. L. H. Wilmot, in fair physical condition, with the following history: No history of consanguinity, heredity nor intemperance in patient nor parents: First symptoms of insanity manifested in 1897 by running away from home: Patient was here from Sept. 29 97 to Nov 30 98 (See Vol 38 Fol. 5 No. 4885.) Disease appears increasing: is variable but never entirely rational: Derangement now manifested by fear of being left alone: & by running away from home: Not disposed to injure anyone: No filthy nor destructive habits manifested: Was always of a sinful disposition: No severe diseases nor injuries to head sustained: Has received hospital treatment as stated above.

On personal examination derangement found to be manifested by insomnia at times, at others by profound sleep from which it is impossible to awaken her by inflicting pain. will jump up suddenly: is generally muttering.

3/20/1900 On admission put upon Infirmary W. (G.H.N. Rpt. Complexion dark. Hair light brown: eyes brown: Skin hot & dry: Small scar on left knee: is dirty: Has 9 upper & 9 lower Teeth: Behavior quiet: Would not talk much but answers questions intelligently.

March to April 3 Summary 14 days, record by Dr. Hyerdal. Very quiet in behavior: Large scar on L. knee. First night slept 5 hours: Refused nourishment: During first week Temperature, pulse & respiration about normal: Appetite poor: Refused nourishment on 26th & fed by tube: Occasional laxatives hypnotics required Slept quite well at night: very quiet, talked very little: Very reactive at times: Up & dressed on ward on 24th looks somewhat sullen & dogged. April 5 - Aug 31. (Dr Linton) Untidy in habits & appearance: Very irritable & obstinate: At times noisy: Cries a great deal: Converses readily: Is resistive & stubborn at times: Appetite not good during summer: Sometimes had to be fed by tube: Bowels require laxatives: Slept very well: June 16-18 Sick in bed: Cathartics given July 21. Vaccinated July 10-30 electrical treatments given three times a week. after that refused it, also refused Tonics &c. July 30 Complained of tooth ache 5 teeth extracted. July 31. Sick in bed, refused food & medicine: Same given by tube: Complained of feeling sick all through August. Medicine given t.i.d. At times refused it & meals. Sept 25 1900 Restless & quite noisy: Cries a good deal: Complains of not receiving proper attention from nurses; or of not receiving medicine. Refuses to take it when given her. Oct 8. Refused to take nourishment. Cried all day. Oct 9. Fed by tube: Cold bath given at bed time. More quiet. Nov 15. Quieter of late: Goes to dining room for meals. Habits clean. Wt. 125 #. Feb 24 1901. Wt. 116 #. General health poor: Appetite fair: Complains a good deal: Is obstinate: cries.

Personal and Medical History of Ida Phillips

Mar. to June 1901 No change in mental or physical condition. May 29 Wt. 117 #. June to Sept. general health fair, patient very melancholy, picks sores in her face and hands, is extremely troublesome, has delusions, illusions and hallucinations, frequently noisy and cries a great deal, looks thin and pale, frequently has to be fed by nurses, constipated, menstruates regularly, has little or nothing to say to those about her, is unoccupied, frequently attempts to escape. Aug. 29 Wt. 120 #. Sept. to Dec. No change in either mental or physical condition, Nov. 29 Wt. 123 3/4 #. Dec. to Feb. 1903 No particular changes. Wt about 117 #.

Personal and Medical History of Sophia Engbard.

Whole No. 5533
Residence, Havanna, Minn.
Date Admission, March 26 1900,
Admitted by Ex Manons. hour, 7 PM.
How Sent, Wd Eggleston Dept. Steele Co.
Sex, female Age, 21 yrs.
Civil Condition, single.
Children, none.
Age Youngest Child, —
Occupation, domestic,
Degree Education, common school.
Profession, Religion, Lutheran.
Habits, Not intemperate.
Nativity, Minn. (Parents born in Germany.
Physicians Committing, J.P. Johnson & E.E. Bigelow
Correspondents, Adolph Engbard (bro) Claremont Minn. 3 mi. from town.

No. of Year, 163
Insane Relatives, none known.
Cause Exciting, unknown.
Cause Predisposing, Puerperal attack.
Form, Recurrent Mania Ac.
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, not.
Date of this Attack, ?
Duration, ?
No. of Attack, 2nd
No. of Admission, 2nd
Age First Attack, 19 yrs.
Time of Leaving, August 27 1900.
Time in Hospital, 5 mo. 1 da,
Result, Discha. Recovered Feb. 5 1901.

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

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Maniacal, can get no rational answers
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,
Exalted

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks people about her are relatives & calls them by name.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Paternal uncle insane.
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. 5 in. PRESENT WEIGHT, 118 lbs USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, Skin in normal condition.
TONGUE, Coatings or Promptness of Movement, white coat.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - rather large. responses normal-
SIGHT, good-
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
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,
No murmurs.
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 relaxed. Uterus slightly retroverted - normal in size excepting cervix which is slightly enlarged-
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, fair - somewhat noisy at night.
BOWELS, Present Condition, Requires laxatives.

Give condensed statement of the 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 Sophia Engbard.

1900

This patient was brought here by Sheriff F.R. Dicora attended by Adolph Engbard in fair physical condition with the following history: No history of consanguinity, heredity nor intemperance in patient nor parents: First attack of insanity came on in Feb 1898 - + patient here from Feb 8'98 to June 4'98 (Rec Vol. 38 Fol 345 No. 4969) First symptoms of present attack manifested by religious manifestations followed by profanity: Disease appears increasing: Disease is variable: Derangement now manifested on various subjects: Not disposed to injure anyone: No filthy nor destructive habits manifested: No peculiarities previously mentioned: No severe diseases nor injuries to head noted. No confinement nor restraint employed: No treatment pursued since leaving hospital.

On personal examination talks incoherently + in a rambling manner. On admission put on Infirmary Ward (G.H.N. Rpt) Complexion fair: hair light brown: eyes blue: Skin in normal condition: Large bruises on upper part of arms: Is dirty: Left nipple depressed: Teeth: 13 upper + 14 lower. Behavior quiet: Has delusions.

March to April 9 Summary 14 da. Rec. by Dr. Heyerdahl. Patient quiet on admission - Slept all night. First week temp. 98-100° - pulse 106 (on 20th) + Resp. 24. On liquid diet. Sleeping doses required each night + cathartics given daily. Second day was noisy + violent. Put in restraint. Slept 3 hrs. Continued incoherent. Very noisy when up. Slept with aid of hypnotics. Second week. At times very noisy. Remained in restraint. Temp. 99°-100°. Took liquid diet. occasional cathartic given: Apr 6 fed by tube + bowels quite regular: Very noisy + resistive. Slept well at night: Talked a good deal.

Apr 23-30. Temp. About normal. Takes liquid nourishment. Bowels more regular with aid of occasional cathartic. Remains in restraint. Sleeps well at night. Resistive when taken up. Noisy + profane at times.

May 9. Takes nourishment regularly. Bowels quite regular. Sleeps well at night. Noisy when anyone is in room. May 10 up + out on ward during afternoon. Taken out of restraint. Slept well at night. May 13 up + dressed daily. Quite noisy, profane + active. Talked loud + at times disagreeable. May 24 Transferred to C2. June 30 Appetite very good: Sleeps well. Habits clean: Bowels irregular. Mental condition improved. Takes outdoor exercise: Works on ward. July 2 Complains some of headache + pain in limbs. Felt a warm some; put to bed. Temp. 103-99. (July 3-5) Pulse 100-80 July 5 up part of day. Appetite good. July 6. Visited by friend + sister. July 17 Vaccinated successfully. Augst Quiet + agreeable on ward. Assists with work. Quite well mentally. Augst 7 Taken home by Mother

Discharged.

Personal and Medical History of

Letter from her Jan 18'1901 - She says she is getting along nicely.

Personal and Medical History of Anna Gavin

Whole No. 5535
Residence, Faribault, Minn.
Date Admission, March 28, 1900
Admitted by Dr. O.C. Heyerdale hour, 3 PM.
How Sent, J. Hunter & A.B. Price Co.
Sex, woman Age, 37.
Civil Condition, Single.
Children, none
Age Youngest Child, -
Occupation, Sewing.
Degree Education, Common school.
Profession, Religion, Roman Catholic
Habits, Not intemperate.
Nativity, Minn. (Father born in Ireland - Mother Canada)
Physicians Committing, P.A. Smith & D.M. Cool.
Correspondents, Mother Mary A. Gavin, Faribault, Minn.

No. of Year, 1st
Insane Relatives, None.
Cause Exciting, unknown.
Cause Predisposing, Previous attack.
Form, Acute Melancholia
Accompanying Bodily Disorder, Nervous.
Suicidal or not, yes.
Date of this Attack, Jan. 1, 1900.
Duration, 3 mos.
No. of Attack, 2nd
No. of Admission, 2nd
Age First Attack, 21 yrs.
Time of Leaving, 16th April 1902
Time in Hospital, This time 2 yrs. 19 ds
Result, Improved. Discharged Oct 14/02 by Bd of C

EXAMINATION ON ADMISSION BY DR. Heyerdale Date of 3/29/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Seems clear, quick.
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 Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, Since 2 Mo. after Christmas.
ONSET, Gradual or Sudden, Gradually.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
No history of heredity
Father, died at 38 of apoplexy.
Paternal Relatives, does not know much about them.
Mother, living well - 65 yrs.
Maternal Relatives, Can give no information.
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Typhoid at 13 yrs. measles childhood.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, only occasionally
OCCUPATION, Healthy or not, housework,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, much as usual, that comfort prevailed.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4½ PRESENT WEIGHT, 130 USUAL WEIGHT, NUTRITION, Fair.
WOUNDS, Abnormalities and condition of Skin, Scar on left cheek & hand. - Skin healthy.
TONGUE, Coatings or Promptness of Movement, slight grayish coat - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - response poor.
SIGHT, good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, good. Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands - marked of tongue.
PATELLAR REFLEX, present. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, Seems normal.
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal.
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 & healthy - uterus somewhat retroverted & enlarged & boggy. Cervix large & boggy. Hymen almost obliterated -
MENSTRUATION, irregular but never caused much trouble - would be regular 3-4 mos. then run over 2-3 mos.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, poor - has been taking some hypnotics.
BOWELS, Present Condition, needs laxatives

Give condensed statement of the 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 in fair physical condition but is somewhat restless & nervous. Talks very rationally & could not keep quiet but wanted to be moving or doing something all the time. Especially at night when she wanted to walk & awaken other people, & would run from one bed to another - Says she could control herself quite well during day but not at night

Personal and Medical History of Anna Gavin.

1900

This patient was brought here by sheriff Gt. Warner, attended by Brother, in fair physical condition, with the following history.- No history of consanguinity heredity nor intemperance in patients nor parents: First attack occurred in 1884 + patient was here from March 11 84 to June 23 84 See Vol. 4 Fol. 67 No. 607.) First symptoms of present attack manifested Jan. 1 1900. Disease appears increasing; Is variable: Derangement now mentioned by Nervousness + irritability: Has shown disposition to injure others + to suicide, but not in any definite way: No filthy nor destructive tendencies noted: No previous peculiarities noted: No severe diseases nor injuries to head sustained: Has been confined to house under surveillance. Has been given Bromides 3ss P.R.N. On personal examination Nervous, restless, + inability to remain quiet. On admission put upon Infirmary (G.H.N. Rpt. Complexion dark: hair dark brown: eyes gray: Skin in normal condition: Scars on left cheek + hand. Is clean: Has 12 upper + 14 lower teeth. Behavior quiet. Talks intelligently.)

Mch 28 to Apr 11 Summary 1st Ha. record by Dr. Heyerdale. On admission quiet in behavior: talked quite sensibly: small scars on left hand + cheek: Slept 5 hrs. the first night: The first week Temp. pulse + resp. about normal: appetite fair: occasional hypnotics + cathartics required: bowels moved regularly. Slept quite well at night: Up + dressed on 30th. Quiet on ward: seemed somewhat melancholy + cried at times: Was wakeful + out of bed the night of April 3rd. Second week. Temp. pulse + resp. about normal: appetite fair: occasional hypnotics + laxatives given. Patient rather quiet in manner altho very nervous + cries at times. Walks about + a good deal seems depressed: is at times restless at night. Apr. 5 Threw cup + broke it. Apr. 28 Restless: Continually wanders up + down: Is depressed: rarely speaks: Does no work. Fairly neat: Appetite poor: Bowels moved by cathartics: Given massage + electrical treatments. June 16 Trans. to A3. July 17 Vaccinated successfully: Nov. 16. Wt. 117¼#. Nov. 29. Shows a slight improvement + does a little work otherwise no change.

Jan 1 1901. Given electrical treatments. General health good: Does no work: very languid. Feb 28 Wt. 128# Mar. to June 1901 General health good, is melancholy and unoccupied, shows no change in mental or physical condition. May 30 Wt. 110#. June to Sept. Patient very indolent, takes no interest in anything, takes out door exercise, does no work, does not care to attend amusements, June 20 July 24 menstruated, August 5 visited by mother, Sept. 3. Wt. 113#. Sept. to Dec. Nov. 13 visited by gentleman friends; during the winter began to take a little more interest assisted a little with ward work. Nov. 30 Wt. 135#. Apr. 16 visited by mother and was taken home.

Personal and Medical History of

Personal and Medical History of Mary Harmeier (or Meyer)

Whole No. 5539

Residence, Rice County.

Date Admission, Apr. 6th, 1900

Admitted by Dr. Ob Heyerdale hour, 3:30 pm

How Sent, Jamp Hunter, Jof P. Rice Co.

Sex, woman Age, 31

Civil Condition, Single -

Children, —

Age Youngest Child, —

Occupation, Housekeeper. Father farmer.

Degree Education, Common School.

Profession, Religion, Lutheran.

Habits, Not intemperate

Nativity, Germany. Parents also

Physicians Committing, Rosco N. Jackson & Chas B. Pillsbury

Correspondents,

No. of Year, 169

Insane Relatives, none

Cause Exciting, masturbation.

Cause Predisposing,

Form, Melancholia chr

Accompanying Bodily Disorder,

Suicidal or not, not suicidal

Date of this Attack, July, 1898.

Duration, 1 yr. nine months.

No. of Attack, 2nd (continuous)

No. of Admission, 2nd

Age First Attack, 26

Time of Leaving, 20th April 1901

Time in Hospital, 1 yr — mos 14 Ds

Result, Recovered — Discht Nov 30/1901.

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Apr. 1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Sluggish

MEMORY, Past Events,

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

dull.

REASONING POWER, Ordinary Subjects,

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 Dulness, 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, 5ft 1in. PRESENT WEIGHT, 145# USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, none - Skin normal. healthy

TONGUE, Coatings or Promptness of Movement, Clear

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, good. Grasp,

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

PATELLAR REFLEX, Increased - 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,

GYNECOLOGICAL EXAMINATION, External genitals normal. Hymen intact. Uterus normal size, retroflexed. Some Leucorrhoea with small whitish discharge.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 when left undisturbed. Untidy in appearance. Morose & melancholy & very disagreeable in manner. General health seems good. Appetite fair & sleeps well.

Personal and Medical History of Mary (Marie) Farmer

1900

This patient was brought here by Sheriff G.W. Mosher attended by Harvey McKenzie and Miss Hattie Thompson in fair physical condition, with the following history:- No history of consanguinity, heredity or intemperance in parents or patient. First attack occured five years ago & lasted three months: This is second attack (continuous) First symptoms manifested in July, 1898 by masturbation and foolish & vulgar talk: Was confined in this (Rochester) Hospital from Dec. 30. '98 to Apr. 29 1899 (Rec Vol. 40 Folio 89. No. 5307) Was discharged Improved Nov. 1, 1899. Disease appears increasing with irregular rational intervals: derangment now manifested by masturbation & filthy talk: no previous peculiarities, severe disease or head injury: Has been given bromides & viburnum com. beside treatment in Hospital- (as above) On personal examination: raving: restless: filthy talk: On admission put on Infirmary: Complexion dark, hair brown, eyes blue: skin normal: eruption on back: no marks scars, or bruises. dirty: very maniacal: used very bad language: ~~12~~ 12 upper & 13 lower teeth.

Apr. 6 to Apr. 30 Summary 1st da. rec. by Dr. Hyndale. On admission behavior noisy & obstinate First week. Temp. 99°, Pulse & resp. about normal: occasional cathartics given bowels quite regular: Slept well at night Somewhat noisy & irritable & very profane at times also sullen & resistive. Second week. appetite fair: medicine t.i.d. occasional cathartics required: Very obstinate & disagreable on ward: slept poorly most of week. Talk incoherent & profane.

May 1- July 31 1900 (Dr. Linton) Patient untidy & very disagreable obstinate & sullen: Inactive & indifferent: Appetite poor: Bowels constipated, requiring laxatives: Sleeps well: Menstruates: July 20 Menstruated. Sept 1- Nov 31 1900. Appetite good: Bowels constipated: Sleeps well. Takes outdoor exercise: Does no work: Is untidy: Sometimes profane: Very obstinate & disagreable. Oct 24 no change.

Dec 1- Feb 28 1900. Appetite fair: Bowels regular: Sleeps well: Menstruates regularly: Is gradually losing in weight. Untidy & Careless: Takes no interest in anything: Is obstinate, disagreable, profane & vulgar: Meds. & Wt 104 lbs

Patient disagreable and obstinate: takes no interest in work: goes riding but refuses to walk; attends no amusements, uses profane language; takes no interest in her personal appearance: appetite good; sleeps well: bowels constipated requiring cathartics. April 25 went home.

Personal and Medical History of

Personal and Medical History of Lauetta Eady

Whole No. 5547
Residence, St. Paul
Date Admission, Apr. 17. 1900
Admitted by Dr. O C Heyerdale hour, 5th pm.
How Sent, Ell Bagille Judge of Probate Ramsey Co
Sex, Woman Age, 33
Civil Condition, married
Children, none
Age Youngest Child,
Occupation, House wife - Husband Livery Stable Keeper
Degree Education, Common School
Profession, Religion, Not a Church member
Habits, Not intemperate
Nativity, Iowa. Parents Virginia
Resident of State + County since 1886
Physicians Committing, Mason Allen + Arthur Bunney
Correspondents,

No. of Year, 177
Insane Relatives, none
Cause Exciting, injury.
Cause Predisposing, Ohr mania
Form, Acute Delirium
Accompanying Bodily Disorder,
Suicidal or not, not suicidal.
Date of this Attack, Aug. 1899
Duration, 1 yr. 8 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 31
Time of Leaving, Apr. 27. 1900
Time in Hospital, 5 d.
Result, Died Acute Nephritis

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Apr. 19 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, Does not talk sensibly.
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,
Maniacal -

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks she has no mouth + cannot eat. cries + talks continually.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
Family history negative.
Father, Died at age of 76.
Paternal Relatives,
Mother, died at age of 78.
Maternal Relatives,
3 Brothers and 2 Sisters, Well.
Children - none

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No history of disease.

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

Copy of petition for appointment of Andrew Adcock as guardian for Lauetta Eady, insane, served + service + admitted April 21 1900
(Filed with commitment papers)
HW/145

RISTICS.

VEIGHT, NUTRITION, Poor.
d of head. - Skin in normal condition
+ normal.

Grasp,

PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
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,

2/9/1900 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, Poor.
BOWELS, Present Condition, Somewhat constipated

Give condensed statement of the 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 poor. Behavior maniacal. Talks incoherently. Is very restless + will not remain in bed, but tosses about + out of bed often. Refuses nourishment most of time + has to be fed with tube. Husband says she had not eaten anything for four days prior to admission + had not drunk anything for 2 days prior to admission

Personal and Medical History of Loretta Leahy

Whole No. 5547
Residence, St. Paul
Date Admission, Apr. 17. 1900
Admitted by Dr. O. C. Heyerdale hour, 8th pm.
How Sent, Ell Baillie Judge of Probate Ramsey Co
Sex, Woman Age, 33
Civil Condition, married
Children, none
Age Youngest Child,
Occupation, Home wife - Husband Livery Stable Keeper
Degree Education, Common School
Profession, Religion, Not a Church member
Habits, Not intemperate
Nativity, Home. Parents Virginia
Residence of State + County since 1856
Physicians Committing, Mason Allen + Arthur Sweeny
Correspondents,

No. of Year, 177
Insane Relatives, none
Cause Exciting, injury.
Cause Predisposing,
Form, Acute Delirious Mania
Accompanying Bodily Disorder,
Suicidal or not, not suicidal.
Date of this Attack, Aug. 1899
Duration, 1 yr. 8 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 31
Time of Leaving, Apr. 27. 1900
Time in Hospital, 5 d.
Result, Died Acute Nephritis

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Apr. 19 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, does not talk sensibly.
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,
Maniacal -

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks she has no mouth + cannot eat. cries + talks continually.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
Family history negative.
Father, died at age of 76.
Paternal Relatives,
Mother, died at age of 78.
Maternal Relatives,
3 Brothers and 2 Sisters, well.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Tonsilitis - none
No history of disease.

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,

and Medical History of

PHYSICAL CHARACTERISTICS.

T, ——— PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION, poor.

UNDS, Abnormalities and condition of Skin, Wound on right side of head. - Skin in normal condition

TONGUE, Coatings or Promptness of Movement, Coated

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

SIGHT, apparently good.

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

HEARING, apparently good

COORDINATION, Arms, Legs, Grasp,

TREMOKS, 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,
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,

2/9/1900 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, poor.

BOWELS, Present Condition, somewhat constipated

Give condensed statement of the 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 poor. Behavior maniacal, talks incoherently. Is very restless + will not remain in bed, but tosses about + out of bed often. Requires nourishment most of time + has to be fed with tube. Husband says she had not eaten anything for four days prior to admission + had not drunk anything for 2 days prior to admission.

Personal and Medical History of Lavetta Keady

1900

This patient was brought here by Deputy Sheriff Gallick attended by Wm. E. Keady (husband) in poor physical condition, with the following history:- No history of heredity, consanguinity or intemperance in patient or parents. First symptoms of insanity manifested in August 1899 by nervousness: disease appears to be increasing: not variable, no rational intervals: derangement was manifested by delusion that her mouth is growing smaller, and that she has no teeth & that her food is poisoned, will not eat, cries & talks irrationally: no disposition to injure others, not suicidal filthy, nor destructive. no previous peculiarities or severe disease. Injured by a fall & punctured wound of head: Has not been confined or restrained & has received no treatment. On personal examination,- patient cries loudly, talks irrationally & constantly has delusions of persecution, refusing nourishment on account of delusions. On admission put upon Infirmary West.

Apr 17 Consultation

Complexion dark: hair brown: eyes gray: skin hot & dry: Scar on R. side of head: Left eye, arms & limbs bruised. Is dirty, Ten upper & fifteen lower teeth: Is very maniacal: Has delusions:

Apr 17 to Apr 30

Summary 14 day Record by Dr. Graysdale Admitted Apr 17. Awake but quiet all night. Given salts & fed by tube. Apr 18 fed by tube at 10 AM. & 5 PM. Bowels moved. Very disturbed & out of bed most of day. Slept from 10 PM. to 4 AM. Noisy when awake. Apr 19. Quieter. Temp: 98⅘, in AM. 101⅗ PM. Slept all night. Apr 20 Fed by tube night & morning: Salts given. Patient disturbed & out of bed. would not keep clothing on put in restraint. Awake all night but quiet. Temp. 99⅘ - 102⅖. Resp. 35. In restraint. very quiet but resistive when out. Apr 21, Temp. 4 AM. 101. Salts given by tube also fed. 1/20 gr. strych. given hypodermically Quite resistive in morning. Died at 3:10 PM.

Died.

Personal and Medical History of

Personal and Medical History of Mary Clement

1900

Whole No. 5548

Residence, Wascca. Minn

Date Admission, Apr. 17. 1900

Admitted by Dr. O. L. Heyerdale hour, 7 pm

How Sent, Jos A Wilson Judge of Probate Wascca

Sex, woman Age, 27

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Housekeeping

Degree Education, common School

Profession, Religion, Congregationalist

Habits, not intemperate.

Nativity, Wascca Co. Mother, N.Y. Father, N.Y. Resident of State + County since birth.

Physicians Committing, J.B. Brastrout + W.A. Chamberlin

Correspondents,

No. of Year, 178

Insane Relatives, none

Cause Exciting, unknown

Cause Predisposing,

Form, Melancholia Ag

Accompanying Bodily Disorder,

Suicidal or not, ~~not~~ suicidal

Date of this Attack,

Duration,

No. of Attack, 2nd - (Continuous)

No. of Admission, 472

Age First Attack, 18

Time of Leaving, Aug. 15. 1900

Time in Hospital, 3 m. 29 d

Result, Died - Suicide by hanging.

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

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.

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Slightly depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,

In regard to pregnancy

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Negative.

Mother, died 38.

Maternal Relatives,

Brothers and Sisters, well.

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

Typhoid at 10 yrs.
Surgical operation on wound.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework.

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

Sleep, Appetite, and Bowels, Good

Discharged at County Jail

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken PRESENT WEIGHT, not taken. USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, Skin normal.

TONGUE, Coatings or Promptness of Movement, Coated - 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, Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands + tongue.

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Slow.

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal. Hymen slightly relaxed. Uterus normal size + position. Slight Mucous discharge present.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, poor

BOWELS, Present Condition, Require laxatives.

Give condensed statement of the 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 fair physical condition. Restless + noisy at times. Gets out of bed often. Thinks she is pregnant + condition caused by some occult means. Also thinks people project their thoughts + ideas into her.

Personal and Medical History of Mary Clement

1900

This patient was brought here by Frank Collins, attended by A.D. Clement in fair physical condition, with the following history. No history of heredity, consanguinity or intemperance in patient or parents. Insanity first manifested in 1891: patient was confined in this (Rochester) Hospital from Sept 26'91 to Oct 28'91 (Rec Vol. 17. Folio 357. No. 2847) also from Aug 27'96 to Feb 18'97 (Rec Vol. 30 Folio 297. No. 4586) and from Jan. 24 to July'99 (Rec Vol. 40 Folio 117. No. 5236) This is second attack (continuous). Symptoms were manifested immediately after her return home in July'99 becoming worse during past few weeks. Disease appears to be increasing. not variable, with no rational intervals. Derangement now manifested on a variety of subjects. confined to no particular one: not suicidal nor filthy. has shown no disposition to injure others: destroys clothing. no parsimonious peculiarities: no acute disease or head injury. Has not been confined nor restrained except as stated above. has received no treatment except in this Hospital. On personal examination:- melancholy, indisposed to notice, & at times excitable. On admission put upon Infirmary west. (Gth N Dept. Complexion dark: hair dark brown: eyes gray: skin in normal condition: No marks, scars nor bruises: Is dirty: Has 13 upper & 15 lower teeth. Behavior quiet: refused to talk.

Apr. 17 to May 1

Summary records by Dr Heyerdahl. On admission very quiet in behavior slept well all night. During first week Temp. 98.8-101.5 Pulse. 80-99. Resp. 17-21. Appetite fair: occasional hypnotics & cathartics required. bowels moved daily: Apr. 18 remained in bed: refused to talk: very quiet. Apr. 19-25 listened at times during day: slept well after 10 P.M. very disagreeable: has morbid ideas. Apr 23 Out of bed after. slept only 3 hrs. noisy when awake. Second week Temp. 99-101.3 25th Pulse 99. Resp. 25. Appetite quite poor: refused nourishment on 30th refused medicine all week. hypnotics given hypodermically for sleep. Apr 28 Noisy during morning & out of bed all day: very resistive. Slept well at night. Apr 28 Up & dressed: very noisy & out of bed Apr 26 Up & dressed. in P.M. put in restraint: Noisy until 2:30. Apr 27 & 29. in restraint slightly noisy at times seems more rational. awake greater part of night: Is actively suicidal: has attempted to kill herself by tying strings or cloth about neck: discovered by nurses: Says she will hang herself. May 1 Taken out of restraint dressed & on ward: frequently attempts suicide. Is fed mechanically. Bowels moved by laxatives. May 15 Trans. to B2. May 16 Held all day in restraint at night. 18 Fed with tube. May 20 More quiet to day: held

Personal and Medical History of

about four hours: took nourishment. Apr. 30 Takes meals regularly: goes out of doors daily: Still very suicidal: destructive at times. Refuses medicine. June 1 Seems somewhat better. takes meals regularly & goes out daily: No restraint at night. July 12 Very trouble some in suicidal attempts: is destructive: fed with tube daily: Refuses food: Given cathartics. July 13 & 14 Took meals regularly. July 15 Found hanging in room at 11:45 AM. having tied a strip of cloth to riser. Body was cut down by nurses & physicians called but all efforts to resuscitate her were of no avail: Relatives were immediately notified & brother came on following day for remains. Patient had been kept in restraint at night since second week here on account of her suicidal tendencies, which were manifested

Died

Personal and Medical History of Maria L. Cartrigny.

Whole No. 5557

Residence, South St. Paul, Dakota Co.

Date Admission, April 20th 1900.

Admitted by Dr. O.C. Heyerdale hour, 6th Pm.

How Sent, P Moran Sup't Dakota Co.

Sex, female Age, 52 yrs.

Civil Condition, widowed.

Children, one.

Age Youngest Child, 27 yrs.

Occupation, Housekeeper.

Degree Education, Common school.

Profession, Religion, Catholic

Habits, Not intemperate.

Nativity, France. (Parents born France)

Physicians Committing, Dr Van Cappellen + Dr Fitch.

Correspondents, Aug Cartrigny, South Park. P.O. Dak. Co. Minn

No. of Year, 18 V.

Insane Relatives, One has been insane.

Cause Exciting, unknown

Cause Predisposing, Previous attack.

Form, Mania Chr.

Accompanying Bodily Disorder, unknown.

Suicidal or not, Not.

Date of this Attack, 2 wks. ago.

Duration, 2 wks.

No. of Attack, 2nd

No. of Admission, 2nd

Age First Attack, 47 yrs.

Time of Leaving, July 2 – 1901.

Time in Hospital, 1 yr 2 mo 12 D (this time)

Result, Improved

Discharged by Bd C

July 5 – 1901

EXAMINATION ON ADMISSION BY DR. Heyerdale Date of Apr 20th 1900

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, rather poor.
Recent Events, poor. Special Subjects,

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

REASONING POWER, Ordinary Subjects, poor
Special Subjects,
Own Mental State, Quiet.

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 Dulness, 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 53.

Paternal Relatives,

Mother, died 47

Maternal Relatives, Mere insane

Brothers and Sisters, 11
Children 2 – One was insane

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Smallpox when young –
Hysterectomy 9 yrs ago.

HABITS, Drinking and Smoking, Says has drank considerably

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework.

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

Sleep, Appetite, and Bowels, good fair Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2½ in PRESENT WEIGHT, 115# USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, Little finger deformed. Skin normal.

TONGUE, Coatings or Promptness of Movement, Grayish coat.

PUPILS, Equality, Size, Response to Light, and Accommodation, Normal. response to light slow.

SIGHT, good

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

HEARING, good

COORDINATION, Arms, good Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands + tongue.

PATELLAR REFLEX, present. Other Reflexes, Elbow R. present.

ARTICULATION, Slurred, Hesitating, Slow, Rather slow.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal.

ARTERIES,



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,

Color and Appearance,

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
First Asymmetrical
Expansion good.
B. sounds Normal – dullness in both apices.

EXAMINATION URINE, Quantity, Sp. g. Reaction,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal – Perineum lacerated. Uterus about due to hysterectomy.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 fair physical condition. Is quiet + sleeps well at night. Seems to have imperative conceptions for as she said at times at home the idea would come into her mind to do something or go somewhere + then she would leave the house + be gone for some time.

Personal and Medical History of Maria L. Cartigny.

1900. This patient was brought here by sheriff St Syland & son, A.E Cartigny in poor physical condition with the following history:- No information concerning consanguinity: No history of heredity vice of intemperance. First attack of insanity occurred in 1894 when patient was in the Rochester hospital from February 21. 95 to Nov 9. 97 (Vol. 178 Fol. 101 No. 4008) First symptoms of present attack manifested two weeks ago by breaking window lights, running around undressed in streets etc. Disease appears increasing: Is variable When in company speaks quite sensibly but gets excited if left alone: Derangement manifested by thinking that neighbors are mean to her: Not disposed to injure anyone: No filthy nor destructive habits: No information concerning previous peculiarities: Patient was once jumped down by two big dogs & was operated upon for ovarian tumor. No restraint nor treatment since leaving Hospital.
On personal examination talked sensibly on all questions but acknowledged that she was out of her mind & wild at times.
On admission put upon Infirmary West / G.H.N. Rpt. Complexion dark: hair glayish black: eyes gray. Skin in normal condition: No marks, scars nor bruises. Is clean. No teeth, has upper & lower plate: Left shoulder higher than right: Some enlarged veins in lower part of abdomen: Behavior quiet: Talks intelligently.

April to May 4 Summary 14 da. record by Dr. Reynolds. Behavior quiet: slept all night first night During first 17 days temp. somewhat above normal: 99²-104³. Pulse 61-105 Resp. 18-24. Appetite fair: cathartics & hypnotics required occasionally. Complained of pain in side & stomach & appeared to suffer a good deal: hot water bag applied - slept well at night: Talked a good deal to physicians

May 15 (Dr Linton) Neat & quiet most of time: Has spells of being disturbed & feeling badly & goes to bed: complains of pain & asks for a plaster: Appetite usually good. Bowels require laxatives: Sleeps fairly well. June 12-14 Sick in bed. headache & pain in abdomen: medicine given. June 17 Complained of being sick again: quite disturbed: Talks incoherently. 19 Still in bed.

June 21. More quiet but still taking medicine. Aug. 14 Sick in bed: pain in back & head. Plaster & cathartics given. Better on 28th & working in dining rooms.

Sept. - Nov 21-1900 (Dr Linton) Appetite fairly good: Bowels constipated requiring cathartics: Still goes to bed frequently complaining of pain in back & sides. Neat & tidy, has delusions. Oct. 28 Trans. to D³. Physical condition unchanged. Nov. 30 Wt. 136#. Attends chapel & amusements: Takes out door exercise: Converses freely. Nov 29 Visited by sons Jan 22 1901 In bed: Complains of pain in side: Given cathartics: Jan 25 Up on ward: Jan 26 Again in bed for a day: Frequently goes to bed with pain in side & asks for plaster

Personal and Medical History of

1901 General health seems very good: appetite good: Works in sewing room: attends chapel & entertainments: Takes outdoor exercise: Talks sensibly Neat & clean: Wt. 149½# Mar 1 - June 1-1901 No change in general condition. Patient in the habit of periodically remaining in bed complaining of pain in side & sometimes in back or leg, calling for liniment and plasters. This condition is largely mental. Such spells occurred. Mar 19; Apr 15; May 2 & May 13. In spite of complaints patient seems to be physically quite well; no medicine needed except an occasional cathartic. Assists with ward work & occasionally in sewing room. May 31 Wt. 147# Went home July 2. 1901

Personal and Medical History of Mrs. Metta Meyer.

Whole No. 5553

Residence, Mt. Pleasant Tp. Wabasha Co. Minn.

Date Admission, April 21. 1900.

Admitted by Dr. C. L. Chapple hour, 7 P.M.

How Sent, Malcolm Kennedy J. of P. Wabasha Co.

Sex, female Age, 47 yrs.

Civil Condition, married.

Children, Four.

Age Youngest Child, Four years old.

Occupation, Housewife (Husband a farmer)

Degree Education, Common school.

Profession, Religion, German Lutheran.

Habits, not intemperate.

Nativity, Germany (Parents also born there)

Physicians Committing, W.S. Wilson & E.H. Bayley.

Correspondents, Mr. Henry Meyer. (husband) Lakelaity, Minn.

No. of Year, 183.

Insane Relatives, None known.

Cause Exciting, No definite cause known.

Cause Predisposing, unknown.

Form, Acute mania

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Not.

Date of this Attack, April 14. 1900.

Duration, 7 days.

No. of Attack, First.

No. of Admission, First.

Age First Attack, 47 yrs.

Time of Leaving, June 21. 1900

Time in Hospital, 2 mo.

Result, Died. Nov. 7. 1900 Improved

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Confused & quick.

MEMORY, Past Events, poor

Recent Events, ds Special Subjects,

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,

Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,

religious.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, dead.

Maternal Relatives,

3 Brothers and 4 Sisters,

4 Children - all well.

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

None.

HABITS, Drinking and Smoking, Occasionally drank quite a good deal - mine-brew &c.

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework.

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

Sleep, Not good Appetite, Fair and Bowels, Quite regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7in. PRESENT WEIGHT, 114# USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, Normal

TONGUE, Coatings or Promptness of Movement, slight coat. 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, good Legs, do. Grasp,

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

PATELLAR REFLEX, present. Other Reflexes, Elbow Reflex present.

ARTICULATION, Slurred, Hesitating, Slow, Quick

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal. Perineum lacerated. Uterus normal in size: retroverted slightly.

MENSTRUATION, always regular - Husband says she menstruated about Apr. 7.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 rather poorly nourished. was admitted in delirious maniacal condition. Talking, singing & very restless. & out of bed often. Seemingly of feeble intellect. Husband says sleep & appetite always good - always worked hard.

Personal and Medical History of Mrs. Metta Meyer.

1900

This patient was brought here by Sheriffs deputy F. J. Lange attended by Mrs. John Meyer. in fair physical condition, with the following history:- No history of consanguinity, luesity nor intemperance given: First symptoms manifested April 14 1900 by sleeplessness, incoherence & religious mania. Disease appears increasing: Derangement manifested as above stated: No filthy nor destructive habits: No severe diseases nor injuries to head: For past week has required constant watching & has been kept in bed as much as possible: Has been given sedatives. On personal examination, is excited, maniacal, delirious. Seems to be a case of acute mania. On admission put upon Infirmary Diet (G.H.N. Rpt Complexion dark: hair Grayish brown: eyes brown: Skin in normal condition: Has small mole on lower part of back: No marks, scars nor bruises noted. Is rather dirty: Has no teeth: Behavior quiet (is very incoherent) Apr 14

Summary 14 day record by Dr. Heysdale. During first week temperature was slightly above normal as high as 100°. Respiration at times up to 28 & pulse to 104. Appetite poor: Given hypnotics & cathartics: Was noisy & disturbed night & day & out of bed a great deal. Apr 14 to May 3 1900

During second week Temp. - pulse & resp. about normal: appetite quite good: medicine given regularly: bowels regular: First part of week was somewhat noisy at times but toward end slept better at night & became quieter June 15 Menstruated: June 21 Very quiet in behavior: converses readily & sensibly: neat & tidy in habits & a good worker: Takes daily exercise: Cheerful & agreeable in manner: Appetite good: occasional cathartics required: Slept well at night but does not seem very strong. Taken home by husband June 21. June 15

Discharged

Letter from husband Oct 4 1900. States that patient is fairly well but if she reads much she becomes excited.

Personal and Medical History of

Personal and Medical History of Mary Strapp.

Whole No. 5554

Residence, St. Paul. Minn.

Date Admission, April 24 1900.

Admitted by O. C. Heyerdale M.D. hour, 7 P.M.

How Sent, E. W. Bazille J. of P. Ramsey Co.

Sex, female Age, 38 yrs.

Civil Condition, Single.

Children, none.

Age Youngest Child, –

Occupation, Housekeeper.

Degree Education, Slight.

Profession, Religion, Catholic.

Habits, Not intemperate.

Nativity, St. Paul. Minn. / Parents- Ireland /

Physicians Committing, J. C. Cavanaugh + H. J. O'Brien

Correspondents,

No. of Year, 184.

Insane Relatives, None.

Cause Exciting, Fell injuring head- 24 years ago.

Cause Predisposing, "

Form, High Grade Imbecile.

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, Not.

Date of this Attack, 24 yrs. ago

Duration, 24 yrs.

No. of Attack, 1st continuous probably.

No. of Admission, 2nd here - also at St. Peter.

Age First Attack, 14 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* 4/30/1900.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, rather poor.

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,
somewhat 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 Dulness, 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, dead.

Maternal Relatives,

Brothers and/Sisters, feebleminded.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says she has had pneumonia + measles.

HABITS, Drinking and Smoking, drinks beer moderately.

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, housework.

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, Skin in normal condition.

TONGUE, Coatings or Promptness of Movement, Coated. prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. size enlarged. 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, fine of hands + tongue.

PATELLAR REFLEX, present. 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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal. Hymen relaxed. Uterus normal size + position.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, good.

BOWELS, Present Condition, Slightly constipated

Give condensed statement of the 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 physical condition, was noisy + disturbed the first night. next day hysterical, screamed groaned + tossed herself about, later very violent necessitating several nurses to hold her. Since then quiet in behavior. while disturbed expressed delusion that someone was going to kill her.

Personal and Medical History of Mary Strapp.

1900.

This patient was brought here by Sheriff's Deputy H Hansen attended by Mrs O. Bucher, Mrs Holyman in fair physical condition, with the following history: No history of heredity, consanguinity nor intemperance in patient nor parents: First symptoms of insanity manifested 24 years ago: Became feebleminded. Was at St. Peter Hospital for a time, (about a year) also at Rochester from April 24'97 to July 7'1899. (Vol. 34. Fol. 173. No. 4755) Disease appears increasing: Is variable: No rational intervals. Derangement manifested by delusions & feebleminedness: Not disposed to injure anyone: Habits filthy & destructive: No peculiarities previously manifested: Received injury to head by fall 24 years ago. Was in confinement at Lonie for one year and at hospitals as above stated: No further facts noted on personal examination. On admission put upon Infirmary West (Gt. W. Rpt. Complexion fair: hair brown: eyes gray: skin in normal condition Small bruise on lower part of back: Is dirty: Has 8 upper & 9 lower teeth several of which are very poor: Behavior quiet: Refused to talk.

Summary of record by Dr Heyerdale. Admitted on Infirmary, bathed & put to bed.

Apr 24 to May 8 Very stupid: had to be lifted around: Apr. 25. Somewhat disturbed during night & day: attacked nurses: put in restraint: Very hysterical Apr 26 Quiet: Trans. to C3. Apr 27 Remained in bed during forenoon sq. Disagreable, resistive & untidy: Complained of pain Apr 30 Trans. to C1. May 10 Disagreable & noisy for a few days.

May 14. Trans A1. Quite agreable & pleasant: Takes nourishment well: General health good: Is hypochondriacal. May 25 Disagreable Trans. to C1.

July 6 Quiet: Canvasses readily: Works in Center dining room: Health good: Trans. to A3. Vaccinated successfully. Nov. 16 219# Nov 22. Complains of pain in left ankle: Swollen. Nov 29. Health good: Agreable on ward Likes indoor to indolence: sleeps well. Feb 18. Trans. to C3. Very nervous & irritable: Disagreable on ward: Assists with work in dining room: Feb 25 Trans to A3 Feb 28 General health good. Wt. 217#

May 1-June 1-1901 Mar 15 patient became disturbed, used profane language; walked excitedly about the ward. Seems to have frequent spells of disturbance during which she gets into a very hysterical manner, and very untidy. is fairly neat when at her best. Appetite very good sleeps well; bowels generally regular; does not take much out of door exercise. Was transferred from A3 to C3 Mar 17. May 14 transferred to D3. May 31 Wt. 208½#

June to Sept July 12 tran. to A3, Aug 30 patient quiet on ward, assists with work in dining room, takes out door exercise, attends amusements and chapel, bowels regular, appetite good, Wt. 212#. Sept. to Dec. No change in mental or physical condition Nov. 30 Wt. 211#.

Personal and Medical History of Mary Strapp.

Dec. to Feb. 1903 No change in condition. Wt about 195#.
Visited by brother on May 9th & 12th 1902.

Personal and Medical History of Augusta Pleska. (or Pleski)

Whole No. 5557
Residence, Zumbrota Minn.
Date Admission, April 26 1900.
Admitted by Dr. E. J. Watson hour, 2 PM.
How Sent, Axel Haller & Ag't. Goodhue Co.
Sex, female Age, 17 yrs.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Servant.
Degree Education, Common school.
Profession, Religion, Not a church member.
Habits, Not intemperate.
Nativity, Germany (Parents also born there)
Physicians Committing, Dr. Hall & Dr. Erlettenbeck
Correspondents, Bro. in law. Edw. J. Lohman Zumbrota (Postoffice)

No. of Year, 1897.
Insane Relatives, None.
Cause Exciting, Overwork.
Cause Predisposing, Unknown.
Form, Acute Mania (Dementia)
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, Not.
Date of this Attack, April 21 1900.
Duration, 4 days.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 17 yrs.
Time of Leaving, July 26. 1900
Time in Hospital, 2 mo. 27 d.
Result, Disc. Nov. 1. 1900 Improved

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* 4/29/1900

MENTAL CHARACTERISTICS.

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

REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, c
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Religious delusions - also thinks those about her are too dirty.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.
LENGTH INVASION, Apr 21 1900,
ONSET, Gradual or Sudden, Sudden.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, died - cancer - 6 yrs ago.
Paternal Relatives,
Mother, living. well
Maternal Relatives,
4 Brothers and 1 Sisters, Well.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
4 weeks ago eruption broke out over body. itched badly.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, fair not good irregular.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2. PRESENT WEIGHT, 120# USUAL WEIGHT, NUTRITION, Anaemic
WOUNDS, Abnormalities and condition of Skin, Skin normal.
TONGUE, Coatings or Promptness of Movement, Slight coat. prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size + response normal.
SIGHT, good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, present Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Slow.
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,

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, poor.
BOWELS, Present Condition, somewhat constipated

Give condensed statement of the 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 admitted in poor physical condition - pale + anaemic. Was in a delirious maniacal condition; destroyed bedding, restless + noisy + most of time out of bed until restrained. Brother-in-law stated that she was always a nervous, sickly child & not well from childhood always sick at menstrual periods. Always very religious. very much so of late.

Personal and Medical History of Augusta Plivka.

1900

This patient was brought here by deputy sheriff St Amis attended by Ed Lohrman and Mrs. Lophin 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 Apr. 21. 1900, by singing and preaching: disease appears stationary: Not variable: Derangement manifested on religious subjects: Not disposed to injure anyone: Not destructive but wets bed: Previous peculiarity, hysteria at menstrual period: No severe diseases nor injuries to head: Has been kept in bed by manual restraint + has been given bromides + opiates: On personal examination talks incoherently, principally on religious subjects.

Apr. 26. On admission put upon ward. Complexion fair: Hair light: eyes gray: Skin hot + dry: No marks: Small scar on left leg: To clean: No bodily peculiarities: Has 13 upper + 15 lower teeth. Behavior maniacal Speech incoherent.

Apr. 26 to May 10 Summary 14 days record by Dr Heyerdale. Patient noisy on admission, talk incoherent: very much excited. During first week Temp. slightly above normal (at times 100°) Respiration as high as 36. + pulse 100. The first day refused supper but after that appetite fair: bowels somewhat constipated + cathartics given also hypnotics for sleep but patient was out of bed part of time + noisy: very much disturbed + tore bed-clothing. Second week, temperature pulse + respiration about normal: appetite good: medicine given four times a day: cathartics given, bowels regular: Sleep interrupted upon ward during day: Melancholy + cried a good deal: Taken out for exercise last two days.

June 13 Menstruating. June 23 Visited by aunt. Neat in habits + quiet in behavior: assists very well on ward: Takes outdoor exercise: bowels generally regular: sleeps well at night: appetite good: seems in very good physical health: July 9 Menstruating. Quiet + agreeable on ward: assists with work: Appetite fair: Sleeps well takes tonic. July 23 Went home on trial.

Discharged

Letter received from Lister Oct 19. 1900. Says patient is very well but is nervous + worries about herself. Patient later applied for position here as nurse.

Personal and Medical History of

Personal and Medical History of Amelia Plaster.

Whole No. 5559
Residence, Washington Co. Minn.
Date Admission, April 27 1900.
Admitted by Dr. O. C. Heyndale. hour, 1 PM.
How Sent, F. F. Wilson Jail Washington Co.
Sex, female Age, 58.
Civil Condition, Married.
Children, none.
Age Youngest Child, —
Occupation, Housewife.
Degree Education, None.
Profession, Religion, Lutheran.
Habits, Not intemperate.
Nativity, Germany (Parents also born there.
Physicians Committing, H. C. Clark — G. C. Clark.
Correspondents, Leo Plaster (husband) Stillwater Minn. - (a conjectioner.)

No. of Year, 189.
Insane Relatives, No.
Cause Exciting, Domestic trouble.
Cause Predisposing, Previous attack.
Form, Melancholia
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, not.
Date of this Attack, 2 Mo. ago.
Duration, 2. mos.
No. of Attack, 2nd
No. of Admission, 1st
Age First Attack, 57 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyndale *Date of* April 30 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Sluggish.
MEMORY, Past Events,
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
dull.
REASONING POWER, Ordinary Subjects, } good.
Special Subjects, }
Own Mental State, }
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 Dulness, 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, dead.
Maternal Relatives,
2 Brothers and 2 Sisters,
No children
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Gives no history of any.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Sickly- did a little housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels,

Notice of hearing petition for appointment of Leo Plaster as guardian for Amelia Plaster served & served admitted May 5' 1900.
(Papers filed with commitment papers.

RISTICS.

VEIGHT, NUTRITION, fair.
mal. reponses sluggish.

COORDINATION, Arms, good Legs, good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, None.
PATELLAR REFLEX, Feeble in R. Knee - absent in left. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, slow.
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,

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

GYNECOLOGICAL EXAMINATION, External genitals normal. Uterus normal.

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

Give condensed statement of the 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). In fair physical condition. Is of a phlegmatic temperment & talks very little. Tidy in appearance. Seems to have very little energy.

Personal and Medical History of Amelia Plaster.

Whole No. 5559

Residence, Washington Co. Minn.

Date Admission, April 27 1900.

Admitted by Dr. O. C. Heyerdale. hour, 7 PM.

How Sent, F. D. Wilson Jailer Washington Co.

Sex, female Age, 58.

Civil Condition, married.

Children, none.

Age Youngest Child, –

Occupation, Housewife.

Degree Education, None.

Profession, Religion, Lutheran.

Habits, Not intemperate.

Nativity, Germany (Parents also born there.

Physicians Committing, H. C. Clark + H. C. Clark.

Correspondents, Leo Plaster (husband) Stillwater Minn. - (a confectioner)

No. of Year, 189.

Insane Relatives, No.

Cause Exciting, Domestic trouble.

Cause Predisposing, Previous attack.

Form, Melancholia

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, not.

Date of this Attack, 2 Mo. ago.

Duration, 2. weeks.

No. of Attack, 2nd

No. of Admission, 1st

Age First Attack, 57 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* April 30 1900

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events,

Recent Events, Special Subjects,

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

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

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 Dulness, 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, dead.

Maternal Relatives,

2 Brothers and 2 Sisters,
No Children

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Gives no history of any.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Sickly- did a little housework.

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

Sleep, Appetite, and Bowels,

Personal and Medical History of Amelia Plaster

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 2½ in. PRESENT WEIGHT, 170 lbs. USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, skin normal.

TONGUE, Coatings or Promptness of Movement, white thick coat.

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

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, Feeble in R. knee - absent in left. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, slow.

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal. Uterus normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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). In fair physical condition. Is of a phlegmatic temperment + talks very little. Lucidity in appearance. Seems to have very little energy.

Personal and Medical History of Amelia Plaster.

1900

This patient was brought here by Dr. Z.B. Thomas as sheriff's deputy, attended by Leo Plaster (husband) in fair physical condition, with the following history:- No history of lunacy, consanguinity nor intemperance in patient nor parents: First symptoms of insanity manifested six years ago; of short duration. First symptoms of present attack manifested two weeks ago, by incoherent talk: Disease appears increasing, not variable: Derangement now manifested by melancholia: Not disposed to injure anyone: No filthy habits but removes & destroys clothing: No peculiarities previously manifested: No severe diseases nor injuries to head sustained: Has been confined in City Hospital: Has received general treatment.

On personal examination refuses to talk or eat unless forced: Removes & destroys clothing: Attempts to go out without clothing.

Apr. 27 On admission put upon Infirmary (Gen'l Rpt - Complexion fair: hair light: eyes gray: Skin in normal condition: Is clean: Has 24 upper & 14 lower teeth: Behavior quiet: Refused to talk.)

Apr. 27 to May 11 Summary 14 da. Record by Dr. Heyerdale. First night slept five hours: quiet when awake: Temp. 99° - 100°. during first week - Pulse 68-100. Respiration 18-35. Appetite fairly good: medicine given regularly. Slept well at night. Quiet & stupid during day: untidy in habits: Cried a great deal & very despondent: May 3 dirt of bed all night. Second week temp. 98°-99°. Pulse 68-90. Resp. 17-30 Appetite poor latter part of week, May 7-8 fed by nurse: May 9-10 by tube. Given hypnotics regularly. Slept well: Bowels regular: Usually quiet but at times noisy: wanders about ward picking at locks Talks but little. May 24. Restless, untidy; does not converse At times refuses to keep clothing on: Appetite poor: May 30. Has been sick in bed: Seemed rather weak: Up on ward today Does a little work. Speaks german: June 30 untidy does not converse. Is incoherent. Continually moves furniture about & takes up rugs. Fed mechanically. Takes outdoor exercise

July 20 Somewhat violent: strikes others: Trans. to C2. Sept. 7 Trans. to B3. Oct 16 & 17. Visited by sister. Oct 30 Appetite poor: fed by nurse:

Nov 16. 130½ # Dec 1- Feb 28 1901. Gneral health fair: bowels inclined to be constipated: never attends chapel & amusements: Sometimes requires mechanical feeding. Dec. 28 Abscess forming on right of lower jaw. Lanced, & dressed twice daily: sick in bed until Jan 7. During time took cathartics & enemas given: Never converses answers questions intelligently March 1- Wt. 127 #.

Mar 1 - June 1 - 1901 No change in mental or physical condition, occasionally has to be fed artificially. May 28 Wt. 124 #

June to Sept. Very quiet, never speaks unless spoken to, sometimes resistin

Personal and Medical History of

1901

occasionally refuses to eat and has to be fed by a tube. Sept. 1 Wt. 121½ #.

Sept. to Dec. Condition same both mentally & physically. Nov. 30 Wt. 128 #.

Dec to Feb. 1903 Sept. 9-02 Patient has suppurative glands in neck. Treated daily - Neat in person and habits: quiet, agreeable, rarely speaks unless addressed: answers questions intelligently: is very much depressed: generally sits in her room: assists with the work: appetite poor: bowels constipated: sleeps well: not inclined to exercise. Present Wt 125 #

Personal and Medical History of Florida Herrick

Whole No. 5561
Residence, St. Paul, Minnesota.
Date Admission, May 3rd 1900.
Admitted by Dr. O.E. Hayendahl hour, 7 P.M.
How Sent, E.W. Bazille & agt. Ramsey Co.
Sex, female Age, 45
Civil Condition, married
Children, Four.
Age Youngest Child, Eight years
Occupation, Housewife.
Degree Education, Common school.
Profession, Religion, Baptist.
Habits, Not intemperate.
Nativity, Newyork (Parents also born there)
Physicians Committing, L.E. Penny & C. Wirth.
Correspondents, Henry Herrick - 1722 Blair St. St. Paul Minn.
Telephone of Brooks Bros. Lumbermen)

No. of Year, 19
Insane Relatives, None. cousin.
Cause Exciting, unknown.
Cause Predisposing, unknown.
Form, Acute Mania
Accompanying Bodily Disorder, unknown
Suicidal or not, Not.
Date of this Attack, four or five weeks ago.
Duration, 4-5 wks.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 45 yrs.
Time of Leaving, June 7. 1900
Time in Hospital, 1 m. 4 d.
Result, Disc. Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. O.E. Hayendahl *Date of* 5/3/1900

MENTAL CHARACTERISTICS.

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

DELUSIONS, Systematized, Transitory, Special Subjects,
on mesmerism, spiritualism, Metaurism etc. also of persecution.
HALLUCINATIONS, of hearing. Thinks people are talking to her, especially at night.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, Since about April 10. 1900.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, dead.
Paternal Relatives,
Mother, well.
Maternal Relatives, male cousin insane
Brothers and ~~Sisters~~,
2 sons & 2 daughters all well
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Typhoid when a girl. Had operation - probably curettement
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, Many headaches
OCCUPATION, Healthy or not, housework.
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, 5ft 6½ PRESENT WEIGHT, 124 USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, skin normal.
TONGUE, Coatings or Promptness of Movement, prompt - slight coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, equal - small - responses poor.
SIGHT, 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 hands & tongue.
PATELLAR REFLEX, present. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Clear - quick -
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,

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

GYNECOLOGICAL EXAMINATION, External genitals normal - Perineum slightly lacerated. Uterus about normal. cervix boggy & lacerated. Some colitish discharge present
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, poor
BOWELS, Present Condition,

Give condensed statement of the 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 poor. Very restless at night Has a great many delusions & hallucinations of hearing. Believes she is being treated by Metaurism, electricity, mesmerism etc. which is sent into house through telephone wires - Also believes she hears people talking to her & using vulgar language.

Personal and Medical History of Florida Herrick

1900

This patient was brought here by sheriffs deputy W.E. Hibbard attended by Thomas Grove, in fair physical condition, with the following history: Nothing known concerning consanguinity: No history of heredity nor of intemperance in patient nor in parents: First symptoms of insanity manifested four or five weeks ago: Disease appears increasing: Is variable. Derangement now manifested by spiritualism & religious hallucinations: Not disposed to injure anyone: No filthy nor destructive habits: No severe diseases nor injuries to head: No confinement nor restraint employed: Nothing known concerning treatment received. On personal examination is extremely nervous.

On admission put upon Infirmary Mat/ (Gitn Rpt. Complexion dark: hair dark brown: eyes gray: Skin in normal condition: No marks, scars nor bruises: Is clean: Has only five teeth in lower jaw- (upper plates) (Behavior quiet; has delusions.)

May 3 to May 6 Summary 14 da, Rec. by Dr. Hazendale. On admission hypnotic given: Slept two hours: Very excitable during night. First week Temp. 98°-100°. Pulse 90-116. Resp. 15-24. Appetite good: Occasional hypnotics & cathartics required: Sleep broken on nights of May 3 & 4. Quiet but very nervous & excitable. Has many delusions in regard to hypnotism, mesmerism &c. Thinks people are using these influences against her. May 6 Up & dressed on ward.

Second week. Temp. 98°-100°. Pulse 81-94. Resp. 18-20. Appetite good: Refuses medicine: bowels regular: Sleeps very well at night. Is irritable in manner: very nervous: expresses delusions very freely has hallucinations of hearing at night. Goes out for exercise daily:

June 6 Menstruating. June 8 & 9. Visited by husband: converses readily but, still lacks a great deal about hypnotism &c, thinks hairpins are dangerous. Given daily vaginal douches: Has improved much since coming here. June 9 Taken home by husband.

Discharged.

Letters Received (Oct 17.) from patient & daughter: stating that patient is very well & doing nicely.

Personal and Medical History of

Personal and Medical History of Anna Maria Gilles.

Whole No. 5568

Residence, New Trier, Dakota Co. Minn.

Date Admission, May 14 1900

Admitted by Dr. E. J. Warnow hour, 7 PM.

How Sent, T. P. Moran Jr. of P. Dakota Co.

Sex, female Age, 59

Civil Condition, married

Children, 6.

Age Youngest Child, Sixteen years.

Occupation, housewife.

Degree Education, None.

Profession, Religion, Catholic.

Habits, Not intemperate.

Nativity, Germany - (Parents also born there)

Physicians Committing, Drs Hammans + Dr Van Cappelle

Correspondents, Theodore Gilles. New Trier. Minn (husband)

No. of Year, 1900.

Insane Relatives, None.

Cause Exciting, Probably surroundings

Cause Predisposing, Previous attack.

Form, Melancholia with Delusions.

Accompanying Bodily Disorder, General poor health.

Suicidal or not, Not.

Date of this Attack, About 2 yrs ago.

Duration, About 2 yrs.

No. of Attack, 2nd

No. of Admission, 2nd

Age First Attack, 52 yrs.

Time of Leaving, June 19. 1900

Time in Hospital, 1 m. 5 d.

Result, Died - Chronic Nephritis

EXAMINATION ON ADMISSION BY DR. Heyerdale. *Date of* May 1900.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events,

Recent Events, poor. 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,

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 - does not talk intelligently.

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, 4 ft. 11 in. PRESENT WEIGHT, 87# USUAL WEIGHT, NUTRITION, Poor.

WOUNDS, Abnormalities and condition of Skin, Skin healthy -

TONGUE, Coatings or Promptness of Movement, Slight whitish coat - prompt.

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

SIGHT, seems good.

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

HEARING, seems good

COORDINATION, Arms, good - Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, exag. Other Reflexes, Elbow reflex present not do.

ARTICULATION, Slurred, Hesitating, Slow, slow.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
normal.

ARTERIES,
Somewhat 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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal. Slight whitish discharge present in vagina. Uterus normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 restless - out of bed often - never noisy. Sleepless first few nights. Later became very quiet - mentally + physically. required feeding by tube. Stomach in very bad condition, also teeth, several roots extracted.

Personal and Medical History of Anna Maria Gillen.

1900

This patient was brought here by sheriff J.H. Hyland attended by Theodore Gillen in poor physical condition with the following history: No consanguinity, lunacy nor intemperance in patient nor parents noted: First attack of insanity in 1894 was in this hospital from Aug 9 '94 to Dec 16 '94 (See Vol. 21 Fol. 41 No. 3097) discharged improved: First symptoms of present attack manifested about two years ago: feared that people were talking about her: Disease appears increasing is variable being worse after the least excitement or trouble: Derangement now manifested by thinking that people talk about her & afraid they will hear what she says: 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: Has been given small doses of bromide & chloral: On personal examination is in genral poor health: & appears melancholy. On admission put upon
May 14 Infirmary Mat (G.H.N. Rpt. Complexion dark: hair dark brown: eyes brown: skin in normal condition: Is very dirty: Has 11 uppers & 7 lower teeth all in bad condition: Behavior quiet: Does not speak English.)
Summary of da Record by Dr. Reynolds First week Temp. 98° - 100° Pulse & resp.
May 14 about normal: Took nourishment poorly: Fed by tube: hypnotics
to given: bowels constipated: restless & out of bed often quite re-
May 21 sistive: sleep poor. Second week. Temp. ~~pulse~~ & resp. about normal:
incl. pulse somewhat accelerated: Fed by tube most of time: given hypnotics regularly: bowels moved with cathartics: Patient quiet but very restless & out of bed often. Stomach lavage resorted to: May 23. became less restless & staid in bed, seemed to be sleeping: Left side of face swollen. May 26-27 More disturbed again: hypnotics necessary: seems to be growing weaker.
June 17 Seems to be failing gradually is rather weak: does not converse: is untidy: appetite poor: Is fed by nurses: does not sleep well & wanders about room more or less: laxatives given: failed gradually until 4:30 PM. June 19. When she died

Died.

Personal and Medical History of

Personal and Medical History of Mary Olson #3

Whole No. 5571
No. of Year, 201
Residence, Washington Co. Minn.
Insane Relatives, Unknown.
Date Admission, May 17. 1900
Cause Exciting, Desertion by husband.
Admitted by Dr. O. C. Heyerdale hour, 7 P.M.
Cause Predisposing, Unknown.
How Sent, T. J. Wilson Dep. Washington Co.
Form, Simple Melancholia
Sex, female Age, over 40.
Accompanying Bodily Disorder, none mentioned.
Civil Condition, married.
Suicidal or not, not.
Children, one.
Date of this Attack, March 1 1900
Age Youngest Child, -21 yrs.
Duration, About 2½ mos.
Occupation, housekeeper.
No. of Attack, first.
Degree Education, Can read.
No. of Admission, 1 here.
Profession, Religion, Formerly a Lutheran.
Age First Attack, over 40 yrs.
Habits, Not intemperate.
Time of Leaving,
Nativity, Sweden (Parents also born there)
Time in Hospital,
Physicians Committing, B. J. Murrill & G. B. Matin.
Result,
Correspondents, Dinah Olson, Stillwater, Minn. (daughter)

EXAMINATION ON ADMISSION BY DR. Heyerdale. Date of

MENTAL CHARACTERISTICS.

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

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

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

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

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
depressed & worried.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, about 1st March.

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
no history - died - 67.
Father,
Paternal Relatives,
Mother, died 76
Maternal Relatives,
Brothers and Sisters, living
1 child well.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
says not.

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, bad Appetite, good and Bowels, constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in PRESENT WEIGHT, 129 # USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, skin healthy.
TONGUE, Coatings or Promptness of Movement, prompt - fine tremor.
PUPILS, Equality, Size, Response to Light, and Accommodation, unequal - medium size - responses 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, fine of hands & tongue.
PATELLAR REFLEX, much diminished R. absent Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, normal
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
normal.
ARTERIES,
somewhat 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,

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

GYNECOLOGICAL EXAMINATION, External genitals normal - uterus normal - perineum slightly lacerated - slight whitish discharge present in vagina.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, poor
BOWELS, Present Condition, Constipated

Give condensed statement of the 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 Mary Olson #3.

1900

This patient was brought here by Sheriff's deputy Dr. F.N. Haines attended by daughter Dinah Olson, in fair physical condition with the following history:-
No history of consanginuity, heredity unknown: No history of intemperance: First symptoms of insanity manifested in March 1900. Disease appears increasing: Derangement manifested by constant brooding over desertion of husband: Threatens suicide: Continually absents herself from home: Not disposed to injure anyone: No filthy nor destructive habits: No peculiarities previously mentioned: No severe disease or head injury: Has not been confined or restrained: Desertion of husband is supposed cause of disease: Has received no treatment: On personal examination,- excessive melancholia. Brooding over absence of husband: Talks of nothing else: On admission put upon Inf. West complexion dark: hair brown: eyes blue: skin normal: no marks, scars or bruises: Clean: Has no teeth in either upper or lower maxillary, but has an upper + lower plate. Behavior quiet. Has delusions. Thinks someone is waiting for her to take her home: asks for coat + hat.

May 7 to May 31 Summary 14 da. record by Dr. Greendale. On admission quiet later became disturbed: slept only 3 hrs. First week Temp. pulse + resp. about normal: Appetite very good: Sleeping done given second night: An occasional cathartic given: bowels regular: Slept quite well at night. Very nervous during day + frequently out of bed: Worries a great deal about her husband who left home on March 2nd 1900 Taking all the money. Second week Temp. pulse + resp. about normal. Appetite good: Slept well: bowels regular with an occasional cathartic: Goes out daily for exercise: Worries a great deal about her troubles: given douches.

June 6 1900. Improving slightly altho very restless + talks about troubles. Assists with work. Trans. to A3. July 17. Vaccinated unsuccessfully

Aug 31 1900. Does some work in center dining room: Somewhat better. Sleeps well. Given gynaecological treatment daily, worries a great deal.

Nov 16. Wt. 147½. Nov. 28. Does not converse as readily: Appetite fair. Works in center dining room. Trans. to A1. Dec 1- Feb 28 1901 Appetite good: bowels regular: Sleeps well: disinclined to work: Habits cleanly. Is melancholy + broods over her troubles + takes no interest in anything. Rather stubborn: Says she wants to die: Jan 21. Began to take electrical treatments daily. Mch + Wt. 143#

Mar 1- June 1- 1901 No change in mental or physical condition except that patient takes some interest in ward work. May 30 Wt. 140#

June to Sept. June 26 menstruated. Sept. 1 Wt. 134#.

Personal and Medical History of Mary Olson #3.

Sept. to Dec. 1901 Nov. 6 visited by daughter, is more contented and not so depressed. Nov. 30 Wt. 134#.

Dec to Feb 1903 No change Wt. about 136#. On June 12th Urine taken Mest. Gen'l health was good: eats + sleeps well: assists with work at times: works for the industrial society: attends Chapel exercises: neat and clean in habits and appearance: quite delusional: converses readily answers questions quite intelligently aside from delusions.

Personal and Medical History of Mary Jane Mullen.

Whole No. 5572
Residence, Faribault Co. Minn.
Date Admission, May 17. 1900.
Admitted by Dr. O. C. Heyerdale hour, 7.45 p. m.
How Sent, Larry L. Bullis. J. of P. Faribault Co.
Sex, Female Age, 24
Civil Condition, Single
Children, -
Age Youngest Child, -
Occupation, General House work
Degree Education, Common School
Profession, Religion, Catholic
Habits, Not intemperate
Nativity, Walnut Lake, Faribault Co. Father N.Y. Mother Canada
Physicians Committing, H. Jacoby & M. N. Leland.
Correspondents, Thos. Mullen, Wells, Minn (Father)

No. of Year, 202
Insane Relatives, Two uncles, Tendency to insanity. Son
Cause Exciting, Disappointment in love
Cause Predisposing,
Form, Melancholia Adolescent
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Not Suicidal
Date of this Attack, Dec. 1899
Duration, Since Dec. 1899
No. of Attack, First (continuous)
No. of Admission, 1st Adm.
Age First Attack, 24.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Sluggish
MEMORY, Past Events, fair.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Seems poor.
REASONING POWER, Ordinary Subjects,
Special Subjects, seems poor.
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 Dulness, 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, living well.
Maternal Relatives,
Brothers and Sisters, well
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Gives no history.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, poor. fair. constipated
Menstr. always regular until last Christmas

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in PRESENT WEIGHT, 113# USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, Skin healthy.
TONGUE, Coatings or Promptness of Movement, prompt - clean.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - large - responses fair.
SIGHT, good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, good Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands & tongue.
PATELLAR REFLEX, Exaggerated Other Reflexes, elbow present.
ARTICULATION, Slurred, Hesitating, Slow,
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,

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

GYNECOLOGICAL EXAMINATION,

MENSTRUATION, began at 16 yrs. regular until last 6 mos. when it stopped until this time
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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). On admission physical condition poor. Cries aloud frequently & is depressed. Sleeps only few Mo. when admitted.

Personal and Medical History of Mary Jane Mullen

1900

This patient was brought here by Sheriff B. McDonald, attended by Mrs. McDonald in poor physical condition; with the following history: Patients uncle on mother's side and uncle on father's side both have a tendency to insanity: no history of intemperance or consanguinity in patient or parents: First symptoms of insanity manifested in Dec. 1899 when patient was picked up on the street in Buffalo, N.Y. & taken to Hospital: Disease is probably increasing: never entirely rational. Disease has been manifested at times since Dec. 1899 - attack being continuous. Derangement now manifested on 'love affair': Has shown no disposition to injure others, not suicidal, filthy, nor destructive: no previous peculiarities, severe disease or head injury: Was confined three months in Buffalo State Hospital. Supposed cause of disease is disappointment in love. On personal examination - melancholia, fear at night; insomnia; tendency to run away from home:

May 17 On admission put upon Inf. West. (G. N. R. Pt.) Complexion dark; hair brown; eyes blue; skin normal; no marks, scars or bruises; clean; has 7 upper & ten lower teeth; 3 upper teeth badly decayed; behavior quiet; would not talk freely.

May 17 to May 31 Summary & da record by Dr. Heyerdale. During first week Temp. ranged from 98°- 100. Pulse from 63- 93 - Resp. from 18- 24. Hypnotics given: patient disturbed, noisy & restless: out of bed often. Second week, Temp. 98°- 100. Pulse 68- 110 Resp. 17- 21. Appetite good: Cathartics & hypnotics given: bowels regular. Patient resistive at times: careless in appearance: at times noisy: talks & cries a great deal: Taken out of doors daily: at times resistive.

Abstract of Letter from Thos. Mullen, dated June 4 1900. Parents living - well - had 11 children all living but one who died when a baby: Grandparents also strong & well mentally & physically: Patient left home at 17: never had any severe illness: In 1897 was working in Mankato & the young man with whom she went round to Buffalo N.Y. she followed him there: said she was sick after going there & paid $50.00 doctor's bills. Letters written home in June 1899 first showed symptoms of mental trouble: was committed to hospital in Dec. 1899. (in Buffalo) Two uncles, one on either side of family. Slightly deranged mentally.

June 30. Patient inactive: Appetite poor: Cries a great deal: Takes out door exercise: Trans. to A°. Jan. 30 Visited by relatives. Aug 18 Assists in dining room occasionally

Oct. 7 Attacked nurses while being bathed. Nov 22 Neat: helps some in laundry: Appetite quite good: Occasionally obstinate & cries: Wt. 127#.

Dec 1- Feb 28 1901. Appetite fair: Sleeps poorly & out of bed a great deal: Sleeping doses frequently given: Assists in laundry: At times violent & destructive: Has delusions: Says her father & brother are here & that there are men

Personal and Medical History of Mary Jane Mullen

under her bed at night. Mar - 1 June 1 - 1901 Mar 27 visited by father and sister. Mar. 8 & Apr. 2 menstruated; May 27 broke dishes in the laundry and plants on the ward. Works in laundry but has spells of some disturbance when she cries and prays a great deal; neat in habits and appears physically quite well; appetite good & sleeps well. May 27 transferred to C 1. May 29 Wt. 128#. June to Sept. Still works in the laundry, and is still violent at times. Sept. 2 Wt. 128#.

Sept. to Dec. No change during quarter, Nov. 23 Wt. 107#.

Dec to Feb. 1903 Physical condition is good: takes exercise: eats & sleeps well: menstruates regularly: bowels regular. Is at times quite violent: She does not often volunteer conversation but at times answers questions intelligently Nov 27th Wt 100 #

Personal and Medical History of Margaretta Zabel.

Whole No. 5375

Residence, Town of Elgin. Wabasha Co.

Date Admission, May 29. 1900

Admitted by Dr. D. C. Truesdale hour, 3.6 pm

How Sent, Mrs. Colvin Kennedy for P. Wabasha Co.

Sex, Female Age, 23

Civil Condition, Married

Children, Two (youngest 5 mos.)

Age Youngest Child, Five months

Occupation, House wife - Husband farmer.

Degree Education, Common School

Profession, Religion, Lutheran

Habits, Not intemperate

Nativity, Holstein Germany. Parents also Germany Has been resident of State a few years. Of county about 5 yrs

Physicians Committing, M. Tefft and F. K. Roberts

Correspondents, Edward Zabel - Husband - Pemberton Minn.

No. of Year, 205

Insane Relatives, None Known

Cause Exciting, Child birth

Cause Predisposing,

Form, Mel. Melancholia (some ag.) with delusions

Accompanying Bodily Disorder, None

Suicidal or not, Not suicidal

Date of this Attack, During last 2 mos yrs.

Duration, Two years

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 21

Time of Leaving, Dec. 29/1900.

Time in Hospital, 7 mos. 9 da.

Result, Discha. Recovered Apr. 30/1901.

EXAMINATION ON ADMISSION BY DR. Truesdale *Date of*

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

quick - confused.

MEMORY, Past Events, does not talk coherently.

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

alert - illusive.

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

exalted

DELUSIONS, Systematized, Transitory, Special Subjects,

many - variable

religious - thinks she has no stomach etc.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).

Mother says no insanity in family -

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, 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, not taken PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, poor.

WOUNDS, Abnormalities and condition of Skin, skin leathery.

TONGUE, Coatings or Promptness of Movement, White coated.

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

SIGHT, good

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

HEARING, good.

COORDINATION, Arms, good. Legs, to Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, slight of hands.

PATELLAR REFLEX, present. Other Reflexes, elbow present.

ARTICULATION, Slurred, Hesitating, Slow, quick.

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal. Uterus small - normal. Perineum extensively lacerated.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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). On admission very restless + maniacal noisy talkative, singing, out of bed often. Brother says she was apparently as well as usual 2 weeks before admission - Has many delusions variable in form.

Personal and Medical History of Margaretta Zabel.

1920

This patient was brought here by her husband, Edward Zabel, attended by Mrs Margaret Will (her mother) in poor physical condition, with the following history:- No history of heredity known, no history of consanguinity or intemperance in patient or parents: First symptoms of insanity manifest during last two years- has "seemed unnatural and cranky". Disease appears increasing with irregular rational intervals- Derangement now manifested on religion: thinks she is a child of God & belongs to God and not to her husband: no disposition to injure others: not suicidal, filthy or destructive: Supposed cause to child birth. No previous peculiarities, severe disease, or head injury: Has not been restrained or confined: has received nervines without relief. On personal examination:- Uterus & ovaries fixed & irritable- Is very demonstrative:

May 30 On Admission put upon Infirmary West: (3 A.M. Apt) complexion fair: hair light: eyes gray: condition of skin normal: no marks, scars, or bruises: clean: has 15 upper & 14 lower teeth: very maniacal: Has delusions:

May 30 to June 3 Lumi. 14 da. record by Dr. Heyerdale. First week temp- ranged from 99° to 101.4: pulse from 68-117. Resp. about normal: Took nourishment regularly. given medicine & cathartics: bowels somewhat constipated: Patient very much disturbed & restless up & out of bed often day & night. Had a good many visitors

Second week temp ranged from 99+ to 100. Pulse from 64-102. Given liquid diet: Took medicine regularly: bowels moved well with cathartics. Patient noisy & restless a great deal of time night & day altho began to quiet down the latter part of week: & was taken out on for trial for exercise.

June 10-11-17-21. Visited by relatives. Takes electrical treatments 3x week.

July 30- Visited frequently by relatives. Aug 29 Visited by Dr. Mayo. Sept 30 Confined to bed: In stupor: does not speak or notice anything: Nov 12 Seems very weak: fed mechanically, stimulants & brandy given: Kept in hot packs. Relatives visit her frequently: Nov 26 Still in bed: Does not converse: Takes light diet. Sleeps well: quiet.

Dec 9 Remains in bed part of time: given enemata daily: Fed by nurses: Taken home this P.M. by Brother.

Discharged.

Personal and Medical History of

Personal and Medical History of Lydia Handtke

Whole No. 5576

Residence, Delavan Township - Faribault Co.

Date Admission, May 23rd. 1900

Admitted by Dr. A. F. Kilbourne hour, 8 pm

How Sent, Harry L. Bullis. J. of P. Faribault Co.

Sex, female Age, 28

Civil Condition, Single

Children, -

Age Youngest Child, -

Occupation, House work - Father farmer.

Degree Education, common School

Profession, Religion, German Lutheran -

Habits, Not intemperate

Nativity, Wisconsin - Parents Germany

Physicians Committing, A. J. Hammond & F. M. Hunt

Correspondents,

No. from of Year, 206

Insane Relatives, none

Cause Exciting, masturbation (supposed)

Cause Predisposing,

Form, Chronic Melancholia

Accompanying Bodily Disorder,

Suicidal or not, Not Suicidal

Date of this Attack, July 1898

Duration, nearly two years.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 26

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* 5/26/1900

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Fair

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,
Indifferent.

DELUSIONS, Systematized, Transitory, Special Subjects,
expresses some

HALLUCINATIONS, expresses some

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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,

Maternal Relatives,

Brothers and Sisters, Well.
2 children well.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Diphtheria when a child. also measles & chicken pox.

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 Fair Fair

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4 in PRESENT WEIGHT, 128 # USUAL WEIGHT, NUTRITION, good.

WOUNDS, Abnormalities and condition of Skin, skin healthy

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

PUPILS, Equality, Size, Response to Light, and Accommodation, equal - normal. responses slow.

SIGHT, good

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

HEARING, good.

COORDINATION, Arms, good Legs, do Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, slight of hands.

PATELLAR REFLEX, present Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, external genitals normal. uterus normal cervix normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 excellent health - is very flashy. Disposition very sullen & refused to talk. Later she became more pleasant & expresses some delusions & illusions. Does some work about ward. usually sits quietly about. Not inclined to visit with other patients.

1902

This patient was brought here by Sheriff McDonald, attended by Miss Hattie Brown in good physical condition, with the following history:- No history of heredity, consanguinity or intemperance in parents or patient: First symptoms of insanity manifested in July 1898 - Disease appears increasing with occasional rational intervals: Derangement now manifested on no special subject: Is depressed & non communicative at most times: No disposition to injure others, not suicidal: Is filthy & destructive: Always quick tempered, - easily angered: no sense disease nor head injury: Has not been restrained nor confined, but has been watched: Supposed cause of disease is masturbation: Has received no treatment: On personal examination - upon & asome questions:

May 13 On admission put upon Infirmary West (G.K.N.Ry) Complexion dark: hair dark brown: eyes brown: skin normal: Several red spots on lower part of back & one on right side of abdomen: no scars or bruises: clean: Has 13 upper & 14 lower teeth: behavior quiet: has delusions.

May 13 to June 6 Summary 14 da. rec. by Dr. Hazeldale. First week Temp. slightly above normal: pulse & resp. about normal: appetite good: sleeps well: bowels regular: Very quiet on ward altho obstinate: Talks very little: Second week Temp. pulse & resp. normal: appetite good: sleeps well: quiet in behavior: works some on ward: Takes out door exercise. June 30. Very irritable. Expresses delusions that people come through wards to kill her: At times very disagreable: Menstuates regularly. July 23 Became somewhat violent: Trans. to C2.

July 30 Very violent at times: Attacks nurses: Has to be restrained.

Aug 29. Expresses delusions freely: Is pulling out hair by roots. Takes out door exercise: Oct 29. Cantinues disturbed, noisy: Takes out door exercise. Appetite good. Wt. 179# Jan 29. In good physical condition appetite good: At times noisy: Takes out door exercise at times destructive: Habits dirty: Is disagreable: Expresses delusions of persecution. Is vulgar & profane: Feb 28. Wt 170#

Mar. to June 1901 General health good, has many delusions, and hallucinations of sight and hearing, at times is violent and extremely noisy both by day and night, assists some with the ward work, strikes herself frequently and pulls her hair out, also scratches herself with pins and is very irritable, May 30 Wt. 165#. June to Sept Aug 27 visited by friends Aug. 31 Wt. 156 #.

Sept. to Dec. Does not attend amusements, occasionally attacks nurses, shows no change in mental or physical condition Nov. 23. Wt. 156#.

Dec to Feb 1903 No change Wt about 156#. Was visited by a friend on Jan 18-'02

Personal and Medical History of Belle McColgen

Whole No. 5-5-79

Residence, Zumbro Falls, Minn.

Date Admission, May 29. 1900

Admitted by Dr. J. Manahan hour, 5 p.m.

How Sent, McColgan Kennedy & P. Wabasha C.

Sex, Female Age, 18

Civil Condition, Single

Children, -

Age Youngest Child, -

Occupation, "Table maid" - Father Farmer

Degree Education, Common School

Profession, Religion, Roman Catholic

Habits, Uses Tobacco excessively (?)

Nativity, Zumbro Falls Minn. Father Ireland, Mother Germany. Has been resident of State + county 18 years.

Physicians Committing, M. K. Kremer + J. R. Watson

Correspondents, Mrs. Mc Colgen, Zumbro Falls Minn (Sister)

No. of Year, 2nd

Insane Relatives, None

Cause Exciting, "puerperal"

Cause Predisposing,

Form, Hysteriacal - simple melancholia -

Accompanying Bodily Disorder, Septic peritonitis + Hysteria

Suicidal or not, Suicidal - (tried to cut throat)

Date of this Attack, About 2 mos. ago

Duration, 2 mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 18

Time of Leaving, June 18. 1900

Time in Hospital, 20 d.

Result, Disc. Nov. 7. 1900 Improved

EXAMINATION ON ADMISSION BY DR. Fryerdale Date of 5/31/900.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Good.

Recent Events, " Special Subjects,

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

REASONING POWER, Ordinary Subjects, good.

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 Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation,

HISTORICAL.

LENGTH INVASION, About 6 weeks.

ONSET, Gradual or Sudden, Sudden

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

Father, living - 60 - Excessive use of tobacco.

Paternal Relatives, no insanity known

Mother, living 50.

Maternal Relatives, no insanity known.

Brothers and Sisters, Well

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Confinement Apr. 28th.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework.

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

Sleep, Appetite, and Bowels, Good.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ in. PRESENT WEIGHT, 102 lb. USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, Skin healthy.

TONGUE, Coatings or Promptness of Movement, Thick white coat. 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, good Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, present. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal. Hymen torn - uterus somewhat enlarged + boggy. Cervix do. os uteri somewhat inflamed - Clear thick leucorrhoeal discharge from uterus.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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). In her physical condition - cried + slept little first night + talked rationally + intelligently on all subjects. Says she has done housework + dining room work in Hotel. Could not get along at home Father cranky + brothers wife treated better than she. Has been going with a young man with whom she is desperately in love. About one month ago developed a pelvic peritonitis for which she was curetted. Says she was somewhat delirious afterward but knows what friends told her.

Personal and Medical History of Belle M Calgen

1900

This patient was brought here by Jeff M Clausey attended by her brother + sister, in fair physical condition, with the following history: No history of heredety or consanguinity in patient or parents. Father (?) uses tobacco excessively: First symptoms of insanity manifested about two months ago by crying, nervousness, temper: Disease appears increasing: Variable with irregular rational intervals: derangement now manifested by worry + jealousy: not disposed to injure others: Has attempted to cut her own throat: suicidal tendency now active: not filthy or destructive: previous prominent - "love for one person": Has had Septic peritonitis + hysteria: supposed cause of disease is "puerperal"? Treatment received - curettage, bromides + sedatives: no effect: Has not been confined or restrained: Our personal examination: very nervous, ugly: On admission put upon Inf. Mist. (T.N.N. Rpt.) complexion dark: hair + eyes brown: skin normal: no marks, scars or bruises: clean: Has 16 upper + 15 lower teeth: quiet: talks intelligently:

May 29

May 29 to June 14 ind.

Summ. 14 da. record, by Dr. Heyerdale. First week temp. ranged from 99°-102°. Pulse from 70-108. Resp. about normal: appetite fair: given Hypnotics regularly, also medicine - + cathartics as needed: Very nervous + cried more or less, complained of pain in right side: Always quiet + agreeable: Takes outdoor exercise. Has some headaches. Second week Temp. + pulse about normal: appetite good: Took meals regularly: bowels slightly constipated: Quiet + agreeable on ward: Talks sensibly + rationally: No delusions noted. June 11. Visited by friends. June 13 Visited by Sister

June 18

Neat in habits + appearance: Takes outdoor exercise: appetite good: bowels usually regular: Today sent home on trial.

Discharged.

Letter received from Sister Oct 19th 1900. Says patient does not sleep well + during night has pains around heart + frothes at mouth. is fleshy - Weighs 145#. Is doing housework.

Personal and Medical History of

Personal and Medical History of Lena Knapp

Whole No. 5581

Residence, Lakeville, Dakota Co.

Date Admission, June 1-1900

Admitted by Dr. C. Z Weaver hour, 7 p.m.

How Sent, D. P. Moran, Jr of D. Dakota Co.

Sex, female Age, 49

Civil Condition, widow

Children, Two

Age Youngest Child, 29

Occupation, House keeper. Husband farmer

Degree Education, Common School

Profession, Religion, Catholic

Habits, Not intemperate (Father drunk)

Nativity, Ohio. (Parents Luxemburg)

Physicians Committing, D. O Van Lappelen & J. J. Tiffaney

Correspondents, Miss Lizzie Knapp, Lakeville, Minn. (Daughter)

No. for Year, 211

Insane Relatives, none

Cause Exciting, not known

Cause Predisposing,

Form, Mel Melancholia with delusions

Accompanying Bodily Disorder, none mentioned

Suicidal or not, Not Suicidal

Date of this Attack,

Duration,

No. of Attack, 1st

No. of Admission, 1st time

Age First Attack,

Time of Leaving, Jan. 14 1901.

Time in Hospital, 7 mos. 13 days.

Result, Discharged. Recovered. Apr. 30 1901.

EXAMINATION ON ADMISSION BY DR. Heyerdahl Date of June 5 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
somewhat confused

MEMORY, Past Events, rather poor.

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,

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Thinks dead.

Maternal Relatives,

Brothers and Sisters, 6
1 Challenged

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. 6 in PRESENT WEIGHT, 128 # USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, Skin normal.

TONGUE, Coatings or Promptness of Movement, very light white coat.

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

SIGHT, poor.

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

HEARING, fair.

COORDINATION, Arms, Quite good Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, marked of hands

PATELLAR REFLEX, normal. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size N

Apex Beat, Regularity, N.

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal - Uterus normal - Cervix normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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). In poor physical condition. Very nervous & evidences some hysterical manifestations. Seems confused in her ideas & cannot remember well.

Personal and Medical History of Lena Knapp

1900

This patient was brought here by Sheriff John Highland, attended by Lizzie Knapp & John Sander in fair physical condition, with the following history: No history of heredity or consanguinity: father drank considerable: First symptoms of insanity manifested 1½ y. by desire to be alone & petting about everything; disease appears stationary: no rational intervals: Derangement now manifested by: loss of memory, irritability of temper, denying having relatives, imagining something wrong will happen: no disposition to injure others, not suicidal, filthy nor destructive: no previous peculiarities severe disease or head injury: was confined five weeks in Sanitarium in Minneapolis (Lawrences Institute) Cause of disease unknown: treatment unknown: On personal examination:- Is worried about answering questions: Shows loss of memory: denies having brother or sister: On admission put upon Infirmary Mat (L.H.N. Rpt) Complexion dark. Hair & eyes brown: skin normal: Has several moles on face: no marks, scars or bruises: clean: Has 13 upper & 12 lower teeth. Behavior quiet: very absent-minded.

June 1 Summary 14 da. record. by Dr Heyerdahl During first week temp. pulse & resp. about normal: Appetite fair: hypnotics necessary for sleep: medicine given regularly: cathartics necessary. Very nervous & altho talks quite sensibly has a great many delusions in regard to relatives. Is very peevish & complains of some pain, especially in stomach hot water bag applied & high enema given.

June 15 Second week Appetite fair medicine & cathartics given: Complains of some pain in stomach has improved some: Takes out-door exercise, Sleeps well with hypnotics.

June 30. Appetite fair: Converses readily: Seems rather hypochondriacal: & worries about pains & aches: Assists with work: Takes outdoor exercise: Bowels regular: Sleeps poorly: Takes electrical treatments. Aug 2. Visited by daughter. Oct 22. Trans. to A3. Nov 16 '14. 135th. Nov 30. In bed a couple of days: pain in back: Condition only temporary.

Personal and Medical History of

Personal and Medical History of Caroline L Streck

Whole No. 5582

Residence, Carrimona, Fillmore Co.

Date Admission, June 4 1900

Admitted by Dr. Ole. Haugedal hour, 1:45 pm.

How Sent, C. W. Farrington, Sh. of Fillmore Co.

Sex, female Age, 28

Civil Condition, Single

Children, -

Age Youngest Child, -

Occupation, House work

Degree Education, Common School

Profession, Religion, Lutheran

Habits, Not intemperate

Nativity, Germany. Parents also. Has been Resident of State & County 23 years.

Physicians Committing, J. H. Phillips & Mrs. A. Love

Correspondents,

No. of Year, 2/2

Insane Relatives, none

Cause Exciting, unknown

Cause Predisposing,

Form, Melancholia (Stuporose)

Accompanying Bodily Disorder, none mentioned

Suicidal or not, not suicidal

Date of this Attack, Last Thursday (May 31)

Duration, 4 d.

No. of Attack, 2nd

No. of Admission, 1st

Age First Attack, 28

Time of Leaving, Oct. 24 1900.

Time in Hospital, 4 mo. 20 da.

Result, Discharged Feb. 5/1901

EXAMINATION ON ADMISSION BY DR. Haugedal *Date of* June 7

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, fair

Recent Events, " Special Subjects,

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

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State,

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 Dulness, 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 - Cancer of liver.

Paternal Relatives,

Mother, living & well.

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 5½ PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, Poor

WOUNDS, Abnormalities and condition of Skin, ~~poor~~ healthy.

TONGUE, Coatings or Promptness of Movement,

PUPILS, Equality, Size, Response to Light, and Accommodation, yes. equal & 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 present

PATELLAR REFLEX, present. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, 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, External genitals normal. Hymen torn. uterus normal in size & position. cervix normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 poor - very restless day & night & very resistive, out of bed often. does not talk freely. & at the restless she appears indifferent & dull.

Personal and Medical History of Caroline L. Streck

1900

This patient was brought here by Wm. Streck (brother) attended by John Krugel (brother-in-law) in poor condition, with the following history:- No. History of heredity consanguinity or intemperance in patient or parents: First symptoms of insanity manifested about three months ago: attack lasted ten days: First symptoms of present attack manifested last Thursday: Disease appears stationary, not variable: with no rational intervals: Derangement now manifested by delusions on many subjects: no disposition to injure others; not suicidal, filthy nor destructive: no previous peculiarities, severe disease or head injury: cause of disease is unknown: Has not been confined or restrained & has received no treatment: On personal examination:- patient is very quiet, but has delusions on many subjects:

June 4 On admission put upon Infirmary West (Gyn'd. Rpt. Complexion dark: hair light brown: eyes gray: skin hot & dry: eruption on back & face: So clean: has an upper plate & six of her own lower teeth - Behavior quiet: has delusions)

June 18 Summary 10 da record (Dr Hyndale) During first week. Temp, 98°-100°. - Pulse & resp. somewhat accelerated: given liquid diet; hypnotics & cathartics: At first was very restless & disturbed & out of bed at night & at times noisy, but toward latter part of week very quiet: talked very little: slept well.
Second week Temp, pulse & resp. normal: given medicine & cathartics appetite good: somewhat resistive when given medicine: Very quiet on ward: Takes outdoor exercise

July 6. Visited by brother: General health good: 19 Trans to A3, Aug 31. Seems somewhat brighter: neat: Health good: Does some work in laundry:

Oct 24 1900. Quiet & agreeable: Expresses no delusions: Allowed to go home.

Discharged.

Letter received from patient Jan 25 1901. Says she is very well.

Personal and Medical History of

Personal and Medical History of Emilie Neumann

Whole No. 5584

Residence, North St. Paul Ramsey Co.

Date Admission, June 5. 1900

Admitted by Dr. Ob. Heyerdale hour, 7 p.m.

How Sent, C. M. Bazille, J. of P. Ramsey Co.

Sex, Female Age, 42

Civil Condition, married

Children, Eight

Age Youngest Child, five years.

Occupation, Housewife - Husband laborer.

Degree Education, Can read, but not write

Profession, Religion, German Lutheran

Habits, Not intemperate

Nativity, Germany; Parents also (Has been resident of State + Co. since 1873)

Physicians Committing, D.C. Jones, + Arthur Brenny

Correspondents, Julius Neumann (Husband) N. St. Paul Minn

No. of Year, 2nd

Insane Relatives, Father

Cause Exciting,

Cause Predisposing,

Form, Melancholia with delusions (religious)

Accompanying Bodily Disorder, none mentioned

Suicidal or not, not suicidal

Date of this Attack, 1 year ago

Duration, one year

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 41

Time of Leaving, December 17 - 1901

Time in Hospital, 1 Yr 6 mo 12 Ds

Result, Improved: Discha July 9-1902 (By B of C)

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of*

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, fairly good.

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, fair

Special Subjects, "

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
on religious

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Committed suicide

Paternal Relatives, Father's father committed suicide

Mother, had a very bad temper

Maternal Relatives, Mother's mother insane

Brothers and Sisters,

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

HABITS, Drinking and Smoking, She always drank heavily of wine etc.

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 3 PRESENT WEIGHT, 135 USUAL WEIGHT, NUTRITION, poor.

WOUNDS, Abnormalities and condition of Skin, Skin healthy.

TONGUE, Coatings or Promptness of Movement, prompt. Slight whitish coat.

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

SIGHT, good.

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

HEARING, Poor.

COORDINATION, Arms, good Legs, do. Grasp,

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

PATELLAR REFLEX, diminished Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

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,

Color and Appearance,

EXAMINATION URINE, Quantity, Sp. g. Reaction,

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal - Perineum extensively lacerated: Uterus enlarged + boggy. cervix do. Os inflamed - Uterine endometritis present with some discharge

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 the Lord's angels + they talk to her but she does not know what they say - says god directs her to do certain things Says she is born from the Holy Ghost.

Personal and Medical History of Emilie Desmond.

1900

This patient was brought here by Dep. Sheriff Tawson, attended by Julius Desmond (husband) in poor condition, with the following history: Father committed suicide while insane: no history of consanguinity or heredity in patient or parents: First symptoms of insanity manifested one year ago, when she became excessively religious: disease appears increasing: not variable: no rational intervals: derangement now manifested on religion: talks with God and sings & prays most of night: no disposition to injure others: not suicidal, filthy nor destructive: no previous peculiarities, severe disease or head injury: has not been restrained or confined & has received no treatment: cause of disease unknown. On personal examination:- patient says that she holds conversations with God & will do anything He commands & that she wants to die to be with Him.

June 5 Dec. Admission put upon Infirmary West (G.P.H. Rpt complexion dark: hair dark brown: eyes brown: skin in normal condition: No marks, scars nor bruises: is dirty: Has six lower & ten upper teeth all in bad condition: behavior quiet: has delusions)

June 5 to 19th Imms. 14 da. rec. by Dr. Reynolds. On admission temp. pulse & resp. about normal. Appetite very good: bowels somewhat constipated: given cathartics regularly: On admission slept well all night but the next day became quite disturbed & was out of bed a great deal: Afterward slept well & was quiet during day: Talks & pleasant in manner. Second week Temp. pulse & resp. about normal: Appetite very good: bowels regular: slept well: Pleasant & quiet in behavior: Talks very little: Goes out for exercise.

June 30. Quiet as a rule tho occasionally becomes noisy, especially at night: usually sleeps well: Takes outdoor exercise: Sits about ward & reads. Thinks God tells her to pray very hard - which she does: Assists some on ward: Vaccinated. Aug 7 Trans. to A2. Aug 14 Occasionally cries & becomes quite disturbed Trans. to Infirmary

Sept 28 Visited by husband: Oct 30 Reads Bible constantly & prays: Expresses delusion that she constantly hears voice of God: General health good.

Dec 7. Attempted to commit suicide by cutting throat with Knife: Laceration a very small one: Two stitches taken: Jan 17. to Feb 5 1901. Electrical treatments given. Feb 10 General health fair: Wt. 117½ lbs

Mar 1 - June 1 - 1901 Bowels regular though occasionally calls for cathartics: sleeps well: appetite good: is neat in habits and appearance: takes out of door exercise: attends

Personal and Medical History of

chapel: quiet in behavior, seldom converses: assists with ward work. May 17 transferred to B1. May 29 Wt 112 3/4 #

June to Sept. Is still depressed at times, has hallucinations, thinks that God converses with her sings and prays a great deal, assists some with ward work, takes out door exercise. Sept 2 Wt. 115#. Sept. to Dec. Condition about the same during this quarter, answers questions intelligently, converses very little, Sept. 15 visited by husband.

Sept. to Dec. Nov. 30 Wt. 130#. Dec. 1 taken home.

Personal and Medical History of Katherine Heinke.

Whole No. 5587

Residence, St. Paul, Minnesota

Date Admission, June 7th 1900.

Admitted by Dr E. J. Warren. hour, 7 P.M.

How Sent, Ems. Bazille & J. of P. Ramsey Co.

Sex, female Age, 40-45 not given

Civil Condition, married

Children, Three.

Age Youngest Child, 19 yrs.

Occupation, Notable housewife

Degree Education, Common school.

Profession, Religion, Not a church member

Habits, not intemperate.

Nativity, Wisconsin (Parents born in Germany)

Physicians Committing, J. A. Varnegg & G. Stamm.

Correspondents,

No. of Year, 297.

Insane Relatives, unknown.

Cause Exciting, Hysteria.

Cause Predisposing,

Form, General Paresis Delusional Insanity

Accompanying Bodily Disorder, none mentioned

Suicidal or not, not,

Date of this Attack, Two weeks ago-

Duration, Two weeks.

No. of Attack, First.

No. of Admission, First.

Age First Attack, ?

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Heipedale *Date of* June 9, 1900

MENTAL CHARACTERISTICS.

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Riches &c.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, dead - thinks she was insane.

Maternal Relatives,

Brothers and Sisters, Nil 3 children

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Typhoid 8 yrs. ago. Measles when a child

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, until age of 12 yrs

OCCUPATION, Healthy or not,

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

Sleep, Appetite, and Bowels, Constipated

Personal and Medical History of

W. E. Bullard
Belmont
Iowa

Mrs. Heinke
(This address left to day by this party visiting Mrs Fay)

...RISTICS.

...WEIGHT, NUTRITION, fair

...rowish coat -

...rmal -

Grasp,

...ds.

Other Reflexes, Elbow - present

ARTICULATION, Slurred, Hesitating, Slow,

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal - uterus retroflexed & somewhat prolapsed - cervix large & baggy.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 poor: very restless & disturbed - talks a great deal. imagines herself the richest woman in the world. has grandiose ideas &c. talks incoherently, a great deal - sings - is very noisy.

Personal and Medical History of Katherine Hinke.

Whole No. 5587

Residence, St. Paul, Minnesota

Date Admission, June 7th 1900.

Admitted by Dr C. J. Warnow. hour, 7 P.M.

How Sent, Exw. Bazille J. of P. Ramsey Co

Sex, female Age, 40-45 not given

Civil Condition, married

Children, Three.

Age Youngest Child, 19 yrs.

Occupation, Dressmaker housework

Degree Education, Common school.

Profession, Religion, Not a church member

Habits, not intemperate.

Nativity, Wisconsin (Parents born in Germany)

Physicians Committing, J. A. Vuengge + C. Stamm.

Correspondents,

Age First Attack,

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Heizerdale *Date of* June 9, 1900

MENTAL CHARACTERISTICS.

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Riches &c.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, dead - thinks she was insane.

Maternal Relatives,

Brothers and Sisters, Well 3 children

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Typhoid 16 yrs. ago. Measles when a child

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, until age of 12 yrs

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, 5 ft. 8 in. PRESENT WEIGHT, 151½ lbs USUAL WEIGHT, NUTRITION, Poor

WOUNDS, Abnormalities and condition of Skin, Skin Healthy

TONGUE, Coatings or Promptness of Movement, Prompt - slight brownish coat -

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

SIGHT, not as good as formerly

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

HEARING, not as acute as formerly

COORDINATION, Arms, good - Legs, good Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, fair of hands.

PATELLAR REFLEX, present Other Reflexes, Elbow - present

ARTICULATION, Slurred, Hesitating, Slow,

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal - uterus retroflexed + somewhat prolapsed - cervix large + boggy.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 poor: very restless + disturbed - talks a great deal. imagines herself the richest woman in the world. Has grandiose ideas &c. Talks incoherently, a great deal - sings - is very noisy.

Personal and Medical History of Katherine Herinke

1900

This patient was brought here by Deputy Sheriff Hanson attended by A. L. Phillips & Mrs. St. Peire. in poor physical condition, with the following history: No history of consanguinity, heredity nor intemperance in patient nor parents. First symptoms of insanity manifested about two weeks ago by spiritualistic delusions. Decidee appears increasing not variable. Derangement now manifested by quarreling with everybody, claiming to come from a high aristocratic family etc. Not disposed to injure anyone: No filthy nor destructive habits: Patient always of a nervous temperment. No severe diseases nor injuries to head. No confinement nor restraint employed: No treatment pursued. On personal examination denies facts of wrong doing &c claimed by her husband & neighbors.

June 7 On admission put upon Infirmary (G.H.H. Rpt. Complexion dark. hair brown. eyes brown. Skin hot & dry: no marks, scars nor bruises, So clean. Has 1 upper tooth & plate - & 9 lower teeth. Behavior quiet. Has delusions.

June 7 to June 10 Summary 14 da. Record by Dr. Reynolds) Admitted on Infirmary - Ate supper - appetite fair. Became very depressed during night. During first week. Temp. 98°-100° Pulse 80-120. Resp. 18-30. June 10 Fed by tube. Hypnotics & cathartics required Bowels irregular. June 8 & 9 Disturbed, out of bed a good deal: Talk incoherent. inclined to be violent. June 10 Dressed & up on ward. Inclined to be violent - awake until 1 AM. slept afterward. June 11-13 Much disturbed. Talks a good deal, at times very noisy & violent with nurses. Slept only fairly well. Second week. Temp. 97-104°. Pulse 78-114. Resp. variable. Fed mechanically most of the time On restraint all week. After June 20 took nourishment well. Hypnotics & cathartics given: Bowels irregular From June 14-18 incl. patient noisy & disturbed - Slept poorly at night at times violent toward nurses: In restraint at night.

June 26. Noisy & violent, put in restraint: June 30 No change. very restless & incoherent: boisterous in manner. Trans to Cr

Aug 1 Quieted down very much: Takes outdoor exercise. Appetite & general health good. Aug 23. Continues to improve Trans. to Cr.

Sept 28. Fault finding & disagreeable at times: Thinks she has great power in certain lines. Assists with work. Sept 28 Sick in bed: Trans. to Infirmary

Oct 1 Much improved: up on ward. Trans. to Ar, Dec. 6 Very much disturbed.

Dec 17. Taken to city to shop. 18 & 19 Visited by sisters: General health good. Quarrelsome & disagreeable on ward: scolds a great deal & finds fault with everything. Talks rationally. Jan 26 Taken home on trial by sisters - who brought her back again a few

Personal and Medical History of

days later as they were unable to keep her. Feb 1 Trans. Ar. Prev. Menstruates Regularly: Very irritable & disagreeable: General health good. Occasionally scolds & is much excited; Sleeps well. Feb 26 Vaccinated -

Feb 28 1901. Wt. 133#. Mar. to June 1901 No change in mental or physical condition, May 30 Wt. 133½#. June to Sept. June 19 menstruated, converses intelligently, at times expresses delusions, takes care of her room otherwise does no work Aug. 27 visited by daughter, Sept. 2 Wt. 135#. Sept. to Dec. Oct. 10 visited by mother and sister in law occasionally somewhat disturbed, spends most of her time in her room Nov. 30 Wt. 135#.

Dec to Feb 1903. Patient is usually quite agreeable: talks quite intelligently aside from delusions. Is a spiritualist and believes in hypnotism - otherwise seems quite normal. Her general health is good: assists with the work: attends amusements & takes exercise. Dec 1st Wt 141#.

Personal and Medical History of Kate Johnson.

Whole No. 5591

Residence, Faribault, Minn.

Date Admission, June 1st 1900.

Admitted by Dr. O. C. Heyerdahl, 7 Rm.

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

Sex, female. Age, 65.

Civil Condition, married.

Children, none.

Age Youngest Child, -

Occupation, housewife.

Degree Education, academic.

Profession, Religion, Catholic.

Habits, temperate.

Nativity, Canada. Parents born in Ireland.

Physicians Committing, P.A. Smith & D.W. Caal.

Correspondents, Phillip Johnson, Faribault, Minn. (Pharmacist)

No. of Year, 221.

Insane Relatives, one brother.

Cause Exciting, Religious excitement.

Cause Predisposing, heredity.

Form, Chr. Mania

Accompanying Bodily Disorder, none.

Suicidal or not, not.

Date of this Attack, 18 yrs. ago.

Duration, 18 yrs.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, ~~65 yrs.~~ 47

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Heyerdahl *Date of* June - 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
fairly quick - somewhat confused.

MEMORY, Past Events, fair

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,
Quiet

DELUSIONS, Systematized, Transitory, Special Subjects,
Has many transitory - also on religion.

HALLUCINATIONS,

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, About 20 yrs.

ONSET, Gradual or Sudden, gradual.

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

Father, dead - very old man.

Paternal Relatives,

Mother, dead

Maternal Relatives,

√ Brothers and Sisters, living - well - Children - many.

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

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 good Regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2½ PRESENT WEIGHT, 117 lbs USUAL WEIGHT, NUTRITION, fairly good.

WOUNDS, Abnormalities and condition of Skin, Skin healthy.

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

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - small - response very slight.

SIGHT, fair - wears glasses.

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

HEARING, good.

COORDINATION, Arms, Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, present of tongue.

PATELLAR REFLEX, exaggerated Babinski absent. Other Reflexes, Elbow present - wrist jerk.

ARTICULATION, Slurred, Hesitating, Slow,

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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Has painful caruncle on urethra - Vagina & cervix inflamed - congested - Os inflamed - Some endometritis present.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 admitted in fairly good physical condition. Is quiet & sleeps well. Expresses a great many delusions - some of a religious nature.

Personal and Medical History of Kate Johnson.

1900

This patient was brought here by Sheriff's deputy J. B. Thompson attended by her husband & Mrs. Gavin in fair physical condition, with the following history:- No history of consanguinity, one brother insane: No intemperance in patient nor in parents: First symptoms of insanity manifested 18 years ago by religious mania: Disease appears increasing: not variable: Derangement now manifested by delusions; imagines she is opposed by her relations: that people's hair changes color; negroes turn white, clothes are torn etc. Is disposed to injure others: Habits filthy & destructive: Her mind has been on religious subjects for twenty years: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued: On personal examination wanders in her conversation, says people stole her teth & hair. On admission put upon Infirmary list. (Complexion fair: hair gray: eyes blue: skin in natural condition: No marks, scars nor bruises: Is clean: Left nipple absent: has six lower teeth. Behavior quiet: Talks intelligently but not freely.)

June 15 to June 26 Summary 14 Ad. Rec. by Dr. Heyrdale. On admission behavior very quiet: Slept well. During first week Temp. pulse & resp. about normal. June 15. In bed: very quiet. has some morbid ideas: June 16 In bed. quiet. dull in appearance. during rest of week slept well at night. On 16. Resisted being taken to operating room for gynecological examination: Struggled & pulled hair: afterward caused no trouble on ward: Taken out daily for exercise: Record work: Bowels required occasional cathartics: Appetite good: Temp: pulse & resp. about normal: Slept well at night Likes to lie on bed. 21 Visited by husband.

June 30 1900 Quiet: will converse at times: Very contrary about being dressed. Neat in habits & appearance: Has delusions of poisoning also expresses other delusions. Thinks she must wear a band tightly bound about chest: & thinks people try to steal her clothes. Has habit of lying down a great deal. July 21 Vaccinated - General health good: Sept. 27. Trans. to A 3, Nov 16 Wt. 108 1/2 #: Dec 1- Feb 28 1901 Idle. Violent & resistive: especially when being bathed: has delusions: Is as a rule quiet & neat: Likes to lounge around: Does no work. Wt. 104 1/2 #.

Mar. to June 1901 May. 3 to 16 had erysipelas of the face, May - 7-8 visited by husband, May 29 Wt 100#

June to Sept. Patient is very quiet, has many delusions, is unoccupied, lies around about the ward a great deal, at times is very irritable especially when bathed, frequently attacks nurses, Aug. 30 Wt. 102 #.

Sept. to Dec. Nov. 30 visited by husband, objects to taking exercise, no change in mental or physical condition Nov. 27 Wt. 103 #.

Personal and Medical History of Kate Johnson.

Dec. to Feb. 1903 No change. Wt about 97 #. Visited on Apr 1 1902 by a lady friend. July 1st & 17th By husband. Oct. 1st Visited by daughters

Personal and Medical History of Mrs. Ella Provost.

Whole No. 5596
Residence, St. Paul, Minn.
Date Admission, June 16th 1900.
Admitted by Dr O.C. Heyerdale hour, 7 P.M.
How Sent, Ex. Bazille J. of P. Ramsey Co.
Sex, female Age, 42 yrs.
Civil Condition, married
Children, 5.
Age Youngest Child, 14 yrs.
Occupation, nurse.
Degree Education, common school.
Profession, Religion, Episcopal
Habits, Not intemperate.
Nativity, U.S. (Parents also born there)
Physicians Committing, J.T. Rogers - C.E. Riggs.
Correspondents, Wm. Provost (son) 35 E 10th St. St. Paul, Minn.

No. of Year, 236
Insane Relatives, None.
Cause Exciting, Intra Cranial disease.
Cause Predisposing, ?
Form, Acute Mania ?
Accompanying Bodily Disorder, Optic neuritis. probably intra cranial growth.
Suicidal or not, not.
Date of this Attack, 2 days ago.
Duration, 2 days.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 42 yrs.
Time of Leaving, July 4. 1900
Time in Hospital, 18 d.
Result, Dise. Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* June 18 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear.
MEMORY, Past Events, fairly good
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal.
DELUSIONS, Systematized, Transitory, Special Subjects,
None apparent
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 - old age.
Paternal Relatives,
Mother, died Cancer - age 59.
Maternal Relatives,
Brothers and Sisters, 1 sister dead - all rest well 5 children
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Malaria last summer. La Grippe last Winter from which she never fully recovered.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Nursing, + housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Somewhat constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6½ in. PRESENT WEIGHT, 145# USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, Skin healthy.
TONGUE, Coatings or Promptness of Movement, prompt. thick White coat.
PUPILS, Equality, Size, Response to Light, and Accommodation, equal - size normal - Response 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, present Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Slow
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,
Color and Appearance,

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

GYNECOLOGICAL EXAMINATION, Laceration of perineum (slight) Uterus retroflexed. Cystocele + Rectocele + some Prolapse.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 admitted in fair physical Condition. Is quiet + rational. Talks well. Speech rather slow - but probably naturally so. Remembers well.

Personal and Medical History of Mrs. Ella Provost.

1900

This patient was brought here by Dep. Sheriff Hanson attended by son: in fair physical condition, with the following history: No consanguinity, nor heredity known: First symptoms of insanity manifested two days ago by violent excitement: Disease not variable: appears increasing: Derangement manifested by delusions of exaltation: No filthy nor destructive habits: No peculiarities previously manifested: Subject to epileptiform attacks: No confinement nor restraint employed: No treatment pursued: On personal examination has optic neuritis: evidence of cerebral pressure + probably intra cranial growth.

June 16 On admission put upon Infirmary East (G.S.N.Rpt. Complexion dark: Hair black: eyes brn: skin normal condition: So clean: Has 13 upper + 11 lower teeth: Behavior quiet: Talks intelligently.)

June 16 to June 30 Summary of do. Record by Dr. Reynolds. Patient quiet on admission, talked quickly, slept well: During first week Temp., pulse + resp. normal. Appetite good: bowels regular with aid of cathartics: Patient quiet + agreeable: Slept well at night: Took outdoor exercise: Second week Temp. normal appetite good: June 27. Refused medicine: bowels regular: June 23-24 Visited by daughter + a friend: Agreeable + quiet on ward: Out of doors daily for exercise. June 28 Trans. to A3. Expressed no delusions, hallucinations nor illusions: Seemed perfectly rational

July 24 Sent home.

Letter received from daughter Oct 19 1900. States that patient is better than she has been in years.

Discharged

Personal and Medical History of

Personal and Medical History of Fannie B. Giles.

Whole No. 5598
Residence, St. Paul, Minnesota.
Date Admission, June 20. 1900.
Admitted by Dr. O.C. Heyerdale hour, 7 P.M.
How Sent, Ex. W. Bazille J. of P. Ramsey Co.
Sex, female Age, 73.
Civil Condition, widow.
Children, Eight
Age Youngest Child, 32 yrs.
Occupation, housewife.
Degree Education, Common school.
Profession, Religion, Methodist.
Habits, Not intemperate.
Nativity, Newyork (Parents born U.S.)
Physicians Committing, Paul Ritchie + M. Dinsmore
Correspondents, H.P. Giles 921 York Sr. St. Paul

No. of Year, 228.
Insane Relatives, None.
Cause Exciting, Senile Dementia
Cause Predisposing, unknown.
Form, Senile Dementia
Accompanying Bodily Disorder, unknown.
Suicidal or not, not.
Date of this Attack, 1 yr. ago.
Duration, 1 yr.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 72 yrs.
Time of Leaving, Aug. 12. 1900
Time in Hospital, 1 mo. 22 d.
Result, Died - Pneumonia.

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* June 25. 1900

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 Dulness, 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, Not attainable 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

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1/2 in. PRESENT WEIGHT, 101 USUAL WEIGHT, NUTRITION, fairly good.
WOUNDS, Abnormalities and condition of Skin, Skin in normal condition.
TONGUE, Coatings or Promptness of Movement, 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, good Legs, good Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, none.
PATELLAR REFLEX, gone. Other Reflexes, wrist, arm present.
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, weak Size, N
Apex Beat, Regularity, Irregular.
ARTERIES, Slightly sclerotic.

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.
Breath sounds normal.

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

GYNECOLOGICAL EXAMINATION, Lacerated perineum - extensive. Uterus small + atrophied. Has urethral caruncle. Has rectocele, cystocele + some prolapse
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 fairly good physical condition. Is restless + out of bed at times. Is demented + talks incoherently.

Personal and Medical History of Fannie B. Giles.

1900.

This patient was brought here by sheriffs deputy H. Gallick attended by Mrs H.P. Giles in fair physical condition, with the following history: No history of consanguinity, heredity nor intemperance. First symptoms of insanity manifested one year ago by loss of memory & desire to wander away. Disease appears increasing. Not variable. Derangement now manifested by believing her mother is living & needs her at home. No disposition shown to injure anyone. Needs to be watched like a child. No peculiarities previously manifested. No severe diseases nor injuries to head. Has been watched constantly since April 1st 1900. No treatment pursued. On personal examination has symptoms of senile dementia. On admission put upon Sch. Complexion dark. hair gray. eyes brown. Skin hot & dry. No marks, scars nor bruises noted. Is clean. Has 3 upper & 10 lower teeth all bad. Behavior quiet. Talks incoherently.

June 30 to July 3 Summary 14 days record by Dr Heyerdahl. During first week pulse & respiration at times somewhat accelerated. Temp. usually a little higher at night. Appetite good. Requires cathartics. Is very restless during day. Talks incoherently. untidy in habits - a case of senile dementia. Sleeps well at night usually. During second week temperature about normal. pulse & respiration somewhat accelerated. Appetite good. Bowels regular. Is restless, & untidy in habits altho usually sleeps quite well at night. Quiet in behavior

July 5 No change. Trans. to A. Aug 6 Appeared sick. put to bed. coughing some. Temp. 102 2nd. P. 110. R. 36. Ate very little supper. Sponge baths given to reduce fever. Aug 7 Ate very little breakfast. Temp. 101 3 Pulse 80 Resp 20. Trans. to Infirmary.

Aug 8-9 Remained in bed. cough same but swallows expectoration. Temp. 101 6, Pulse 84. Has difficulty in breathing. Very restless during day & more or less so at night.

Aug 11 Is failing. Has rattling sound in chest & throat. Temp. at 4 PM 101 6, Pulse 86. Visited by son. Sponge baths given. Takes liquid nourishment. Aug 12 Temp, 7 AM 106

Aug 13 ~~Ho~~ Pulse 98. Died 5:30 Son present.

Died

Personal and Medical History of

Personal and Medical History of Rose Gerard.

Whole No. 5600
Residence, St. Paul, Minnesota.
Date Admission, June 22, 1900
Admitted by O. C. Heyerdale M.D. hour, 7 P.M.
How Sent, E.W. Bayliss J. of P. Ramsey Co.
Sex, female Age, 25 yrs.
Civil Condition, single.
Children, —
Age Youngest Child, —
Occupation, Housework. Father a planter.
Degree Education, common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
Nativity, Canada (Parents also born there)
Physicians Committing, D. M. Archibald Jno. B Dentry.
Correspondents, Father Mr A. Gerard 563 Aurora Ave. St. Paul Minn.

No. of Year, 230.
Insane Relatives, on mothers side,
Cause Exciting, unknown,
Cause Predisposing, unknown.
Form, Chronic Melancholia
Accompanying Bodily Disorder, nervous exhaustion.
Suicidal or not, not.
Date of this Attack, about 4 yrs. ago.
Duration, 4 yrs.
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. Heyerdale *Date of* June 25/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear.
MEMORY, Past Events, good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert.
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
normal.
DELUSIONS, Systematized, Transitory, Special Subjects,
none - Depressed -
HALLUCINATIONS, none
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, living - well.
Paternal Relatives,
Mother, living.
Maternal Relatives,
Brothers and Sisters, 6 sisters dead.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None
HABITS, Drinking and Smoking, None
HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo + headache
OCCUPATION, Healthy or not, House work
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, good.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2 in PRESENT WEIGHT, 96½ USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin,
TONGUE, Coatings or Promptness of Movement, Coated - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal. Response 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, Exaggerated Other Reflexes, Chin - Elbow - wrist.
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, ?
Apex Beat, Regularity,
aortic stenosis
Regular.
ARTERIES,
Slightly sclerotic.



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,
Color and Appearance,

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical.
Expansion good.

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

GYNECOLOGICAL EXAMINATION, Menstruating

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

Give condensed statement of the 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).

Admitted in fair physical condition - Quiet + sleeps well - Takes nourishment regularly - Talks very rationally - Is Menstruating

Personal and Medical History of Rose Girard

1900

This patient was brought here by Dep. Sheriff Hanson attended by Louise Girard (sister) in fair physical condition with the following history:- No history of consanguinity, insanity on mothers side of family. No intemperance in patient nor parents. First symptoms of insanity manifested about four years ago; on subject of religion. Disease appears increasing in variable but with no rational intervals. Derangement now manifested by delusions. No filthy nor destructive habits. No peculiarities previously shown. No severe diseases nor injuries to head. No confinement nor restraint employed. No treatment pursued. On personal examination patient appears to suffer from nervous exhaustion, mind filled with delusions. On admission put upon Infirmary W. (G.W.N. Rpt.) Complexion dark. hair black eyes brown. Skin in normal condition. is pock-marked. Rather dirty. 13 upper + 14 lower teeth- some decayed. Behavior quiet. had delusions.

June 7 to July 7 Summary 14 da. Records by Dr. Heyerdahl. Patient quiet in behavior. Talked readily. During first week temperature normal. Appetite good. bowels regular. Sleeps well at night. Very quiet. does not talk voluntarily - Second week temp. pulse + resp. about normal. Medicine given three times per day. bowels regular. Sleep good. Up on ward. Very agreeable. Talks when spoken to but is at other times quiet.

July 21 Vaccinated. Aug 7. Trans. to A^3. Oct 11 No change. Wt. 97 3/4 #

Dec 1 - Feb 28 1901. Jan 5 Visited by friend. Given electrical treatments Feb 1st Wt. 94 # Works in Center dining room. Eats meat. Takes outdoor exercise. Bowels regular. Mar. to June No change in mental or physical condition May 24 Wt. 95#. June to Sept General health good, assists with work in center diningroom, quiet on the ward, gets along nicely when let alone but if annoyed becomes extremely irritable and scolds, eats and sleeps well. Aug 31 Wt. 95#. Sept. to Dec. Sept. 25 + 26 visited by father, menstruates regularly, no change in general condition Nov. 25 Wt. 97#.

Dec. to Feb 1903 No change Wt about 100#. June 28, 1902 to July 8th Went camping at Arroyo. Sept. 30th Visited by a friend

Personal and Medical History of

Personal and Medical History of Clara Ryan,

Whole No. 5601
Residence, Wabasha Co, Minn.
Date Admission, June 27, 1900
Admitted by Dr. O. C. Heyerdale hour, 7 P.M.
How Sent, M. Kennedy & apt. Wabasha.
Sex, female Age, 45 yrs.
Civil Condition, single
Children, —
Age Youngest Child, —
Occupation, none.
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
Nativity, Minnesota Parents born in Ireland.
Physicians Committing, P. M. Kelly & W. F. Milligan.
Correspondents, Mother - Mrs. Con Ryan Kellogg Minn.

No. of Year, 301
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, Unknown.
Form, Suicide
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, Not.
Date of this Attack, ?
Duration, ? —
No. of Attack,
No. of Admission, 2nd
Age First Attack, 18 yrs.
Time of Leaving,
Time in Hospital,
Result,

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

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.
dull - not correct.
REASONING POWER, Ordinary Subjects,
Special Subjects, poor.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
indifferent.
DELUSIONS, Systematized, Transitory, Special Subjects,
HALLUCINATIONS, of hearing
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
Mother brother & sister drank some. Cousin died consumption
Father, dead.
Paternal Relatives,
Mother, living.
Maternal Relatives,
Brothers and Sisters, 4 bros + 4 of sisters dead.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, headache + vertigo.
OCCUPATION, Healthy or not, housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, good.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in. PRESENT WEIGHT, 118 lb USUAL WEIGHT, NUTRITION, poor.
WOUNDS, Abnormalities and condition of Skin,
TONGUE, Coatings or Promptness of Movement, prompt. coated.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - eye large - responses fair.
SIGHT, not strong.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, fair
COORDINATION, Arms, good Legs, good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, none.
PATELLAR REFLEX, diminished Other Reflexes, none.
ARTICULATION, Slurred, Hesitating, Slow, hesitating.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal.
ARTERIES,
slightly 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,

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

GYNECOLOGICAL EXAMINATION, External genitals normal. Anteflexion of uterus with some prolapse - slight amorrhoea
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 poor physical condition takes her nourishment well: rests well at night. Talks in a quick, nervous, confused + incoherent manner.

Personal and Medical History of Clara Ryan.

1900

This patient was brought here by Sheriff G.H. Dickman attended by Mother Mrs. Honora Ryan, in poor physical condition with the following history: No history of consanguinity, kindity nor intemperance: First symptoms of insanity manifested in 1893. In 1896 (Aug 14) was brought to this hospital & remained until Sept. 1 1897. when she was discharged as improved: Present attack manifested by destruction of property & household goods: Disease appears increasing: is variable: Derangement now manifested by filthy & profane talk: is incoherent: Is disposed to injure others: Habits filthy & destructive: Before accession of disease manifested a disposition to quick temper: Had a fit when about 14 years old: has been subject to hysteria: Has been under no medical treatment since leaving hospital.

On personal examination talks incoherently all the time

On admission put upon Infirmary Ward (G.H.N. Kpt. Complexion dark: Hair brown: eyes blue: skin in normal condition: No marks, scars nor bruises to clean: Has 10 upper & 12 lower teeth: Is very nervous rather silly in talks & actions.)

June 14 to July 7 Summary 14 da. Record by Dr Heyerdale. On admission talked a great deal: & very incoherently: Slept well during night First week Temp. 98-100°. Pulse & resp. about normal: appetite good: Took cathartic once: bowels regular: Slept well: agreeable & pleasant on ward: Takes out door exercise. Second week Temp. normal: bowels regular: appetite good: Sleeps well: Talks to herself a good deal: Is very agreeable.

July 11 vaccinated.

Sept. Appetite good: Bowels require laxatives: Sleeps well. Assists with ward work: Takes out-door exercise, attends amusements &c.

Sometimes quite noisy & cross & becomes greatly excited & Speech incoherent. Trans. to C^v Sept 11. Dis'l condition unchanged during quarter Wt. nov. 18. 130½#. Dec'l - Jan 7 1901 Appetite very good: bowels constipated requiring laxatives: Sleeps well: Takes outdoor exercise: Assists in dining room: Jan 3 Very irritable: brought in from laundry where she had been assisting after that did no work.

Jan 7 1901. At times extremely noisy & cross: Talks incoherently. Mench. 4 Wt 132#.

Mar 1 - June 1 - 1901 Works in dining room. No change in mental or physical condition. May 31 Wt 129½ #. June to Sept. Aug. 26 visited by mother, patient at times irritable and quite disturbed and uses profane language at times, works in the dining room, reads and attends amusements Sept. 1 Wt. 135#. Sept. to Dec. Nov. 8 menstruated, no change during quarter Nov. 30 Wt. 138¾#.

Dec. to Feb 1903 Patient very much disturbed about Sept. 5 d. Attacked another patient to day. At times uses vulgar and profane language. Is incoherent and

Personal and Medical History of

rarely answers questions intelligently: Is rather childish: menstruates regularly: Appetite good: sleeps well: attends amusements and Chapel. Assists in the dining room. Dec 1st Wt 144 #.

Personal and Medical History of Pauline Brodhag.

Whole No. 5607
Residence, St. Paul, Minnesota.
Date Admission, June 23 '1900.
Admitted by Dr. E. J. Wanous hour, 7 PM
How Sent, Ex. Bazille Insp't. Ramsey Co.
Sex, female Age, 44 yrs.
Civil Condition, married.
Children, Four.
Age Youngest Child, 9 yrs.
Occupation, housework & husband's Brass polisher
Degree Education, Common school.
Profession, Religion, German Lutheran.
Habits, used liquor freely. also both parents used it
Nativity, Germany (Parents born there)
Physicians Committing, E. C. Eichelberger & J. Woolsey.
Correspondents, Eugene Brodhag 162 Como Ave St. Paul, Minn (husband)

No. of Year, 232.
Insane Relatives, None.
Cause Exciting, intemperance
Cause Predisposing, "
Form, Acute Melancholia
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, not.
Date of this Attack, 4 mos. ago.
Duration, 4 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 44 yrs.
Time of Leaving, Aug. 9. 1900
Time in Hospital, 1 mo. 17 d
Result, Disc. Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Hyndale *Date of* June 25/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick.
MEMORY, Past Events, good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert.
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal
DELUSIONS, Systematized, Transitory, Special Subjects,
HALLUCINATIONS, ?
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, does not know about.
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters, bro. died - accident.
4 children living 6 dead -
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking, Drank some beer.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Constipated.

Personal and Medical History of

Pioneer Press. Oct. 3 1900

WARRANT FOR HUSBAND.

Wife Accuses Him of Threatening to Kill Her.

Pauline Brodhag, 162 Como avenue, complained to the county attorney yesterday that her husband, Eugene H. Brodhag, who is employed at the Union Brass works, has frequently within the past year threatened her life. She claims that on Sunday evening he drew a revolver and chased her and the children into the street, compelling them to take refuge with neighbors. She says that the threats are made when her husband is under the influence of liquor. A warrant was issued for Mr. Brodhag.

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 120 USUAL WEIGHT, NUTRITION, good.
and condition of Skin,
omptness of Movement, prompt - coated - indented.
Response to Light, and Accommodation, Equal - normal - responses nor.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, good Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, slight of hands.
PATELLAR REFLEX, diminished Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
normal - regular.
ARTERIES,
normal.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical & well developed.
Expansion good.
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 - uterus normal size & shape. Has a severe leucorrhoea with considerable discharge.
MENSTRUATION, says began at age of 13.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, good.
BOWELS, Present Condition, Constipated

Give condensed statement of the 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 admitted in good physical condition quite rational - tells about seeing stars & hearing sounds like that of rattlesnake but says she has not heard it since coming here.

Personal and Medical History of Pauline Brodhag.

Whole No. 5607
Residence, St. Paul, Minnesota.
Date Admission, June 23 1900.
Admitted by Dr. E. J. Wanous hour, 7 P.M.
How Sent, Ed. Bazille Supt. Ramsey Co.
Sex, female Age, 44 yrs.
Civil Condition, married.
Children, Four.
Age Youngest Child, 9 yrs.
Occupation, Housewife Husband Brass polisher
Degree Education, Common school.
Profession, Religion, German Lutheran.
Habits, used liquor freely. also both parents used it.
Nativity, Germany (Parents born there)
Physicians Committing, E. C. Eshelby & C. J. Woolsey.
Correspondents, Eugene Brodhag 162 Como Ave St. Paul. Minn (Husband)

No. of Year, 232.
Insane Relatives, No
Cause Exciting, unknown
Cause Predisposing,
Form, Acute Mel.
Accompanying Bodily Disorder,
Suicidal or not, not.
Date of this Attack, 4 mos. ago.
Duration, 4 mos.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 44 yrs.
Time of Leaving, Aug. 9. 1900
Time in Hospital, 1 mo. 17 d
Result, Disc. Nov. 6. 1900 Recovered

...crafi salary.
REPAIRING of trunks and valises wanted by a man who understands the work thoroughly.
NURSES—We have efficient women who would like to get nursing to do.
WOMEN for washing, ironing, housecleaning, etc., can be obtained from this office; also men to do odd jobs, such as cleaning up yards, removing ashes, beating carpets, etc.

BUSINESS CHANCES.

WHEAT HAS HAD A BIG BREAK AND IS going much higher; buy now, while prices are low; $20 will margin 1,000 bu 2 cents; send for our free book, "Facts and Figures," explaining option trading. The Osborn Grain Co., 814 and 815 Phoenix building, Minneapolis, members chamber of commerce.

FOR SALE—NEWSPAPER IN GROWING town, prosperous Minnesota county; paying plant; fine outfit; late faces of type; reason for selling, ill health; stand investigation.

EXAMINATION ON ADMISSION BY DR. Hoyerdale *Date of* June 25/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick
MEMORY, Past Events, good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert.
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal
DELUSIONS, Systematized, Transitory, Special Subjects,
HALLUCINATIONS, ?
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, does not know about.
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters, bro. died - accident.
4 children living 6 dead -
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking, Drank some beer.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, good Appetite, good and Bowels, constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 PRESENT WEIGHT, 120 USUAL WEIGHT, NUTRITION, good
WOUNDS, Abnormalities and condition of Skin,
TONGUE, Coatings or Promptness of Movement, prompt - coated - indented.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal - responses nor.
SIGHT, good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, good Legs, do Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, slight of hands.
PATELLAR REFLEX, diminished Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
normal - regular.
ARTERIES,
normal.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical & well developed.
Expansion good.
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 - uterus normal size & shape. Has a severe leucorrhoea with considerable discharge.
MENSTRUATION, Says began at age of 13.
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, good.
BOWELS, Present Condition, Constipated

Give condensed statement of the 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 admitted in good Physical condition quite rational - Tells about seeing stars & hearing sounds like that of rattlesnake but says she has not heard it since coming here.

Personal and Medical History of Pauline Brodhag.

1900

This patient was brought here by Dep. sheriff Hanson attended by husband, with the following history:- No consanguinity & heredity noted: Patient & both parents used liquor freely. First symptoms of insanity manifested four months ago by delusions: Disease appears increasing, not variable: Derangement now manifested by Delusions: hears voices & rattlesnakes: is troubled with insomnia: No disposition shown to injure anyone: No filthy nor destructive habits: No peculiarities previously mentioned: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued: On personal examination was in a melancholic condition On admission put upon Infirmary (Ehrn Rpt. Complexion dark: Hair brown: eyes gray. Skin in normal condition: No marks nor scars Small burns on R. arm: said husband did it in a quarrel: Dirty & hair had not been combed for three mths. Has 7 upper & 8 lower teeth: Behavior quiet: Talks intelligently.)

June 23 to July 7. Summary 14 da. record by Dr Hyerdale. During first week Temp. &c. about normal: Appetite good: Cathartics given: Behavior quiet: Slept well at night. Not inclined to converse but answers questions: Takes outdoor exercise: Is agreeable: Second week Temp. &c. about normal: Takes cathartics occasionally: Very quiet on ward. Sleeps well at night: Agreeable during day: Does not talk much: Given douches

July 21 Menstruating: Is very helpful on ward: Talks intelligently: quiet in behavior & pleasant: Goes out for exercise: Aug. 8 Little Change: Bowels generally regular: appetite good: Takes outdoor exercise

Aug 9 Sent home.

Discharged.

Personal and Medical History of

Personal and Medical History of Mary Ebert.

Whole No. 5805.
Residence, Wabasha Co, Minn.
Date Admission, June 27 1900
Admitted by Dr. E. J. Wanous. hour, 7 PM.
How Sent, M. Kennedy J. of P. Wabasha Co.
Sex, female Age, 81 yrs.
Civil Condition, married.
Children, one.
Age Youngest Child, 58
Occupation, Housewife
Degree Education, Common school.
Profession, Religion, Catholic.
Habits, Not intemperate.
Nativity, Germany. (Parents born there.) Resident of State + Co. since 1858.
Physicians Committing, W. F. Milligan + J. F. Bond.
Correspondents, John Brindle (son) Wabasha, Minn. in town.

No. of Year, 735
Insane Relatives, None.
Cause Exciting, Domestic trouble.
Cause Predisposing, unknown.
Form, Senile Dementia
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Is not.
Date of this Attack, Several years ago.
Duration, Several years.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 70-80-
Time of Leaving, August 19 - 1901.
Time in Hospital, 1 year 1 mo 23 ds
Result, Unimproved — Discharged by B of C April 14 - 1902

EXAMINATION ON ADMISSION BY DR. Heyerdal *Date of* July 2 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick.
MEMORY, Past Events, good
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert - apparently correct.
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
normal
DELUSIONS, Systematized, Transitory, Special Subjects,
Of poisoning.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
Consumption.
Father, died - consumption.
Paternal Relatives,
Mother, died rheumatism.
Maternal Relatives,
Brothers and Sisters, Bro. died consumption
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, One Dau.
Head Injuries, and Surgical Operations),
none.
HABITS, Drinking and Smoking, none
HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo.
OCCUPATION, Healthy or not, housewife - midwife.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Poor Good Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3¼ in PRESENT WEIGHT, 115 lb USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, good.
TONGUE, Coatings or Promptness of Movement, Coated - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal. response to light good - to accom. fair
SIGHT, fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, fair.
COORDINATION, Arms, good. Legs, good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, of tongue.
PATELLAR REFLEX, absent Other Reflexes, Babinski not present on R.
ARTICULATION, Slurred, Hesitating, Slow, good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
aortic + mitral stenosis. not strong. regular
ARTERIES,
fair condition.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical 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, Slight laceration of perineum: rectocele: cystocele: mucous warts uterus atrophied, retroverted, adherent. external haemorrhoids.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, good.
BOWELS, Present Condition, free

Give condensed statement of the 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 only fair. Is very talkative + expresses a great many delusions - especially of poisoning - thinks people are trying to poison her

Personal and Medical History of Mary Ebert.

1900

This patient was brought here by sheriffs deputy Gil. Dickman attended by Mrs. Dickman in poor physical condition, with the following history:- No history of consanguinity, heredity nor intemperance in patient nor parents: First symptoms of insanity manifested several years ago Disease appears stationary, not variable. Derangement now manifested by delusion that husband is attempting to poison her: 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 talks incoherently. On admission put upon Inf. Ward (Y.H.N. Ept. Temperature normal: hair gray: eyes blue: scar about mouth: is dirty: tumor on right buttock: dark area on lower R. leg: one upper + one lower tooth several roots: Noisy on admission

January to July 11 Summary 14 da. record by Dr. Hospedale. During first week temp. + c. normal. Appetite good: given cathartics but once. Bowels quite regular: expresses many delusions: Slept well at night. Talked a great deal: has delusions in regard to poisoning: Remained in bed first week. Second week Temp. + c. about normal: Appetite fair: Medicine given three times a day: bowels regular: up + dressed after July 4th Slept well: Many delusions: Talks much but causes no trouble July 11 Trans. A'.

Sept 1. Appetite poor: Bowels constipated: Requires cathartics: Sleeps well most of time sometimes disturbed: has delusions regarding food: thinks that patients who wait in dining room poison it. Usually quiet tho sometimes quite disturbed. Very neat in personal appearance. Sept 24-27 Complained of pain in head + lungs: Kept in bed greater part of day: + cathartics + expectorants given. Nov. 16 Wt. 137½ lbs.

Dec 1- Feb 28 1901. Appetite fair: Sleeps well: Bowels constipated: Takes cathartics: on special diet: Attends chapel: Assists in dining room: neat + clean:

Dec 27 very much excited: Sleeping dose given. Feb 5. Put to bed. Complained of headache: Feb 7 up + dressed: Has delusions: Says patients put poison in food + at times becomes much excited + refuses to eat. Spends part of day reading prayerbook. Wt. 118 lbs.

Mar 1- June 1- 1901 Apr. 29 patient fell while working in dining room hitting her leg and hip. no fracture or dislocation seemed apparent: massage and liniment applied: takes cathartics. Complains of a great deal of pain in the injured part. Weight not taken.

June to Sept. Patient still in bed during June, is very delusional in regard to food, thinks it has been poisioned, spends most of her time reading her prayer book. July 7 complained of pain in right side of abdomen refused to get up, cathartics given, July 8 vomited green substance, trans. to infirmary, Aug 4. up on ward.

Personal and Medical History of

1901

Aug. 18 visited by son, Aug. 19 taken home by son, April 14 1902 discharged by Board of Control, unimproved.

Discharged.

Personal and Medical History of Mary Nord.

Whole No. 5606
Residence, Carlton Co, Minn.
Date Admission, June 28 1900.
Admitted by Dr. E. J. Waring. hour, 7 P.M.
How Sent, F. T. Wilson J of P. Wash. Co.
Sex, female Age, 21 yrs.
Civil Condition, married.
Children, One.
Age Youngest Child, 14 days.
Occupation, housewife.
Degree Education, Can read & write.
Profession, Religion, Lutheran.
Habits, not intemperate.
Nativity, Washington - (Parents born Sweden)
Physicians Committing, T. C. Clark. - B.F. Merrill.
Correspondents, Mr. Fred Nord - Willow River Minn.

No. of Year, 236.
Insane Relatives, none -
Cause Exciting, Puerperal -
Cause Predisposing, unknown.
Form, Puerperal Insanity (Maniacal) acute Mania
Accompanying Bodily Disorder,
Suicidal or not, not.
Date of this Attack, 8 days ago.
Duration, 8 days.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 21 yrs.
Time of Leaving, July 26. 1900
Time in Hospital, 28d
Result, Discharged Nov. 6. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* July 27 1900

MENTAL CHARACTERISTICS.

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

REASONING POWER, Ordinary Subjects, good.
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal

DELUSIONS, Systematized, Transitory, Special Subjects,

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

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden, Sudden
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Travel - well.
Paternal Relatives,
Mother, Rheumatism.
Maternal Relatives,
Brothers and Sisters, 5
Children - one
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Confinement
HABITS, Drinking and Smoking, Good.
HEADACHES, VERTIGO, OR CONVULSIONS, No.
OCCUPATION, Healthy or not, housewife
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, good

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ PRESENT WEIGHT, 135 lb USUAL WEIGHT, NUTRITION, good.
WOUNDS, Abnormalities and condition of Skin, Skin in normal condition.
TONGUE, Coatings or Promptness of Movement, no coating - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - large. normal
SIGHT, good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good.
COORDINATION, Arms, good - Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, fine of Landois.
PATELLAR REFLEX, present Other Reflexes, absent.
ARTICULATION, Slurred, Hesitating, Slow, good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
strong - regular - 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,

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

GYNECOLOGICAL EXAMINATION, Perineum lacerated - beginning cystocele + rectocele. leucorrhoea - vaginitis uterus baggy - retroflexed to R. cervix cystic - endometritis
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, good.
BOWELS, Present Condition, fair

Give condensed statement of the 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).
In Maniacal Condition - very noisy + disturbed, Sleepless at night, pulled large handfuls of hair out - talked a great deal.

Personal and Medical History of Mary Nord

1900

This patient was brought here by Sheriff's deputy H.S. Thomas attended by Mrs. M.A. Young in good physical condition with the following history:- No consanguinity, heredity nor intemperance in patient nor parents: Insanity developed six days after confinement, appears increasing (child 14 days old) Derangement manifested by puerperal mania: No filthy nor destructive habits: No previous peculiarities: No severe diseases nor injuries to head: No confinement nor restraint employed: No further facts obtained upon personal examination. On admission put upon Infirmary W. (G.P.M.Ref. Complexion fair hair brown, eyes grayish blue: Skin in normal condition: Both arms bruised: Tongue clean: Teeth in good condition: Rash on lower part of back: Is noisy & incoherent.

June 4th to July 1st Summary 1st day record by Dr. Reynolds. Very restless & noisy: several bruises on limbs: Did not sleep any during night. During first week Temp. 98°-100°, Pulse 64-104. Resp. 24-29. Fed mechanically on July 4. Hypnotics & cathartics required: Patient very much disturbed & violent toward nurses: June 30 Remains much disturbed & very restless put in restraint. Menstruating Slept well during night. July 1 Becoming more quiet: Slept most of day & well during night. July 2 Very much disturbed: Sleeping Dose given in evening: Slept well during night July 3 In bed: Very much disturbed: Given douche: Slept a good deal each day & night July 4 Slept a great deal worried when awake: Second week Temp. only slightly above normal at times: Pulse & Resp. about normal. Fed on July 5 by tube. Remainder of week took nourishment well: Hypnats & cathartics given: Bowels regular. Slept well: At times worried & cried. July 17. Fed mechanically. Talks sensibly July 21 Converses readily: agreeable: assists on ward.

July 26 1900 Taken home by brother. General health good. Has improved very rapidly

Discharged.

Letter received from husband. Oct 28 1900. States patient is very well.

Personal and Medical History of

Personal and Medical History of Emilie Wanke. or Petrick

Whole No. 5611
Residence, Wabasha Co, Minn.
Date Admission, June 30 1900
Admitted by Dr. L. C. Lapple hour, 10 30 Am.
How Sent, M Kennedy & appt. Wabasha Co.
Sex, female Age, 51
Civil Condition, divorced
Children, six
Age Youngest Child, Twinyears.
Occupation, none.
Degree Education, Common school.
Profession, Religion, Lutheran
Habits, Not intemperate.
Nativity, Wisconsin Parents born in Germany
Physicians Committing, W. T. Adams & N. S. Tefft.
Correspondents, Mrs. Amelia Petrick Elgin, Minn (mother) lives in town - telephone connections

No. of Year, 7441
Insane Relatives, None
Cause Exciting, unknown
Cause Predisposing, "
Form, Melancholia Chronic
Accompanying Bodily Disorder, none mentioned
Suicidal or not, Not.
Date of this Attack, 1897.
Duration, since 97.
No. of Attack, 1st Continuous
No. of Admission, 2nd. 1778 1858 5611
Age First Attack, 28 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Heyerdahl *Date of* July 3 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear on some subjects, confused on others
MEMORY, Past Events, Good.
Recent Events, Poor Special Subjects, poor.
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert. illusive.
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
normal.
DELUSIONS, Systematized, Transitory, Special Subjects,
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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).
None.
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
3 boys 3 girls.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Fell on ice when young.
HABITS, Drinking and Smoking, No.
HEADACHES, VERTIGO, OR CONVULSIONS, No.
OCCUPATION, Healthy or not, Housework - helped in field.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels,
good.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 PRESENT WEIGHT, 135 lb USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, Skin in normal condition.
TONGUE, Coatings or Promptness of Movement, Coated - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, equal - size normal - responses good.
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, fair
COORDINATION, Arms, good Legs, good. Grasp,
TREMORS, ~~Hands~~, ~~Tongue~~, ~~Facial~~ Muscles, General, slight
PATELLAR REFLEX, present. Other Reflexes, absent except jaw jerk.
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,

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

GYNECOLOGICAL EXAMINATION, Retroflexion - cystic degeneration of ov - laceration of cervix - leucorrhoea
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 admitted in fairly good physical condition - Very quiet + talks very little Has a marked aversion to admitting that her maiden name was Petrick.

Personal and Medical History of Emilie Wanke

1900

Jan 1 This patient was brought here by sheriff's deputy Frederick Petrick. attended by Mrs Amelia + Mrs. Emily Petrick in fair physical condition with the following history:- No history of consanguinity, heredity nor intemperance in patient nor parents. First symptoms appeared in 1887. when she was in this hospital from Jan 19 '87 to Oct 30 '87. never entirely recovered from this attack: disease appears stationary: not variable: Derangement now manifested by lack of interest in surroundings + by bursts of temper + violence: Is disposed to injure others: No filthy nor destructive habits: No peculiarities previously manifested: No severe diseases nor injuries to head: No confinement nor treatment employed since leaving hospital. On personal examination has general appearance + expression of insanity. On admission put upon Infirmary W. (Gen'l Rpt Complexion normal: hair dark Brown: eyes blue: No marks, scars nor bruises: Is clean: has 12 upper + 12 lower teeth: behavior quiet.)

June 30 to July 12 Summary 12 da. record by Dr Heyerdale. Admitted on ward + put to bed: quiet in behavior: During the first week Temp. pulse + resp. about normal: Appetite good: an occasional cathartic required: slept well first two nights then more restless. Tho quiet + agreeable during day: Second week. quiet + agreeable. slept well after second night: Taken out of doors daily for exercise. July 11 Vaccinated: Visited by nephew. Quite demented: neat: does a little work on ward: General health good: Takes outdoor exercise: Assists with work: Has peculiar ideas: Is retiring: Talks very little but answers when spoken to: Aug 9. Visited by friends

Aug 8. Seems to have improved mentally. Aug 21. Visited by brother. Menstruates regularly: General health good: Sept 13. visited by a friend: + also on Oct 25 + 28 wt. 135 1/2 #. Is somewhat depressed as a rule: General health good. Takes outdoor exercise: Does some work. Takes gynaecological treatment.

Dec Neat: quiet. Appetite good: Sleeps well: Takes outdoor exercise: Given gynaecological treatments: works in laundry daily Mar to June 1901 General health good, assists with work in laundry, patient is melancholy and very quiet on the ward May 30 Wt. 125 #. June to Sept. No change in mental or physical condition August 27th. Wt. 136 #.

Sept to Dec. Sept. 3 visited by mother, neat in habits and appearance, assists with work in the laundry, shows no change in mental or physical condition, Nov. 22 Wt. 142 #.

Dec to Feb 1903 Works regularly in the Laundry. No change in condition. Wt. about 149 #. June 14th '02 returned from a week's outing at Oronoco. Rather careless in appearance but habits cleanly. Does not readily converse or answer questions: rather irritable and stubborn. General Health good. Appetite fair. sleeps well: menstruates regularly.

Personal and Medical History of

works in Laundry. Attends Chapel and amusements

Personal and Medical History of Lena Anderson. #3

Whole No. 5618

Residence, Lake City, Minn.
Resident of State) No
Date Admission, June 30. 1900

Admitted by Dr. O. C. Heyerdale hour, 7 PM

How Sent, McKennedy & Apst. Wabasha Co.

Sex, female Age, 37.

Civil Condition, married

Children, none.

Age Youngest Child, —

Occupation, Housewife

Degree Education, Common school.

Profession, Religion, Lutheran.

Habits, Not intemperate.

Nativity, Sweden. (Parents also born there)

Physicians Committing, W. F. Wilson & E. A. Bagley.

Correspondents, Erick Anderson (husband) Box 851, Lake City, Minn. (works in wagon factory)

No. of Year, 7427

Insane Relatives, Father, insane one year.

Cause Exciting, Overheated

Cause Predisposing, Heredity

Form, Acute Mania with delusions

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, Not.

Date of this Attack, June 25' 1900

Duration, 1 week,

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 37 yrs.

Time of Leaving, Sept. 24 1900.

Time in Hospital, 2 mo. 25 da.

Result, Discha. Improved. Feb 6' 1901.

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* July 5 1900.

MENTAL CHARACTERISTICS.

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

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,
exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,
Religious

HALLUCINATIONS,

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, June 25' 1900.

ONSET, Gradual or Sudden,

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

Father, insane 1 yr. Recovered.

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
husband thinks she had sunstroke

HABITS, Drinking and Smoking, good

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches

OCCUPATION, Healthy or not, farm-work - housework,

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

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6 PRESENT WEIGHT, 111 lbs USUAL WEIGHT, NUTRITION, poor.

WOUNDS, Abnormalities and condition of Skin, healthy.

TONGUE, Coatings or Promptness of Movement, Slight coating - prompt.

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

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, 70 72

Apex Beat, Regularity, Regular but rapid
normal.

ARTERIES,
Normal

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, Genitals normal. retroflexion.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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). Admitted in fair physical condition very maniacal in behavior & talks a great deal of the time in an incoherent manner praying & calling upon Jesus &c. very restless at night & takes only a small amount of nourishment. Is up & out of bed a great deal and frequently removes clothing.

Personal and Medical History of Lena Anderson #3

1900.

This patient was brought here by Dep. Sheriff A.P. Foley attended by husband & nurse Peterson. in poor physical condition with the following history:-
No history of consanguinity: father insane one year: First symptoms of insanity manifested June 23 1900 by irrational conversation: Disease appears increasing: is variable but with no rational intervals: Derangement now manifested by delusions (religious) & hallucinations: Is at times maniacal: Not disposed to injure anyone: Patient always quiet but subject to headaches before accession of disease: No history of intemperance in patient — nor parents. No severe disease nor injuries to head sustained. Habits neither filthy nor destructive: Has required constant watching & forcible restraint at times. & sedative treatment pursued.
On personal examination has appearance of acute mania.
June 30 On admission put upon Infirmary list (5ft 7½in Compl. Complexion normal: Hair Brown: eyes Blue: Skin in normal condition: Several bruises on limbs & back: Is clean. Has 8 lower teeth upper set false: & scratches on right shoulder: Is quiet & somewhat resistive.)
June 30 to July 13 Summary 14 da. record by Dr. Heyerdale. On admission violent: did not sleep any: During first week Temp. 99-101. Resp. 22-28. Pulse 78-115. Fed mechanically. July 1-2-3-4. July 5 Took well. July 6 Fed mechanically in morning: Hypnotics & cathartics required. Patient very much disturbed: Fights nurses when they go into her room: Complains of distress in stomach Talks incoherently & continually: Expresses religious delusions: Thinks she is going to die: Sleep -variable.
Second week Temp. about normal Pulse 72-104 Resp. 22-24. Fed mechanically most of time altho occasionally drank milk voluntarily Hypnotics & cathartics required: Patient very noisy & talkative: Out of bed often: In restraint night of 10th Did not sleep any. July 11 Out on lawn: more quiet but did not sleep during night July 13 Up & dressed & on lawn: Warm bath given at night with hypnotic: quiet but did not sleep. July 28 Visited by Father Aug. 12 & 13. by father Aug 30 In restraint: Violent (Progressed)
Sept 8 Wt. 123. Visited by husband. Appetite very poor. Fed mechanically: Does not retain nourishment. Does not rest day or night. Bowels require laxatives. Is very restless & disturbed: very noisy: untidy: Kept in restraint most of time. Sept. 14 Taken home: no improvement.

Discharged.

Letter from husband Jan 14 1900 States wife is not well physically has consumption. Mentally not very well.

Personal and Medical History of

Personal and Medical History of Nettie E. Stilwell.

Whole No. 5618
Residence, Kasson, Dodge Co, Minn.
Date Admission, July 3 1900
Admitted by Dr O.C. Heyendale hour, 3 P.M.
How Sent, J. J. Hunt J. of P. Dodge Co.
Sex, female Age, 38.
Civil Condition, married
Children, Six
Age Youngest Child, 11 yrs.
Occupation, Housewife (Husband a day laborer)
Degree Education, Common school.
Profession, Religion, Methodist Episcopal
Habits, morphine habit.
Nativity, Newyork. (Parents also born there)
Physicians Committing, C.L. Chambers. + J. Bedient.
Correspondents, Jas. E. Stilwell. Kasson, Minn.

No. of Year, 248.
Insane Relatives, None.
Cause Exciting,
Cause Predisposing,
Form, Simple
Accompanying Bodily Di
Suicidal or not, Not.
Date of this Attack, 3
Duration, 5 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 35
Time of Leaving,
Time in Hospital,
Result, Improv



EXAMINATION ON ADMISSION BY DR. Heyendale. *Date of* July 7 1900

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.
Alert. apparently correct.
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
exalted Depressed
DELUSIONS, Systematized, Transitory, Special Subjects,
of persecution.
HALLUCINATIONS, sight + hearing.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, died delirium tremens
Paternal Relatives, Grandmother - died cancer - Cancer
Mother, died - congestion of lungs.
Maternal Relatives, Grandmother tuberculosis.
Brothers and Sisters, none 5 children healthy
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No.
HABITS, Drinking and Smoking, uses beer - snuff morphine
HEADACHES, VERTIGO, OR CONVULSIONS, vertigo - headaches.
OCCUPATION, Healthy or not, housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5in PRESENT WEIGHT, 115# USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, skin normal.
TONGUE, Coatings or Promptness of Movement, prompt - coated.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal - responses good.
SIGHT, poor
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, poor - - abscess in right ear.
COORDINATION, Arms, Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, ~~General~~,
PATELLAR REFLEX, absent. Other Reflexes, absent
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,
Chest symmetrical. Expansion good. 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,

GYNECOLOGICAL EXAMINATION, Anteflexion - adhesions on right: ovarian abscess on right purulent discharge from uterus: venereal warts: leucorrhoea: slight cystocele: rectocele:
MENSTRUATION, slight laceration of perineum, cervix cystic: right ovary inflamed - adherent
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 admitted in poor physical condition: manifests symptoms of hysteria + complains of numerous pains + aches. Is extremely talkative + constantly complaining of not receiving sufficient attention from nurses. Admits having used morphia + beer during last 1½ or 2 years. Is very restless + walks about ward a great deal.

Personal and Medical History of Nettie E. Stilwell.

1900

This patient was brought here by Sheriff Joel Tucker attended by Mrs. Woods, A.M. Maxson + husband; in fair physical conditions, with the following history:-
No history of consanguinity nor heredity. Patient addicted to morphine habit. First symptoms of insanity manifested 5yrs. ago by hysteria; disease appears increasing, is variable but with no rational intervals: Derangement manifested on all subjects. Is disposed to harm others: No filthy nor destructive habits: No peculiarities previously manifested: No severe diseases nor injuries to head. No confinement nor restraint employed. No treatment pursued. No further facts noted on personal
July 3 examination: On admission put upon Infirmary Mest. (Gen. Rpt com-
plexion dark: hair light brown: eyes blue. Skin in normal condition
Bruises on hips; says husband took a whip to her. Is clean:
Left eye a little smaller than right. Has 11 upper + 11 lower
teeth. Very much excited talks continuously in rambling manner.
July 3 to July 17 Summary 14 da. record by Dr. Feyerdale. Patient expressed delusions, hallucinations + illusions. Slept well after 11:30 P.M. During first week temp. pulse + resp. about normal: appetite fair: Sleeping doses occasionally necessary. bowels regular with aid of cathartics. Sleeps well at night. Very disagreable + loud in talk. Says she has been using morphine during last few years. June 8 somewhat noisy early part of evening. Transferred to C3. Second week Appetite good. medicine given regularly. Bowels regular with occasional cathartic Noisy + troublesome: somewhat more restless at night than she was July 10 Visited by husband. July 11 Cried a good deal + pretended to be sick. July 14 Complained of cramps + disturbed other patients on ward. Restless at night. Tidy in habits. Continues disagreable: Struck patient + nurses. Still complained of pain in head + ear. July 20 Disturbed most of time: Talkative: Complained of being weak. Had delusions: Says she spits blood: none seen. Appetite good. Laxatives given when necessary Complains a great deal + cries. Visited by husband + taken home today Dec 17 Returned. Jan 15-26 Given electrical treatments very loud in manner + behavior: Is a kleptomaniac. Very disagreable + complaining. Jan 26 Visited by husband + taken home.
April 9- patient received on ward + given bath: very talkative has hysterical spells of crying; takes outdoor exercise; appetite good; sleeps well; bowels regular; helps with ward work. Apr. 26. transferred to D3. Patient has many crying spells: works in dining room; takes expectorant. May 5. transferred to D1 patient very disagreable causes a great deal of disturbance

Personal and Medical History of

among the other ladies on the ward: very talkative; assists with work in dormitory: still continues expectorants. May 26- taken home.
Feb. 5-1902 Admitted on ward bathed and put to bed: has slight bruise on left hip: very dirty; converses intelligently: trans. to D.1 West.
Feb. 16 visited by son: Feb. 28. neat in habits and fairly so in appearance: very disagreeable: complains of numerous ailments and frequently quarrels with other patients: appetite good: takes out door exercise; Wt. 118#.
May 27 Seems much better mentally: assists with work on ward: takes out door exercise: good appetite: sleeps well: still complains of headaches and other physical ailments May 31 Wt. 120½#.
June 12. assists with work: appetite fair: attends chapel and amusements bowels regular: was taken home on trial by husband June 12. 1902.

Personal and Medical History of Josephine Johnston.

Whole No. 5619

Residence, St. Paul, Minn.

Date Admission, July 3 1900.

Admitted by Dr OC Hayerdale. hour, 7 P.M.

How Sent, Ex. Bazille J of P. Ramsey Co.

Sex, female Age, 28 yrs.

Civil Condition, married.

Children, Two.

Age Youngest Child, 14 mos.

Occupation, Housewife (Husband a machine wood worker)

Degree Education, Common school.

Profession, Religion, Mission church.

Habits, Not intemperate

Nativity, Minnesota (Parents born in Sweden)

Physicians Committing, Norman W. Foster. + O Marhl.

Correspondents, John Johnston (Husband) 187 Penna. Ave. St. Paul, Minn.

No. of Year, 249.

Insane Relatives, Maternal uncle at Hastings, Asylum.

Cause Exciting, Worry over desertion of husband.

Cause Predisposing, probably heredity.

Form, Melancholia agitans.

Accompanying Bodily Disorder, Emaciation.

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, 26 yrs

Time of Leaving, October 16 - 1901.

Time in Hospital, 1 Yr 3 mos 13 ds

Result, Unimproved: Discharged by Bd of Deed of Pulmonary Tuberculosis at St Paul July 26/1902

EXAMINATION ON ADMISSION BY DR. Hayerdale Date of July 5 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Clear - quick

MEMORY, Past Events, Good

Recent Events, " Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Alert + appears correct.

REASONING POWER, Ordinary Subjects, good.

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

normal.

DELUSIONS, Systematized, Transitory, Special Subjects,

of fear + persecution. Believes people intend to harm her.

HALLUCINATIONS, none

ILLUSIONS, "

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, died tuberculosis

Paternal Relatives,

Mother, died tuberculosis

Maternal Relatives, mothers bro - nervous (?)

Brothers and Sisters, one bro dead - 7 Children

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

brain fever when a child

HABITS, Drinking and Smoking, habits good.

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

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

Sleep, Appetite, and Bowels,

sleep + appetite capricious - bowels regular.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft PRESENT WEIGHT, 81 lbs. USUAL WEIGHT, NUTRITION, poor

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt - white coat.

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

SIGHT, normal

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

HEARING, normal

COORDINATION, Arms, good Legs, good. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, fine of tongue.

PATELLAR REFLEX, present. B - Other Reflexes, Babinsky - others absent.

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity, anaemic no organic murmurs - sounds normal - regular - rapid.

ARTERIES,

normal.

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, venereal warts - endometritis. anteflexion, vaginitis, occasional prolapse of rectum

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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). Admitted in poor physical condition. Husband states that she has spells in which she assumes a staring expression + which last from one to five minutes. They are probably hysterical manifestations. They began about a month before admission. Has had none since coming here

Personal and Medical History of Josephine Johnston.

1900

This patient was brought here by Dep. Sheriff Hanson attended by husband, in fair physical condition with the following history:- First symptoms of insanity manifested two years ago. husband left her & she worried about his absence. Disease appears increasing, is variable. Derangement now manifested by fear of being killed, attempts to get away to go to baby. Will not sleep. Not disposed to injure anyone. No filthy nor destructive habits. No peculiarities previously manifested. No recent diseases nor injuries to head. Was in St. Lukes hospital, St. Paul for two weeks. has been given bromides, rest &c. On personal examination is nervous, emaciated, continually begs to see child.

July 3 On admission put upon Infirmary (Gr. Nkpt. Complexion dark. hair brown. eyes gray. Skin in normal condition. No marks, scars nor bruises. Is dirty. has 13 upper & 14 lower teeth. Behavior quiet. Talks intelligently.)

July 3 to July 17 Summary 14 da. record by Dr. Snyder. During first week temp. pulse & resp. about normal. appetite fair. bowels very loose. Slept well at night. Was restless & nervous during day. July 6 Had prolapse of rectum. replaced & compress applied. No further trouble. July 8 Up on ward restless & looking out of window asked after to be allowed to go home. worried & cried a good deal slept well at night. Second week little change. Appetite fair. Emmas given to prevent straining at stool. bowels regular. Very nervous & restless asked to be sent home. July 30 Visited by sister

Sept 1. Appetite poor. eats from tray. Bowels regular. Does not menstruate. Usually sleeps well. Kept in bed. Untidy in habits & dress. Very stubborn in behavior & childish. Continually asking to be taken to St Paul. Often attempts to escape while out walking. Has prolapse of rectum

Oct 24 Trans. to B'. Nov 12 Wt 110.

Dec 3 Operated upon by Dr Mayo. 3 linear applications made by Paquelin Cautery. & 3 linear incisions made along prolapsed mucous membrane. Patient made an uneventful recovery. Highest temperature 100.4 Pulse 100. Resp. 19. Was given nothing first day or two but warm water. Slight emesis following operation. Bowels moved on 3d day. given castor oil each night. bowels moved daily after Dec 16th. Kept on milk diet. Dec 29. Up during day. Jan 8 Trans. to B'. Jan 19. Escaped through ward door & ran six miles to Chester. was returned by a man 2½ hrs. later

March 1- Wt. 103. Since operation seems very much quieter. Assists with ward work. & is more sensible & not so childish. Habits cleanly but still careless about appearance. Takes more interest in things about her.

Mar. June 1-1901 No change in mental or physical condition: assists with ward work. May 29 Wt. 96½ #.

June to Sept. Patient has become quite helpful on the ward, is more quiet and talks more sensibly

Personal and Medical History of

1901

occasionally tries to escape while out walking. Sept. 2 Wt. 83 3/4 #.

Sept. to Dec. Patient is neat in habits and appearance, converses readily and sensibly at times at other times is mixed, still worries about home. attends amusements, takes out door exercise, still working, Oct. 16 patient sent home. During the winter patient died of tuberculosis in St. Paul.

Died

Personal and Medical History of Mrs. Anna Peterson #2

Whole No. 56 w/w

Residence, St. Paul, Minn.

Date Admission, July 10 1900.

Admitted by Dr. A. Linton hour, 7 P.M.

How Sent, E.W. Bazille J. of P. Ramsey Co.

Sex, female Age, 35 yrs.

Civil Condition, married

Children, five.

Age Youngest Child, 10 mos. recently died.

Occupation, Housewife (husband a janitor.)

Degree Education, Public school.

Profession, Religion, Not a church member.

Habits, Not intemperate.

Nativity, Sweden (Parents also born there)

Physicians Committing, Dan'l. Paul. & A.W. Whitney.

Correspondents,

No. of Year, 4 5 y.

Insane Relatives, unknown.

Cause Exciting, Perhaps death of child.

Cause Predisposing, Previous attack.

Form, Recurrent Mania

Accompanying Bodily Disorder, none mentioned

Suicidal or not, Attempted to jump out of window.

Date of this Attack, July 9 1900

Duration, 7 days.

No. of Attack, 2nd

No. of Admission, 2nd

Age First Attack, 34 yrs.

Time of Leaving, July 28, 1900

Time in Hospital, 18 d.

Result, Died - Chronic Nephritis

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 Dulness, 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 PRESENT WEIGHT, 115 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,

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 Mrs. Anna Peterson #3

1900

This patient was brought here by Dep. Sheriff Hayson attended by Peter Peterson in fair physical condition with the following history: No consanguinity nor heredity known. No intemperance in patient nor in parents: First symptoms of insanity manifested eleven years ago. attack lasted six weeks - second attack two years ago + patient was in the Rochester State Hospital from Apr. 13 '98 to Nov 14 '98 (Vol. 38 Fol. 221 No. 5019) First symptoms of present attack manifested July 8 1900 by delusions + incoherent talk. Disease appears increasing: Not variable: Derangement manifested by religious dementia: 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: No treatment pursued. On personal examination prays + is excitable: Talks incoherently: On admission put upon Infirmary West (G.H.N. Rpt. Complexion dark: hair light: eyes gray: Skin hot + dry: Small scratch + bruise on left knee: Is dirty: Has four upper + six lower teeth with several roots: Behavior quiet: Has delusions.

July 10 to July 24 Summary to date as recorded by Dr. Heyerdale On admission very resistive; did not sleep at night: First week temp. ranged from 98-104. Pulse from 92-124. Resp. from 18-24. Fed by tube first four days: July 15 took milk: Given hypnotics + hypodermics of strych. Bowels moved freely with aid of cathartics: Patient very resistive + noisy, out of bed + very active. Received scratches on limbs by climbing on heater + sliding off: fought nurses. In spite of hypnotics did not sleep any the first week. July 15 Cold pack applied to head: sponge baths given.

Second week: Temp. 101 2 - 104 6. Pulse 95 - 145 Resp. 23-28. Took fair amount liquid nourishment: given hypodermics of strych. also cathartics: Sponge baths given to reduce temp. Very restless: delirious at times + violent July 18 In restraint. Taken out at 10:30 Am. on 19th Quiet in bed. Left side of face swollen. Restless + delirious + quite violent. In restraint during night: July 21 Out of restraint during day: Face badly swollen + seemed very painful. Rested more quietly in bed. July 22nd Slept about 4 hours during night (in restraint) 23 Slept about 6 hrs. July 24 Temp 100 - 100 7 - Pulse 80 - 90. Resp. 26. 1/40 gr. Strych. given every 3 hours. Took milk + egg nog. Well. Hot compresses applied to face during night. July 25 Very restless all day. Out of restraint until night. Slept quite well. July 26 Swelling on side of face, which is an infected parotid gland, lanced + a large amount of pus removed. drainage applied. Large carbuncle on shoulder also lanced. Strychnia given every four hours. Temp. 102 4 - 104 6.

July 27 Temp. 103 1 - 105 4 Pulse 130 - 166. Resp. 29-46. Took some nourish-

Personal and Medical History of

1900

ment + tonic also water + whiskey: finally unable to take nourishment + nutritive enema given - not retained. Strych. given every four hrs. Bowels moved slightly: Sponge baths given to reduce temp. Patient very restless: seems in pain: extremities cold: pulse rapid + weak: seemed to be failing. Died at 12:15 P.M.

Died.

Personal and Medical History of Sarah D. Raymond.

Whole No. 5676
Residence, Blue Earth. Minn.
Date Admission, July 17' 1900
Admitted by Dr. O.C. Huyerdale hour, 11 A.M.
How Sent, H.L. Bullis J. of P. Faribault Co.
Sex, female Age, 86 yrs.
Civil Condition, widow
Children, one
Age Youngest Child, 50 yrs.
Occupation, Housewife.
Degree Education, Common school.
Profession, Religion, Methodist Episcopal.
Habits, Temperate.
Nativity, New York. (Parents born in N.Y.)
Physicians Committing, J.A. Broberg + J.E. Cooper,
Correspondents, Chas. S. Raymond. Blue Earth, Faribault Co. Minn.

No. of Year, 756.
Insane Relatives, None.
Cause Exciting, senility
Cause Predisposing, Previous attack.
Form, Senile Dementia
Accompanying Bodily Disorder, None mentioned
Suicidal or not, not.
Date of this Attack, 3 mos ago.
Duration, 3 mos.
No. of Attack, 2nd
No. of Admission, 1st
Age First Attack, 82 yrs.
Time of Leaving, February 28th 1902 -
Time in Hospital, 1 year 7 mos 16 ds
Result, Died. Cpht in Senile Dementia

EXAMINATION ON ADMISSION BY DR. Huyerdale *Date of* July 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, Quite good.
Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, Good for a woman of her age.
Special Subjects,
Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, About 4 yrs.
ONSET, Gradual or Sudden, Gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Family history excellent.
Father, Died at 102
Paternal Relatives, grandmother over 100,
Mother, died at 99 yrs.
Maternal Relatives,
Brothers and Sisters, 2 bros. 2 sisters living. 1 son. - Well. 3 children died young.
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,

Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3 in. PRESENT WEIGHT, 90# USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, prompt - slightly coated.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal - responses to light fair to accom - do.
SIGHT, fairly good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, good. Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands & coarse of tongue
PATELLAR REFLEX, Left slight - right absent. Other Reflexes, Jaw jerk slight, wrist present. Elbow present.
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, Size, good Normal
Apex Beat, Regularity, Regular

ARTERIES,
Slightly sclerotic.

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Symmetrical (?)
Expansion fair
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 haemorrhoids. uterus atrophied - retroflexed. adherent.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 admitted in fair physical condition. Talks fairly well for a woman of her age. Talks considerably about her money which may or may not be a delusion. Has been married twice.

Personal and Medical History of Sarah D. Raymond.

1900

This patient was brought here by Sheriff Sandy McDonald attended by son - Chas. D. Raymond - in fair physical condition, with the following history: No consanguinity, heredity nor intemperance known in family: First symptoms of insanity manifested four years ago, attack lasted 2-3 mos. First symptoms of present attack noted about 3 weeks ago by hallucinations: Disease appears increasing; variable with irregular rational intervals. Derangement now manifested by seeing devils & angels - becomes unmanageable. Not disposed to injure anyone. No filthy nor destructive habits noted: Before accession of disease had an excitable temper: No severe diseases nor injuries to head: has been watched for three weeks: No treatment pursued: On personal examination talks incoherently & drives away devils. On admission put upon Infirmary W.[ard] G.H.N.Rpt. Complexion dark: hair gray: eyes blue: skin hot & dry: Large scar on R. shoulder: Small bruise on R. arm: Is clean: Has no teeth: Behavior quiet: Has hallucinations.

July 25 to July 28 Summary 14 da. Record by Dr Heyerdale. Had hallucinations: Talked a great deal: is incoherent. Slept well during night. Temp. Pulse & Resp. about normal. Up on ward on second day: Very tidy in habits & appearance & quite agreeable. Second week Temp. pulse & resp. about normal: appetite good: bowels regular: has some hallucination about bugs: but is quiet pleasant & agreeable. Takes out door exercise: Transferred to A[3] on July 29, July 31. Fell down flight of stairs & bruised arm & shoulder.

Aug 30 Very much disturbed & talks about going home: General health good: When disturbed sleeps poorly at night. Oct. 6 Quite disturbed Requires hypnotics. Oct 9. Fell bruising right wrist: ~~Cast applied~~ Examined by Drs. Linton & Heyerdale. Oct 28 Fell down stairs leading to dining room & fractured right wrist, also bruised skin - Trans. to Infirmary

Oct 9. Confined to bed: Very comfortable: Complained of eyes hurting her: has conjunctivitis. Is inclined to keep picking at cast on arm:

Nov 30 Up on ward: General health good: Dec 1 - Feb 28 1901 Patient old & feeble: has cataracts of left eye & partial of right. General health good: appetite good: neat: Plaster cast removed from arm but arm bandaged: Seems able to use it quite well. Feb 10. In bed with severe cold. Feb 20 Lips. Wt. 126#

Mar. to June 1901 Patient is very old and feeble, sight is very defective owing to a cataract, is very agreeable and pleasant on the ward, May 30 Wt. 113 1/4#.

June to Sept. During summer patient up and about the ward, seems fairly well about as usual, walking about aimlessly and expresses many delusions, is losing some physically, seems more feeble, Sept. 2. Wt. 114#.

Personal and Medical History of

Sept. to Dec. 1901 Oct. 7 tripped on the carpet and fell spraining left hip, sent to Inf- and thereafter remained in bed. Nov. 30 Wt. 85 1/4#. Dec. to Mar 1902

Patient received massage and such treatment as could be given, failed gradually during the winter Feb. 28 died at. 6:55 A.M.

Diagnosis was Exhaustion in Senile Dementia.

-- Dead --

Personal and Medical History of Mary Crow

Whole No. 5630

Residence, Hartland, Minn.

Date Admission, July 16 1900.

Admitted by Dr. C. L. Chapple hour, 7 P.M.

How Sent, H. Blackmer & A. P. Freeborn Co.

Sex, female Age, 29 yrs.

Civil Condition, married.

Children, 3.

Age Youngest Child, one year.

Occupation, housekeeper. (husband a farmer)

Degree Education, Common school.

Profession, Religion, Lutheran.

Habits, Not intemperate.

Nativity, Freeborn Co. Minn. (Norway birth place of parents)

Physicians Committing, G. W. Barck & E. Von Berg.

Correspondents, Carl Hendrickson, (father) Hartland, Freeborn Co. Minn. (3½ mi. out)

No. of Year, 240

Insane Relatives, Mother here for 6 mos.

Cause Exciting, Disappointment in marriage.

Cause Predisposing, Unknown.

Form, Acute Melancholia

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, not.

Date of this Attack, Mch. 1900.

Duration, 4 mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 29 yrs.

Time of Leaving, Nov 22 1900

Time in Hospital, 4 mo. 6 da.

Result, Discha Recovered April 30 1901.

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* July 20. 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Clear - quick

MEMORY, Past Events, good

Recent Events, " Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Alert - correct.

REASONING POWER, Ordinary Subjects, good.

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

normal.

DELUSIONS, Systematized, Transitory, Special Subjects,

Thinks mama cares for him.

HALLUCINATIONS, none.

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Consumptive / living.

Paternal Relatives, 2 aunts died consumption.

Mother, Died Rheumatism - has one uncle insane.

Maternal Relatives,

3 Brothers and 5 Sisters, well - 3 Children Mill - (1-3-5 yrs.)

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

Scarlet fever when a child

HABITS, Drinking and Smoking, good.

HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo.

OCCUPATION, Healthy or not, housework.

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

Sleep, Appetite, and Bowels, [illegible]

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in. PRESENT WEIGHT, 118# USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, Skin in normal condition.

TONGUE, Coatings or Promptness of Movement, slight coat - prompt.

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

SIGHT, fair

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, slight - Other Reflexes, absent.

ARTICULATION, Slurred, Hesitating, Slow, good.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

normal.

ARTERIES,

normal.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical. Expansion good - 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, Anteflexion of uterus. cervix hypertrophied, boggy, eroded. endometritis - leucorrhoea. general anemia - slight laceration of perineum slight cystocele - rectocele.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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).

In poor physical condition - Sleepless at first - Appetite poor. Urination difficult - at times requires catheterization. Is very quiet in behavior & manner.

Personal and Medical History of Mary Crow.

1900

This patient was brought here by Dep. Sheriff E. J. Ellickson, attended by Carl Hendrickson (father) In fair physical condition, with the following history:- No consanguinity: Mother was at this hospital for six months ( ). No history of intemperance in patient nor parents: First symptoms of attack (just) manifested in March 1900. became restless & melancholic: Disease appears increasing: is variable: Derangement now manifested on no particular subject- is afraid of others & thinks nothing is going right Not disposed to injure anyone: No filthy nor destructive habits noted: No peculiarities previously manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued. On personal examination is restless & fearful & excitable. On admission put upon Infirmary Gen'l Hpt. Complexion fair: hair light: eyes gray: skin in normal condition: Large scar on R. side of neck: Is clean: Has 11 lower & 9 upper teeth: Behavior quiet: has hallucinations of hearing.

July 16 to July 30 Summary 14 da. record by Dr. Reynolds. On admission quiet in behavior but sleepless at night. During first week temp. pulse & resp. normal: Sleeps poorly at night. Hypnotics given regularly: Appetite fair: has hallucinations & delusions: Imagines she hears people talking about her: bowels constipated: cathartics given: given tonics: milk & cod-liver oil. During second week: Appetite poor: cathartics necessary: Sleeps better July 27 Vaccinated. Aug 30. Quiet & neat: Does not talk much & is indifferent to surroundings: expresses no delusions: Is melancholy: at times she brightens up a little & assists nurses. Asks to be allowed to go home. Sept 29 Continues much improved: General health good: Seems to be in deep study a great deal of time. Says she is homesick & cries. Appetite good: bowels regular.

Nov 1 1900 Visited by husband. Nov 18 by sister. Nov 21 Has been somewhat brighter of late & takes more interest in things: Takes outdoor exercise. Nov. 22 Sent home.

Discharged.

Letter received from sister May 1 1901. Said patient appeared entirely well, & was taking care of children but was thin, pale & did not sleep well.

Personal and Medical History of

Personal and Medical History of Florence Van der Voeren.

Whole No. 5631

Residence, St. Paul, Minn.

Date Admission, July 21' 1900

Admitted by Dr. O. C. Heyerdale hour, 7 PM.

How Sent, Henry Gallick Ct. Com, Ramsey Co.

Sex, female Age, 31 yrs.

Civil Condition, married

Children, none

Age Youngest Child, —

Occupation, housewife (husband a clerk)

Degree Education, fair

Profession, Religion, Roman catholic.

Habits, Intemperate.

Nativity, Kentucky

Became resident of State in 1877 - of County in 1892.

Physicians Committing, E. F. Abbott + E. A. Borchardt.

Correspondents, husband Adrian Van der Voeren.

No. of Year, 241

Insane Relatives, None known

Cause Exciting, Organeracy.

Cause Predisposing, unknown,

Form, "mania a potu"

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, not.

Date of this Attack, July 18' 1900

Duration, 3 days.

No. of Attack, has had several,

No. of Admission, 1st. (In Home of Good Shepherd 4 yrs.)

Age First Attack, about 30 yrs.

Time of Leaving, Oct. 9. 1900

Time in Hospital, 3 mo. 18 d.

Result, Disc. Oct. 9. 1900 Recovered

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* July 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Clear - quick

MEMORY, Past Events, Good

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Alert correct

REASONING POWER, Ordinary Subjects, good

Special Subjects,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

normal

DELUSIONS, Systematized, Transitory, Special Subjects,

none

HALLUCINATIONS,

ILLUSIONS,

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

HISTORICAL.

LENGTH INVASION, gradual

ONSET, Gradual or Sudden,

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

Father, none dead - Cause unknown.

Paternal Relatives,

Mother, dead

Maternal Relatives,

Brothers and Sisters, none

Children none

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

Scarlet fever when young. Erysipelas - several times - diphtheria when a child.

HABITS, Drinking and Smoking, bad - drinks beer

HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo - hysteria

OCCUPATION, Healthy or not, housework.

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

March 8' 99. Nov. 8' 99. July 1900 - last attack.

Sleep, Appetite, and Bowels, Irr.

Personal and Medical History of Florence Van der Voeren.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5in PRESENT WEIGHT, 113½ USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt.

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

SIGHT, poor

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, present. Other Reflexes, elbow wrist + jaw present but slight

ARTICULATION, Slurred, Hesitating, Slow, good -

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

no murmurs - sounds strong 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,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Genitals normal - Slight Hæmorrhoids. Cervix inflamed + hypertrophied. Leucorrhoea.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 physical condition. Expresses no delusions. Husband says has occasional "spells" which come on after excessive drinking. When she breaks furniture + is quite crazy violent + destructive. She was four years in Home of Good Shepherd St. Paul. She + husband quarrel terribly owing to her bad habits.

Personal and Medical History of Florence Van der Hoeven.

1900

This patient was brought here by Dep. Sheriff Hanson attended by husband Adrian Van der Hoeven, in good physical condition with the following history: No consanguinity, heredity known: Habits not good: Patient has had several attacks of insanity during past year, of short duration: First symptoms of present attack manifested July 18, became violent & destructive & broke furniture: Disease appears increasing: Is variable: Derangement now manifested by violence, jealousy, drink: No disposition shown to injure anyone but during paroxysms destroys everything: before accession of disease was erratic & hysterical: No severe diseases nor injuries to head sustained: Has been confined for four years in House of Good Shepherd. Has been given sedatives as needed. No further facts noted on personal examination.
On admission put upon Infirmary West. (G.H.N.Rpt. Complexion dark: hair light brown: eyes gray. Small bruise on elbow: Is clean: Has 15 upper & 13 lower teeth: Is quiet & talks intelligently.

July 21 to Aug 4th 1900

Summary 14 da. Record by Dr. Haydale. Admitted in fairly good physical condition. During first week Temp. pulse & resp. about normal. Appetite fair. Sleeps well at night Bowels regular. Very quiet on ward & agreable. Given tonic July 24 Menstruated. Second week. Temp. pulse & resp. normal. Appetite good. bowels regular. Talks intelligently. Sleeps well at night. Does not express any delusions.

Aug 4th Visited by husband & taken to city. Sept 15-16. Visited by husband. Oct 9 Very well. Sleeps well. Much improved physically. Sent home.

Discharged

Personal and Medical History of

Personal and Medical History of Henrietta Beyerstadt.

Whole No. 5633
Residence, Winona Co. Minn.
Date Admission, July 24 1900
Admitted by Dr. O. C. Heyerdale hour,
How Sent, H.L. Buck J of P. Winona Co.
Sex, female Age, 84.
Civil Condition, widowed.
Children, five
Age Youngest Child, 39 yrs.
Occupation, housewife (husband dead)
Degree Education, Reads & writes german.
Profession, Religion, Lutheran.
Habits, Not intemperate.
Nativity, Germany (Parents also born there)
Physicians Committing, E.S. Muir & L.A. Kelly.
Correspondents, Arthur Beyerstadt. (son) 204 E. Wabasha St. Winona, Minn

No. of Year, 743.
Insane Relatives, None.
Cause Exciting, Senility.
Cause Predisposing, unknown.
Form, Senile Dementia.
Accompanying Bodily Disorder, Anaemic, emaciated.
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, 82 yrs.
Time of Leaving, May 25-1901
Time in Hospital, 10 mos. 1 day.
Result, Death Fracture of femur.

EXAMINATION ON ADMISSION BY DR. Heyerdahl *Date of* Aug 1 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, poor.
Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

REASONING POWER, Ordinary Subjects, poor.
Special Subjects,
Own Mental State, demented.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

DELUSIONS, Systematized, Transitory, Special Subjects,
In regard to money.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, drinks beer.

HEADACHES, 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, PRESENT WEIGHT, USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, Skin healthy.
TONGUE, Coatings or Promptness of Movement, prompt. white coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. normal. responses slight.
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, good Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, no.
PATELLAR REFLEX, slight Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Mitral regurgitant Weak
Apex Beat, Regularity, Regular.
ARTERIES,
Sclerotic.
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,

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

GYNECOLOGICAL EXAMINATION, Perineum lacerated, rectocele, cystocele, prolapse, retroflexion, adhesions, Cervix hypertrophied, eroded; endometritis, leucorrhoea, haemorrhoids.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, fair.
BOWELS, Present Condition, somewhat constipated.

Give condensed statement of the 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 poor. Demented & very irritable, peevish & constantly asks for something; her money - water - beer - something to eat &c &c. Sleeps only fairly well at night. Is up at times calling & pounding on door. Talks a great deal about her money.

Personal and Medical History of Henrietta Bugenstadt.

1900

This patient was brought here by Sheriff A.W. Fuhrmann in fair physical health, with the following history:- No history of consanguinity, heredity now intemperance: First symptoms of insanity manifested two years ago by despondency over marriage of daughter: Disease appears increasing: Is variable: Derangement now manifested by fancying that people are going to kill her for her imaginary fortune. Tries to run away half clothed. Not disposed to injure anyone: Dislikes being washed + putting on clean clothing: No filthy nor destructive habits: No previous peculiarities manifested. No severe diseases nor injuries to head: Has been confined at home: No treatment pursued. On personal examination did not know her whereabouts: Has imitation money which she thinks genuine: Is anaemic emaciated + tremulous.

On admission put upon Infirmary L.G.H.D.Hpt. Complexion fair: hair gray: eyes blue: Skin in normal condition. Small ulcer on toe: dorsal bruises on legs + arms: Is clean: Spine curves to right. Is maniacal + has delusions

Summary 1st da. noted by Dr Heyerdale. During first week temp. + pulse somewhat accelerated at times resp. normal in morning, usually higher in afternoon: Appetite fair: Takes a glass of beer morning + night: Cathartics occasionally needed. Has an infected toe (second toe right foot) caused by corn. Patient is a case of senile dementia, restless day + night + sleeps more or less at times although she does not remember over a period of half an hour at a time: out of bed + pounding on door a good during night. July 25 Toe quite swollen as well as foot. Incision made in toe also one in left side of foot + hot bi-chloride compresses applied. July + Aug. 7

Has complete prolapse of uterus which was replaced on July 29th. During 2nd week pulse + respiration somewhat accelerated at times Temperature about normal. Still gives beer: Appetite good: Requires cathartics: Sleeping doses occasionally given. Toe somewhat inflamed with slight discharge Aug 6 Uterus prolapsed, repeaced + tamponed. Aug 8 Visited by daughter + friend. Aug 14 Toe continues inflammed: incision made. Aug 17 Toe removed by Dr Heyerdale: Visited by daughter Aug 24 Visited by daughter Sept 5 + 6 + Oct. 17 + 30 + Nov. 4 Visited by friends Nov. 25 untidy: very resistive, begs + cries constantly for something to eat. Requires occasional hypnotics Dec 1 - Feb 28 1901 Kept in bed most of time: Habits dirty: Bowels constipated: Appetite fair. Does not sleep well. Is disagreeable + resistive + at times violent. Is given cathartics + hypnotics. Dec 8 + 9. Fought nurses pulled hair. Has been put upon course of trional treatment 20 gr. t.i.d. + sulfonal 10 grains t.i.d. Quieter + more contented. Does not scold so much. Complains of being hungry always. Given several lunches during day.

Feb 27, 1901. Face badly bruised during night. Said room mate did it - room mate

Personal and Medical History of

said she fell out of bed - Case investigated by Dr Linton Feb 28 Visited by 2 sons. March 3 1901. Cut. 8½ in.

Apr. 2. Tumor noticed on left cheek below eye; this was lanced and a large quantity of pues removed. Wound was dressed and patient put in restraint to keep her from removing the bandage. Apr. 30. + May 1. visited by daughter. Was very excited during and after the visit Patient continues noisy and at times very disagreeable; incoherent in speech; inclined to doze during the day and wakeful and noisy at night. May 16 patient attempted to take rocking chair from another patient, her dress was pulled and she slipped and fell with her left leg turned back and beneath her. Examination revealed extra capsular fracture of the left femur + Was transferred to Infirmary and leg put up in an extension, anchored by sand bags. Patient during confinement was very untidy and noisy requiring hypodermics of morphine. Appetite good; stimulants and enemas given Patient did not sleep very well, became weaker and stuporous, finally died at 1:35 P.M. May 25-1901

Died

Personal and Medical History of Mrs. Elsie Gasahl.

Whole No. 5638
Residence, St. Paul, Minn.
Date Admission, August 1st 1900.
Admitted by Dr. L.A. Linton hour, 6:45 P.M.
How Sent, E.W. Bazille & ag't. Ramsey Co.
Sex, female Age, 41 yrs.
Civil Condition, widow
Children, Three.
Age Youngest Child, 14 yrs.
Occupation, Dressmaker & housewife.
Degree Education, Rudimentary.
Profession, Religion, Presbyterian.
Habits, not intemperate.
Nativity, Switzerland (Parents also born there.)
Physicians Committing, A.B. Ancker & Waldon Lucas,
Correspondents,

No. of Year, 1
Insane Relatives, none
Cause Exciting, hard work & trouble.
Cause Predisposing, unknown.
Form, Acute Melancholia - Delusions
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, not.
Date of this Attack, six weeks ago
Duration, six weeks.
No. of Attack, ?
No. of Admission, 1 here (St. Paul City & Co. Hospital.)
Age First Attack, ? At asylum Napa California for 8 mos 7 yrs ago.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Hayden *Date of* Aug. 9 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick.
MEMORY, Past Events, Good.
Recent Events, " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert - correct.
REASONING POWER, Ordinary Subjects, good.
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal
DELUSIONS, Systematized, Transitory, Special Subjects,
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, died at 63 of Pneumonia
Paternal Relatives,
Mother, Tuberculosis
Maternal Relatives,
Brothers and Sisters, 5 children - 3 living
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking, Drank beer.
HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo
OCCUPATION, Healthy or not, housekeeper.
Detail Date, Duration, and Character of Previous Attack, if any,
7 yrs ago - Confined in hospital for insane 7 mos. at Napa California
Sleep, Appetite, and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7in PRESENT WEIGHT, 98# USUAL WEIGHT, NUTRITION, ?
WOUNDS, Abnormalities and condition of Skin, Skin normal.
TONGUE, Coatings or Promptness of Movement, Coated. 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, good Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, Slight of tongue
PATELLAR REFLEX, Exaggerated Other Reflexes, elbow & wrist present
ARTICULATION, Slurred, Hesitating, Slow, good.
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, Perineum lacerated, cystocele, rectocele, anteflexion, erosion, leucorrhoea.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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).

Admitted in fairly good physical condition. seems very tired - does not appear to be sick - wants to lie in bed or sit about quietly.

Personal and Medical History of Mrs. Elsie Gasahl.

1900

This patient was brought here by sheriffs deputy Hanson attended by Mrs. J. M. Orms, in fair physical condition, with the following history: No history of consanguinity, heredity nor intemperance in patient nor parents: First symptoms of this attack of insanity manifested six weeks ago by depression & madness: disease appears stationary, not variable: Derangement now manifested by thinking she is a physical wreck: Is passive & apathetic & generally depressed & melancholic. Not disposed to injure anyone: No filthy nor destructive habits: Before accession of disease was irritable & high-tempered: No severe diseases nor injuries to head: Has been in bed at C & C. hospital since July 10, 1900 & has been given tonics & hydrotherapy - results negative. On personal examination is passive & indifferent to proceedings & surroundings.
On admission put upon Infirmary (C.H.R. Rpt. Complexion dark: hair black: eyes brown: Skin in normal condition: A few small scars on legs & arms: Is dirty: Has a partial upper plate & 8 upper & 13 lower teeth: Behavior quiet: has delusions.)

Aug 1 to Aug 15 Summary 14 da. record by Dr Heyerdale. First week Temp. pulse & resp. about normal. Appetite fair. Salts given occasionally. Very quiet in behavior. Sleeps well at night. Express some delusions: Says she is sick & unable to be up: Began menstruating on Aug 7. Wants to stay in bed during day. Up on ward on Aug 14th. Takes out door exercise daily. Second week. Temp. normal: Appetite fair. Given medicine regularly: also cathartics: Bowels somewhat constipated. Sleeps well at night. Quiet in behavior: Still thinks she is not well & wants to remain in bed Aug 18 Wants to do a/v. Takes outdoor exercise: Oct 19 No change. Works in dining room: Nov. 17. Confined to bed: Says she is pregnant & is afraid to move for fear of causing abortion. Occasionally goes to bed for a day or two with various aches & pains. Dec 1 - Feb 28 1901 Wt. 96#. General health fairly good: Does not seem very strong physically: Still thinks at times that she is pregnant. Very quiet. March to June 1901 Patient remains the same in both mental and physical condition May 30 Wt. 99 1/2 #.

June to Sept. Patient is neat in habits and appearances, melancholy, has delusions, sits quietly about the ward, takes little interest in her surroundings, takes out of door exercise, is almost always unoccupied, reads some, menstruates regularly, Aug. 31 Wt. 95#.

Sept. to Dec. No change in mental or physical condition Nov. 30 Wt. 98#.

Dec. to Feb 1903 No particular change Wt about 97#.

Personal and Medical History of

Personal and Medical History of Anna Lampe

Whole No. 5637
Residence, St Paul. Ramsey County
Date Admission, July 31. 1900
Admitted by Dr. O. C. Heyerdale hour, 7 p m.
How Sent, Henry Dallick, Court. from Ramsey Co.
Sex, female Age, 29
Civil Condition, married
Children, 2
Age Youngest Child, four years.
Occupation, House wife, Husband fireman Officer.
Degree Education, Common School.
Profession, Religion, Methodist
Habits, Not intemperate
Nativity, Ohio. parents Germany
Physicians Committing, Eugene Hubbell & Texas P. Noyt
Correspondents, Husband Gill. Lampe 705 Dakdale St St Paul.

No. of Year, 267
Insane Relatives, None
Cause Exciting,
Cause Predisposing,
Form, Melancholia followed by paranoia
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Suicidal
Date of this Attack, 3 mos. ago
Duration, 3 mos.
No. of Attack, 2nd
No. of Admission, 2nd
Age First Attack, 27
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale Date of

MENTAL CHARACTERISTICS.

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

REASONING POWER, Ordinary Subjects, Good
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
0

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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,
Had previous attack
Sleep, Appetite, and Bowels, Good

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in PRESENT WEIGHT, 106 lb USUAL WEIGHT, NUTRITION, Poor
WOUNDS, Abnormalities and condition of Skin, Normal
TONGUE, Coatings or Promptness of Movement, Coated - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal - responses 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, Fibrillary tremor of tongue.
PATELLAR REFLEX, Exaggerated Other Reflexes, Elbow - right jaw.
ARTICULATION, Slurred, Hesitating, Slow, good -
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, Size, Strong
Apex Beat, N Regularity, Regular.



ARTERIES,
Normal.

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest Symmetrical. Expansion good. 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, Perineum lacerated. Cystocele, rectocele, External hæmorrhoids, cervix hypertrophied. Cystic endometritis. leucorrhoea. enlarged gland of Duvernay on L.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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).

Admitted in poor physical condition. quiet in behavior & manner - Sleeps well at night. appetite quite good. Very incoherent & seems demented. Language disconnected. & laughs foolishly at times.

Personal and Medical History of Anna Lampe

1900

This patient was brought here by Deputy Sheriff Lawson, attended by husband Geo. W. Lampe, in poor physical condition, with the following history of intemperance, consanguinity or heredity in patient or parents: First symptoms of insanity occurred in May 1898 when patient was confined in this (Rochester) Hospital from June 21. 1898 to May 16. 1899. (See Vol. 38 Folio 289- Case No. 5072) Discharged improved. First symptoms of present attack manifested three months ago by various delusions + incoherence of speech: Disease appears increasing, not variable: no rational intervals: derangement now manifested by delusions + hallucinations, rambling speech, hysterical laughter, etc. No disposition to injure others: threatens suicide: not filthy nor destructive: no previous peculiarities, severe disease or head injury: Has not been confined + restrained except as stated above: Cause of disease not known. Has received bromides + hypnotics. On personal examination:- Vacant stare hysterical laughter incoherent speech, mental wandering On admission put upon I. W. Complexion dark, hair black: eyes brown: skin normal: no marks or scars: a few small bruises on back: clean: Has 16 upper + 15 lower teeth: behavior quiet: Incoherent

July 31 to Aug 14 Summary 14 da record by (Dr Heyerdahl) Admitted our Infirmary bathed + put to bed. During period: Neat in habits + appearance: Incoherent + does not talk at all intelligently: General health fair: Takes outdoor exercise: Appetite good. At times noisy: Slept fairly well. Inactive.

Aug 30. No. change. Sept. 15 Very noisy at times + scolds + is profane + vulgar: Nov. 1 Appetite good, bowels constipated: given cathartics: Takes exercise: Occasionally works a little: Tidy in habits: Expresses no delusions but talks incoherently to herself. Sometimes answers questions sensibly. At times irritable + noisy. Nov 26. Operated upon by Dr Mayo for Bartholinian Cyst: Excitement + repair of perineum Reaction slow. Took the anesthetic well + made an uneventful recovery. Up on ward on Dec 16. Jan. 15 Appetite good: Bowels regular: Sleeps well: Clean + neat. At times noisy: Vaginal douche given 3 × week.

Jan 15 1901 Trans. to D3. Jan. 25 Vaccinated Feb. 14 Seems irritable + easily excited. Menstruation did not affect mental condition. Takes outdoor exercise: Assists in dining room occasionally: Attends chapel + amusements. General health seems good: Menstruates regularly.

March 4 Wt 109. Mar 1- June 1- 1901 Mar 5- Apr. 15 menstruates Apr. 29 patient in bed complained of pain in left side, emesis refused breakfast + dinner Tem. 104.4°; Pulse 120; Resp. 24. Baths given to reduce temperature. Milk diet. May 3 menstruated.

Personal and Medical History of Anna Lampe

1901

Patient inclined to be constipated; and emesis when solid food taken. Has daily lavage of stomach washings shows signs of hemorrhage. Case diagnosed as ulceration of stomach is suspected. May 7 feeding by mouth was stopped and saline enemetas were given, a quart every three hours; patient did not seem to loose under this treatment; did not complain of hunger, seemed quiet + contented; at the end of a week was put upon peptonized milk no emesis followed. May 29 Wt 86¼# Clinical record for the time showed May 29 some distension of abdomen; emesis occurred and contents of stomach green in color: bowles constipated; stools black streaked with blood; considerable flatus passed from bowels. Pain continued, cathartics + enemas given, washings from the bowel thin and dark; breath and stools quite offensive, tongue covered with white coating. May 24 began to expectorate bloody expectorations. Stools continued thin and dark and she complained frequently of headaches; cathartics in the way of castor oil given at night also turpentine. At the time she was received on Inf. Tem. was 104 ½° and ranged from that to normal, Pulse 66 to 118 Resp. 17 to 30.

June to Sept 1901 June 2 operation for gastric ulcers by Dr. Will Mayo. Had uninterrupted recovery from the same. Gastro enterostomy performed, Murphy button not found. June 28 was up on ward seems to be about the same as before the operation. Is at times disturbed and uses profane and vulgar language, takes exercise and attends chapel, at times assists a very little with ward work. during latter part of summer seemed considerably brighter, works in dining room, Sept. 1 Wt. 114#.

Sept. to Dec. Nov. 9 menstruated, quite irritable, scolding considerably, not so well mentally, Nov. 30 Wt. 113⅓#.

Dec to Feb 1903 Patient is careless in appearance: is at times quite disagreeable and uses vulgar and profane language at times. Is entirely incoherent: never answers questions intelligently. Does'nt voluntarily converse: at times talks to herself: General health fair: appetite good: bowels inclined to be constipated: takes exercise: does no work. Dec. 1st. Wt. 106½#.

Personal and Medical History of Elizabeth McGovern.

Whole No. 5639
No. for Year, —
Residence, Denver, Colorado.
Insane Relatives, One cousin.
Date Admission, August 7 1900
Cause Exciting, unknown.
Admitted by Dr. E. J. Watrous hour, 7 P.M.
Cause Predisposing, " (possibly Heredity)
How Sent, J. A. Leonard J of P. Olmsted Co.
Form, Melancholia with delusions
Sex, Female Age, 44 yrs.
Accompanying Bodily Disorder, unknown.
Civil Condition, Single.
Suicidal or not, Not.
Children, none.
Date of this Attack, 5 mos. ago.
Age Youngest Child, —
Duration, 5 mos.
Occupation, Domestic
No. of Attack, First.
Degree Education, Common school.
No. of Admission, First.
Profession, Religion, Roman Catholic.
Age First Attack, 44 yrs.
Habits, Not intemperate.
Time of Leaving, 26th September 1901.
Nativity, Minnesota (Parents born Ireland.)
Time in Hospital, 1 yr. 1 mo. 19 dys
Physicians Committing, C. T. Granger + J. G. Cross
Result, Recovered — Discharged Nov 30/1901
Correspondents, John McGovern (uncle) Rochester, Minn. 5 mi. west of town.
Kate McGovern C/o Dr Abbott. 557 Dayton Ave, St Paul. (sister)
N.B. In case of illness or death notify St. Mary's Hospital (M.E.S. nuns)

EXAMINATION ON ADMISSION BY DR. Heyerdale Date of Aug 11 1900.

MENTAL CHARACTERISTICS.

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks her trouble comes from dental work which she had done.
HALLUCINATIONS,
ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 - frozen
Paternal Relatives,
Mother, died at menopause
Maternal Relatives,
Brothers and Sisters, 2 dead - 1 had paralysis.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Small pox.
HABITS, Drinking and Smoking, good
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches for about a year - vertigo.
OCCUPATION, Healthy or not, housework -
Detail Date, Duration, and Character of Previous Attack, if any.

Sleep, No Appetite, Fair and Bowels, Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in PRESENT WEIGHT, 94½ lbs USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, coated - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal - responses 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, of hands.
PATELLAR REFLEX, present Other Reflexes, Elbow - wrist exaggerated.
ARTICULATION, Slurred, Hesitating, Slow, good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, Good Size, N.
Apex Beat, N Regularity, Regular.



ARTERIES,
Slight sclerosis -

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.
Slight dullness in lapices - Mantoux radio in R. apex.

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

GYNECOLOGICAL EXAMINATION, In every way normal except uterus retroflexed.

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

Give condensed statement of the 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).

Admitted in fair physical condition - was sleepless at night - moaned both at night + day. Bewailing her troubles. Has a fair appetite, sleeps well with aid of hypnotics - Goes out of doors daily.

Personal and Medical History of Elizabeth Mc Govern.

1900

This patient was brought here by Sheriff Vine attended by Julia + Mary Mc. Govern, in fair physical condition, with the following history: No consanguinity one cousin insane: No intemperance in patient nor parents. First symptoms of insanity manifested five months ago by insomnia + confusion of ideas: Disease appears increasing: not variable: Derangement now manifested by delusions in regard to teeth: Thinks her trouble was caused by dental work: Is disposed to injure others Habits filthy + destructive: No peculiarities previously manifested: No severe diseases nor injuries to head: No confinement nor restraint employed, no treatment pursued: On personal examination is in constant state of unrest: wring. her hands + moans: complains about her teeth. On admission put upon Infirmary West

Aug 7/1900 W. H. N. Rpt. Complexion dark: hair grayish brown: Eyes gray: Skin in normal condition: No marks, scars nor bruises noted: Is clean: Has 8 upper + 7 lower teeth: Is very nervous: Answers questions intelligently)

Aug 7/1900 (Summary 14 da. record Dr. Heyerdahl) Admitted on Infirmary: Very nervous. Slept quite well and to night. During first week. Temp. somewhat elevated - 98°-100. Pulse 64-91 -

Aug 21/1900 Resp 18-22. Appetite good during week: Occasional hypnotics + cathartics required: Bowels regular. Slept well with exception of nights of 10th 11th + 17th. Restless + nervous during day. Talks quite intelligently but worries a great deal. Second week temp. pulse + resp. about normal: Appetite good: Hypnotics + cathartics given occasionally. Slept well during week. Somewhat more quiet altho still worries some. Takes out-door exercise Takes meals regularly.

Sept 3 1900 Patient visited frequently by relatives: Sleeps very poorly: Appetite fair: Takes out door exercise: Oct 15. + 25 Visited by relatives: Assists with ward work: Takes regular electrical treatments. General condition unchanged. Dict- Feb 28 1901 Feb 14 Fell + injured hip - Examined by Drs. Linton + Heyerdahl. No definite injury found. Feb 25- Examined again - no injury. Feb 28 W. B. 24th A

Mar. to June 1901 Mar. 12 patient is quite lame as a result of a fall she slipped on the floor and struck her hip, was put to bed, hip was examined and no apparent injury discovered. Mar 18. is upon ward somewhat lame and quite disturbed mentally, expresses many delusions of persecution, neat in habits and appearance, walks almost constantly up and down the ward will not sit down, appetite poor fed by nurses. Apr. 8 patient fell and bruised her right cheek Apr. 13 in bed complained a great deal of hip, May 4 patient up on ward, May 23 visited by sister and niece, May 30 hip giving considerable trouble she has a great deal of pain in it. Patient has tubercular infection of hip due to bruise in March Wt. 77#.

Personal and Medical History of

June to Sept 1901 July 9 visited by cousin July 15 went out and spent the night with cousin returned July 16; visited again by cousin July 18. July 20 taken to Dr. Mayo's office and hip examined by X ray and nothing found. Aug. 10 visited by friend, foot and knee badly swollen, Aug 30-31 visited by niece, relatives and friends, wheeled out of doors daily in chair Wt. 68#.

Sept. to Dec. Sept. 1st. visited by relatives- Sept. 7 by niece Sept. 10-25-25 by friends. Sept. 26. Patient up on ward, neat in habits and appearance, is very lame and unable to walk without the aid of a cane or chair, appetite poor, sleeps fairly well, constipated, talks intelligently, quiet in behavior, is still quite melancholy, Sept. 26 taken to her sister in Denver, Colo. by Miss. Gleason, Head Nurse, left this A.M.

It is reported sometime later that patient died at her sister's home in Denver, Colo.

— Discharged —

Personal and Medical History of Catherine Hallen.

Whole No. 5640
Residence, St. Paul, Minnesota.
Date Admission, 9th August 10th 1900.
Admitted by Dr. E. J. Warnow hour, 7 P.M.
How Sent, Ell. Bayille Jof P. Ramsey Co.
Sex, female. Age, 44 yrs.
Civil Condition, married.
Children, seven.
Age Youngest Child, 4 mths.
Occupation, housewife.
Degree Education, Common school.
Profession, Religion, not a church member.
Habits, not intemperate.
Nativity, Sweden. (Parents also born there)
Physicians Committing, J. Leavitt - Arthur Swenny.
Correspondents, Olaf Hallen. 60 Winnipeg Ave. St. Paul. Minn.

No. of Year, 3.
Insane Relatives, not to known.
Cause Exciting, Puerperal condition.
Cause Predisposing, previous attack.
Form, Lactational Insanity
Acute Melancholia - agitated.
Accompanying Bodily Disorder, unknown,
Suicidal or not, not.
Date of this Attack, Aug 7th 1900.
Duration, 3 days,
No. of Attack, 2nd.
No. of Admission, 1st.
Age First Attack, 43 yrs.
Time of Leaving, Sept. 17th 1900
Time in Hospital, 1 mo. 7 da.
Result, Discha. Recovered Feb. 5th 1901.

EXAMINATION ON ADMISSION BY DR. Heyerdahl *Date of* Sept 7th 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick -
MEMORY, Past Events, Good -
Recent Events, do. Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert - Correct
REASONING POWER, Ordinary Subjects, Good -
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Somewhat depressed.
DELUSIONS, Systematized, Transitory, Special Subjects,
None present
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden, Sudden
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Dead -
Paternal Relatives,
Mother, Dead -
Maternal Relatives,
~~Brothers~~ and ~~Sisters~~, 4 children - 2 dead.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None.
HABITS, Drinking and Smoking, good except drinks too much coffee
HEADACHES, 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, 5 ft 2 PRESENT WEIGHT, 114 lbs USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, Skin normal.
TONGUE, Coatings or Promptness of Movement, 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, good Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, none.
PATELLAR REFLEX, present. Other Reflexes, R. met - both elbows present
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, Strong Size, N
Apex Beat, N Regularity, 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,

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

GYNECOLOGICAL EXAMINATION, Lacerated perineum: cystocele: rectocele: retroflexion endometritis: leucorrhoea.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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). On admission in very poor physical health. Very much disturbed mentally: had many delusions of persecution: delirious & maniacal: Out of bed & very restless. Acute Nephritis present. At time of exam - Very much improved mentally & improving rapidly physically.

Personal and Medical History of Katherine Hallen.

1900

This patient was brought here by Dep. Sheriff Hanson attended by Olaf Hallen in poor physical condition, with the following history:- No consanguinity, heredity nor intemperance in patient nor parents: First symptoms of insanity were manifested in April 1899 attack lasting two weeks: First symptoms of present attack manifested Aug 7 1900 talked & acted irrationally Disease appears increasing: In variable: no rational intervals: Derangement now manifested by general delusion: Patient not disposed to injure anyone: No filthy nor destructive habits: No peculiarities previously manifested: was confined four weeks ago: No treatment has been pursued. On personal examination patient is at times quiet, at others violent: talks irrationally & is sleepless. On admission put upon Infirmary W (G.H.D. Rpt Com-plexion dark: eyes blue: hair light brown: Skin hot & dry: Tenderness to umbilical hernia: In dirty: has 4 upper & 5 lower teeth: Several varicose viens: Behavior quiet: has delusions.)

Aug 10 to Aug 15 Summary 14 da Record by Dr Reynolds Admitted on Infirmary, bathed & put to bed: Has varicose viens & small bruises: Extremely noisy & violent toward roommate: Hypnotic given: During first week took nourishment well. Temp. high 104°. due to given regular hypnotics Bowels quite constipated: moved by cathartics & enemata. Breasts filled with milk requiring close attention Much disturbed & out of bed frequently: Aug 11. Attempted to choke herself with hands: very noisy: Put in restraint on the 13th & kept there part of each day. Sponge & hot baths given frequently. Second week took nourishment well: given stimulants regularly: Bowels regular: hypnotics required. Improved very much but continued very restless & out of bed a good deal when not in restraint. Attempted suicide by tying sheet about neck on Aug 17. Fed mechanically once. on 18 When out of restraint climbed on radiator & fell off no serious injury resulted. Aug 30 More quiet. At times cries a great deal & is resistive. Bowels constipated. Sleeps well: Sept 10 Converses readily: at times melancholy & cries: Takes outdoor exercise: Appetite good. Inclined to constipation. Sleeps quite well: Sept 16 & 17 Visited by husband: Very rational & sensible. In good general health.

Sept 19 Taken home by husband.

Discharged.

Letter received from husband Oct 1 1900. Stated wife was very well & happy

Personal and Medical History of

Personal and Medical History of Christine Billings.

Whole No. 5644

Residence, Brownsville, Minnesota.

Date Admission, August 16' 1900.

Admitted by Dr O. C. Heyerdale hour, 4 P.M.

How Sent, L. Budahl Jo. P. Houston Co.

Sex, female Age, 35 yrs. (or 37)

Civil Condition, married -

Children, three.

Age Youngest Child, five months.

Occupation, housewife (husband a laborer)

Degree Education, read & write.

Profession, Religion, Lutheran.

Habits, ? Tr.

Nativity, Minnesota (Parents born in Germany)

Physicians Committing, Drs. A.M. Crandall & O. C. Rhines.

Correspondents, Ira Billings, Brownsville, Minn.

No. of Year, 7

Insane Relatives, None.

Cause Exciting, unknown.

Cause Predisposing, Previous attacks.

Form, Mania with delusions

Accompanying Bodily Disorder, sleeplessness, nervousness.

Suicidal or not, Not.

Date of this Attack, August 11' 1900.

Duration, 5 days.

No. of Attack, 2nd

No. of Admission, 2nd

Age First Attack, 32 yrs. (or 34)

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Aug. 14' 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quick - confused

MEMORY, Past Events, fairly 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,

exalted.

DELUSIONS, Systematized, Transitory, Special Subjects,

has many.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Suicided - at 50 yrs. a hard drinker

Paternal Relatives,

Mother, died at 34 of heart disease

Maternal Relatives,

3 Brothers and 3 Sisters,

3 children living - well -

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

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, dizzy spells every month

OCCUPATION, Healthy or not, housework -

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

Sleep, Appetite, and Bowels, constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 4 in. PRESENT WEIGHT, 139# USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, Skin normal.

TONGUE, Coatings or Promptness of Movement, prompt. coated.

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

SIGHT,

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

HEARING,

COORDINATION, Arms, good. Legs, good. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, present. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, good.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, No Murmurs, Strength, Sounds, Size, N.

Apex Beat, N. Regularity, Regular.



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

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical.
Expansion good.
B. sounds normal.

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 the 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). Admitted in fairly good physical condition. Is very loud & frequently obscene in language. Takes nourishment well. Goes out of doors daily.

Personal and Medical History of Christine Billings

1900

This patient was brought here by Sheriff G.M. Blesrud attended by Mrs Carrie Schwartz in poor physical condition, with the following history:- History of consanguinity unknown. No heredity nor intemperance: First attack of insanity came on in February 1897 & patient was in this hospital from March 12, 1897 to June 11, 98 (See Vol. 34. Fol. 173 No 4706) First symptoms of present attack manifested Aug 11, 1900. by raving: Disease appears increasing: not curable: Derangement manifested by incoherence on all subjects: Not disposed to injure anyone: No filthy nor destructive habits. No peculiarities previously manifested: Received injury to head in February 1897. Has been confined to house for four days. No treatment pursued: On personal examination appears mildo irrational & is in a condition of nervous excitability: sleeping little. On admission put upon Infirmary Ward. (G.P.M. Rpt. Complexion dark. hair light brown: eyes gray. Skin hot & dry. A few bruises on arms. Is clean: Has 8 lower teeth & an upper plate: Behavior maniacal: Talk incoherent.

Aug 6-31 Summary 14 day record by Dr. Bryerdale: Behavior quiet: at times talks incoherently: Temp. on admission 101½ took nourishment: bowels moved freely. Aug 16-21 Temp. 98½ to 100: pulse 78-91: Appetite very fair: somewhat sleepless, requiring hypodermics: bowels quite regular: breasts contained milk: During 1st week talked a great deal in a loud noisy manner: afternoon of Aug 17 up & dressed & out of doors: Remained up on ward most of week: Aug 21 Transferred to B1: Breasts emptied daily: During second week temp. about normal: appetite good: Receives tonic three times daily: bowels regular: was quite agreeable most of time at times disagreeable, talking loudly & noisily: assisted with ward work: Sometimes profane: out of doors daily.

Oct 1, 1900. Tidy in habits but careless in appearance: Very talkative: has delusions Sometimes profane & quarrelsome: Appetite good: Bowels inclined to be Constipated: Laxatives & tonics given Works in laundry part of time: Takes daily out-of-door exercise. Nov 16 Wt. 133½ lbs Dec 1 - Feb 28, 1901 General health good: Works regularly on ward & sometimes in Laundry. At times will not talk, occasionally becomes disturbed & expresses delusions freely. Thinks people consider her a thief. Takes out door exercise.

Mar to June 1901 Mar. 30 patient disturbed mentally, very loud and profane in her language tran. to No. 1. Apr. 18 very quiet and agreeable tran. to C. 3. West. May 30 Wt. 122 #. June to Sept General health good, at times is irritable and noisy, expresses many delusions, work regularly on the ward. June 30 Wt. 133#. Sept. to Dec No change in mental or physical condition Nov. 28 Wt. 136 #.

Personal and Medical History of Christine Billings.

Dec to Feb 1902 No change in condition. Wt. about 124#. Patient visited by husband on July 4, 1902. Jan 13 '03 visited by friends.

Personal and Medical History of Ellen Bye.

Whole No. 5645
Residence, Villa of Cannon Falls.
Date Admission, August 17. 1900
Admitted by Dr E. J Marcus hour, 7 P.M.
How Sent, Axel Hallen & of P. Goodhue Co.
Sex, female Age, 48 yrs.
Civil Condition, married.
Children, five.
Age Youngest Child, 9 yrs.
Occupation, housewife.
Degree Education, Common school.
Profession, Religion, Swedish Lutheran.
Habits, Temperate - Father a drunkard
Nativity, Norway - Parents also born there
Physicians Committing, Ed. Maryland & F. N. Dimmick
Correspondents, C. O. Bye (husband) Cannon Falls, Minn.

No. of Year, 8.
Insane Relatives, unknown.
Cause Exciting, "
Cause Predisposing, Previous attacks.
Form, Melancholia agitans. acute
Accompanying Bodily Disorder, pulse accelerated.
Suicidal or not, attempted by hanging & drowning.
Date of this Attack, 5 mos ago
Duration, 5 mos.
No. of Attack, 3rd
No. of Admission, 1 here.
Age First Attack, 38 yrs.
Time of Leaving, Aug 20. 1900
Time in Hospital, 3d.
Result, Died Apoplexy.

EXAMINATION ON ADMISSION BY DR. Heyerdale Date of Aug. 20 1900

MENTAL CHARACTERISTICS.

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

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

DELUSIONS, Systematized, Transitory, Special Subjects,
religious
HALLUCINATIONS, religious.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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. 7 PRESENT WEIGHT, 133# USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, normal. Body covered with large black & blue bruises
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal.
SIGHT, Seems good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Seems good.
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,
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, Lacerated perineum, rectocele, cystocele, Haemorrhoids. uterus antiflexed. Cervix lacerated & cystic. Leucorrhoea.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 fair. Very violent at first & actively suicidal - tried to hold head under water when being bathed - also tried to get out of window. Hypnotics given for sleep. Bowels moved by cathartics. Talked very little - took good amount of nourishment.

Personal and Medical History of Ellen Bye.

1900

This patient was brought here by Sheriff's deputy J.A. Anderson attended by husband, in fair physical condition, with the following history:- No consanguinity: heredity unknown: not intemperate but father a drunkard: First attack occurred about 1890 lasting two years: Second in 1895 lasting 5 to 6 weeks: First symptoms of present attack manifested six weeks ago, by religious hallucinations: Disease appears increasing: not variable: Derangement now manifested by thinking she is lost, belongs to the devil &c: wants to go to insane asylum &c. Not disposed to injure anyone: Tried to drown & hang herself: Is destructive of clothing: Previously manifested religious impressions & melancholia: No severe diseases nor injuries to head: Has been watched carefully & manual restraint employed: Received treatment.

Aug 17 On personal examination is very excitable & nervous pulse accelerated. On admission put upon Infirmary G.H.N. 1901 Complexion dark: hair black: eyes blue: skin in good condition: Several large bruises on legs, feet & arms: Is very dirty: Could not count her teeth: Is very maniacal: has delusions.)

Aug 17 to Aug 31 Summary Record by Dr Hyerdale. On admission very resistive: Left foot & ankle discolored: many bruises- Noisy after 1st P.M. Didnot sleep Put in restraint & hypodermic given: Is an active suicide: 18th Temp. A.M. 106° Pulse 84 Resp. 20 P.M. 99- Pulse 102. Resp. 20. Sleeping dose given Took nourishment: Remains in restraint: Expresses many delusions: Noisy during night: Slept four hours. Aug 19 Temp. 5 A.M. 101. Pulse 86. P.M. 101° P. 74 R. 26. Appetite fair: Bowels moved: Patient in restraint: quiet most of time: Talks quite sensibly at times but still expresses morbid ideas: Noisy during night Slept four hours. Aug. 20 Temp. 102°. Took breakfast: In restraint until 11.30. Seemed quite stupid. At 2 P.M. was seen sitting on side of bed apparently in about the same physical condition as in morning: At 2:15 found lying across bed: breathing with difficulty: became nauseated. Physicians called & stimulants given but patient died at 2:40. Cause of death apoplexy.

Died.

Personal and Medical History of

Personal and Medical History of Mabel L. Sheriff.

Whole No. 5647
Residence, St. Paul, Minnesota.
Date Admission, 18th August 1900.
Admitted by Dr. O. C. Heyerdale hour, 7 P.M.
How Sent, Ed. Bazille Jr. P. Ramsey Co.
Sex, female Age, 16 yrs.
Civil Condition, single.
Children, —
Age Youngest Child, —
Occupation, none.
Degree Education, Public School.
Profession, Religion, Episcopal.
Habits, not intemperate.
Nativity, Minn. (Parents born in Canada)
Physicians Committing, W. Archibald & A. Sweney.
Correspondents, Mr. Sheriff 2714 Langford Ave. St. Paul, Minn.

No. of Year, 10.
Insane Relatives, maternal aunt.
Cause Exciting, unknown.
Cause Predisposing, unknown.
Form, Pubescent Insanity
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, not.
Date of this Attack, 15 mos. ago.
Duration, 15 mos.
No. of Attack, 1st.
No. of Admission, 1st. here. (At St. Josephs St. Paul)
Age First Attack, 14 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Aug 24 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - sluggish.
MEMORY, Past Events,
Recent Events, good - Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert - Correct.
REASONING POWER, Ordinary Subjects,
Special Subjects, good.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
normal somewhat 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 Dulness, 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, living
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None except Scarlet fever
HABITS, Drinking and Smoking, good.
HEADACHES, VERTIGO, OR CONVULSIONS
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, good

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5 in PRESENT WEIGHT, 101# USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt. coated
PUPILS, Equality, Size, Response to Light, and Accommodation, equal - large - response to light & accom nor.
SIGHT, good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, poor Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, slight of tongue.
PATELLAR REFLEX, present - but diminished Other Reflexes, wrist & elbow present.
ARTICULATION, Slurred, Hesitating, Slow, good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, N.
Apex Beat, Regularity, regular.
ARTERIES,
normal.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion good
B. sounds, vesicular



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, Passed up 22 — Sp. g. 1026 Reaction, acid Color and Appearance, Yellow. Cloudy & flaky sed.
Albumen, Heat: albumen Nitric acid: albumen Heller: albumen Sugar, Fehlings sol: o — Bismuth: o —
Casts and Crystals, Several uric acid crystals: Urates. amor. Epithelium, a few cells. —

GYNECOLOGICAL EXAMINATION, Genitals normal - leucorrhoea. uterus retroflexed cervix hypertrophied. cervicitis.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 admitted in fairly good physical condition. Is somewhat indifferent to surroundings. When asked how she feels usually answers "I don't know." Patient seems to be in good physical condition, except that she evidences some incoordination of lower extremities. Altho she seems quite intellectually. still her mind seems to be quite sluggish.

Personal and Medical History of Mabel L. Sheriff.

1900

This patient was brought here by Dep. Sheriff W.S. Lamb attended by Mrs. St. Pierre in fair physical condition, with the following history:- First symptoms of insanity manifested 15 months ago by delusions & illusions of impregnation appears unbraving; not suicidal. Derangement now manifested by a delusion of masturbation is irritable & noisy. 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. Was given sedatives & tonics & has been at St Josephs hospital, St. Paul, where she received tempory improvement. On personal examination says that her hands go without her knowledge to her genitals & that she knows by the sound of her voice & taste that she has masturbated; is noisy & uncontrollable & at times is melancholy.

On admission put upon Infirmary. (G.H.U. Rpt complexion fair: Lar brown eyes brown: Skin in normal condition: No marks, scars nor bruises: Is clear: Has 14 upper & 14 lower teeth: behavior quiet: Talks intelligently)

Aug. 18 to Sept. 7 Summary 14 day record by Dr. Heyerdahl: Talks hesitatingly and answers questions slowly: Slept all night: ate light lunch: during first week temp 98 2/5 to 100: Pulse 70 to 95 Resp. 18-20: Appetite rather poor: Takes medicine three times daily: Somewhat constipated: bowels moved by enema once during week: During 2nd week Slept quite well at night: was up & dressed on the 21st: took outdoor exercise daily thereafter: untidy in appearance: does not help herself at all: has to be dressed & undressed: very sluggish untidy in habits: Temp. pulse & resp. about normal: appetite rather poor: bowels regular. talked very little

Sept. 9 Visited by mother. Sept. 30 Untidy: has to be dressed & undressed. Appetite fair: Has to be taken to dining room at mealtime. Oct 9 Visited by father

Oct 9th. Is brighter: waits upon herself more & talks readily: Attends amusements: Takes outdoor exercise. Sleeps well.

Dec 9. Untidy: Appetite good: bowels regular: Converses intelligently.

Jan 9 to 10 Complained of pain in abdomen: Remained in bed until the 14th. Given electrical treatments from Jan 18 to Feb. 10th Feb. 13 Very disagreeable much of time: untidy: health quite good: Given cold baths for tonic effect Feb 27. Improved. Generally cheerful & neat.

Feb 28 Vaccinated. Wt. 108½ lbs. Mch 12. Went home.

Mar. to June 1901 Apr. 15 patient returned, was given put to bed until Apr. 26. converses quite intelligently, is untidy in appearance and habits, seems to have no control over bladder, at times noisy, sleeps well, appetite fair, bowels regular, attends chapel and amusements, takes out door exercise, sometimes is quite disagreeable towards other patients, Apr. 29 was quite disturbed and resistive, put in restraint Apr. 30 for one day, May 6 received electrical treatment June 1 Wt. 108 lbs.

Personal and Medical History of

1901

June to Sept. Talks a great deal to herself, seems to have illusions and imagines that people are calling her, has prolapse of rectum bowel protruding four to five inches. July 1st. visited by sister, is very untidy in habits and appearance. Sister remained from July 31 until Aug. 12 and kept patient out of doors a greater part of the time without any apparent change, she seems to be losing both mentally and physically, wanders about the ward in an aimless way and seems unable to express herself Sept. 2 Wt. 102 lbs.

Sept. to Dec. Nov 22 was taken to Inf. and was operated on Nov. 24 for prolapse of rectum, Peters operation, reaction from this was good, remained quietly in bed during convalescence, caused little trouble, pleasant and agreeable, but soliloquized a great deal as usual, during the time Temp did not rise above 99.8, P. 110 - R. 22. First twenty-four hours nothing given by mouth, some emesis during first two days, was quite restless, water given the second day, then buttermilk and beer alternating one-half ounce every hour, this was increased gradually to one and two ounces. Nov. 27 had slight movement of bowels Nov. 28 given light diet of milk and toast three times a day, also buttermilk and beer continued enemas given once a day also vaginal douches. Dec. 2 stitches removed. During Dec. 3 was quite nauseated after this time had little trouble of any kind, up on ward Dec. 11.

During September the condition of patient has not changed; very incoherent, talking to herself; either unwilling or unable to answer questions; very stubborn and resistive; indifferent to her surroundings always well, continues refusing to take her nourishment and is fed by tube, very untidy, bowels constipated during latter part of September and first of October very rapid improvement taking place, patient began to converse intelligently, and in every way seems much better; taken out for exercise. Oct 5th visited by Father, was sent to Lime Springs, Ia., to be taken care of by Miss Maude Moore. reports since then show that the improvement continues. Dec. 1901 to Aug. 1902 Patient very much disturbed mentally; resistive; dirty & vicious in habits; untidy in appearance; fed by tube at times; wilful, obstinate and resistive; failing gradually; Patient went camping at Oronoco from June 27th to July 8th. Had visit with her sister Feb. 20th.

Dec. 2-02 to Jan. 1903 No changes

Personal and Medical History of Effie Lang.

Whole No. 5648
Residence, St. Paul, Minn.
Date Admission, August 21, 1900.
Admitted by Dr. O. H. Heyerdale hour, 7 P.M.
How Sent, Ex. Bazille Jap. Ramsey Co
Sex, Female Age, 30.
Civil Condition, married
Children, Three.
Age Youngest Child, Two years.
Occupation, Housewife.
Degree Education, Public school.
Profession, Religion, Adventist.
Habits, not intemperate.
Nativity, Wisconsin (Father Mass. Mother N.H.)
Physicians Committing, J.H. Johnson & A. Sweeney.
Correspondents, Mr. Arthur Stewart --- Jessamine St. St. Paul, Minn.

No. of Year, 11
Insane Relatives, none.
Cause Exciting, ?
Cause Predisposing, unknown.
Form, Melancholia agitans (delusional)
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, yes - attempted drowning -
Date of this Attack, February 1900
Duration, 6 mos.
No. of Attack, first
No. of Admission, 1 here - (at Sanitarium Lincoln, Neb.)
Age First Attack, 30 yrs.
Time of Leaving, Nov. 9, 1900.
Time in Hospital, 7 mo. 18 da.
Result, Dischg. Unimproved Feb. 6, 1901.

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Aug. 21.

MENTAL CHARACTERISTICS.

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

REASONING POWER, Ordinary Subjects, fair
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal - at times depressed.

DELUSIONS, Systematized, Transitory, Special Subjects,
Religious
HALLUCINATIONS, of sight & hearing -
ILLUSIONS, yes?

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, Living.
Paternal Relatives, Aunt has haemorrhages of lungs
Mother, Living - Heart trouble.
Maternal Relatives,
Brothers and Sisters, 2
3 Children -
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None.
HABITS, Drinking and Smoking, good -
HEADACHES, VERTIGO, OR CONVULSIONS, none -
OCCUPATION, Healthy or not, housework -
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, fair Appetite, good and Bowels, regular.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4½ in PRESENT WEIGHT, 105 USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, Coated - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, equal - large - responses good.
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good
COORDINATION, Arms, Legs, good. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, none -
PATELLAR REFLEX, diminished Other Reflexes, clonus
ARTICULATION, Slurred, Hesitating, Slow, Slight
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, N. Fair
Apex Beat, Regularity, Regular - slow

ARTERIES,
Normal.

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, Slight laceration, cystocele, rectocele, urethral caruncle, mucous warts: retroflexion: cystic degeneration. erosion. cervicitis, leucorrhea
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, poor.
BOWELS, Present Condition, good

Give condensed statement of the 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).

Admitted in good physical condition. Is active & a good worker on ward - Mentally is slow - Expresses a good many religious delusions.

Personal and Medical History of Effie Long.

1900

This patient was brought here by Dep. Sheriff W.H. Land. attended by Mrs. Delamaker, (80 Thomas St., St Paul) in fair physical condition, with the following history:- First symptoms of insanity manifested at puberty, has never been strong mentally or physically since then: Disease appears increasing & variable: Derangement now manifested by hearing voice of God. Wishes to carry out his commands, even if they are to destroy herself & children. Has attempted suicide by drowning: No filthy nor destructive habits: Before accession of disease was decidedly susceptible to religious impressions: No severe diseases nor injuries to head: No confinement nor restraint employed: Has received general care at home & at Sanatarium: On personal examination talks freely of her hallucinations & admits that she will obey the voices. Has placed herself & children in positions of danger because of the voices. On admission put upon Infirmary Ward G.H.N. Rpt. Complexion dark: hair brown, eyes gray: Skin in normal condition: Is clean: Has 11 upper & 9 lower teeth & one upper tooth on plate: Behavior quiet: Has delusions.

Augs to Sept 5

Summary 14 day record by Dr. Hespendale: On admission quiet and agreeable: talked quite sensibly but expressed some delusions: slept well all night: During first week temp. 97 to 99 2/5 Pulse 60 to 90: Resp. 14 to 22: bowels regular: medicine given three times daily: hypodermics required occasionally for sleep: up and dressed Aug 23: out of doors daily from that time: During 2nd week Temp. pulse & resp. were normal: appetite good: bowels regular medicine continued: slept well: very quiet: assisted with work: expressed a desire to be sent home Sept 30 Nat: Very nervous & excitable: wanders aimlessly about ward muttering to herself: Has trouble on ward, imagines that god tells her to do certain things, such as running away, refraining from talking, refusing nourishment &c. At times is somewhat violent & noisy. Oct 7. Attempted to escape while out walking 9 to 8 & 9. Visited by mother & taken home.

Discharged.

Letter received from Mother Jan 15 1901. Stated that patient was no better. She staid in St Paul 3 months & then was sent to husband in Illinois & ten days later was committed to Watertown State hospital.

Personal and Medical History of

Personal and Medical History of Augusta Otto

Whole No. 5649
Residence, Pickerel Lake, Minnesota
Date Admission, August 23, 1900
Admitted by Drs. L. A. Linton hour, 8.35 P.M.
How Sent, H. Blackmer J. of P. Freeborn Co.
Sex, female Age, 21 yrs.
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, housework.
Degree Education, partial.
Profession, Religion, Not a church member.
Habits, Not intemperate.
Nativity, Minnesota (Parents born in Germany)
Physicians Committing, F.L. Wilcox & G.W. Bard.
Correspondents, Mrs. Otto, Albert Lea, Minn. (Lives in town)

No. of Year, 1st
Insane Relatives, none.
Cause Exciting, unknown
Cause Predisposing, unknown
Form, acute Mania with delusions.
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, Not.
Date of this Attack, 2 weeks ago (?) probably over a year
Duration, 2 weeks.
No. of Attack, First
No. of Admission, First.
Age First Attack, 21 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Aug 24 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick.
MEMORY, Past Events, Good
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert - correct.
REASONING POWER, Ordinary Subjects, Good
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
normal.
DELUSIONS, Systematized, Transitory, Special Subjects,
Delusions of persecution.
HALLUCINATIONS, of sight & hearing
ILLUSIONS, yes.
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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, living.
Maternal Relatives,
Brothers and Sisters, 3 half sisters.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None
HABITS, Drinking and Smoking, Good.
HEADACHES, VERTIGO, OR CONVULSIONS, Headache
OCCUPATION, Healthy or not, housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Good Good Irregular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7in. PRESENT WEIGHT, 118# USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, prompt
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - large - to light slow.
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, Good
COORDINATION, Arms, Good Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, slight of tongue.
PATELLAR REFLEX, present Other Reflexes, Wrist & elbow present.
ARTICULATION, Slurred, Hesitating, Slow, Good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, N. weak
Apex Beat, N Regularity, regular
slow.
ARTERIES,
normal.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion poor
Inspiratory rales on right. Dullness in right apex & infraclavicular region.
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, Genitals normal - leucorrhoea.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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).

Admitted in fairly good physical condition. Expresses many delusions of persecution. Says people in the city wind up her brain & that people try to injure her. Has hallucinations of sight & hearing

Personal and Medical History of Augusta Otto

1900

This patient was brought here by Sheriff E. N. Ellickson attended by Wm. Otto in fair physical condition, with the following history: No consanguinity, heredity nor intemperance known in family: First symptoms of insanity manifested two weeks ago: Disease appears increasing: Is variable: Has delusions - thinks when she speaks that it is someone else talks about machinery: No filthy nor destructive habits: Is disposed to harm others: No perverse peculiarities noted: No severe diseases nor injuries to head: No confinement nor restraint employed: Has received medical treatment in Albert Lea. On personal examination talk irrational & looks wild.

On admission put upon Infirmary Ward (W. N. Apt. Complexion dark: hair light brown: eyes gray. Skin normal: a few scars on neck: a few small bruises on legs & arms: Is clean. - Has 16 lower & 13 upper teeth: Behavior quiet: Has delusions & hallucinations:

Aug 23 to Sept 7 Summary 14 day record by Dr. Heyerdale. On admission answered questions readily: During first week temp. pulse and resp. normal: appetite good. Aug 30 cathartic given: bowels regular three times: up & dressed: quiet & agreable on ward: took out door exercise daily: slept well at night: expressed many delusions of persecution: Second week: Temp: pulse & resp. normal: appetite good. medicine given three times daily: bowels regular: slept well: talked to self: assisted with work: went out of doors daily Sept. 20 Nat. Generally quiet but at times scolds & is profane. Expresses delusions freely: Talks of hypnotism: Assists with work: Trans. to B 3. Oct 1st Scolds & is violent & attacks nurses.

Nov 3 1900 Attacked nurses: up on ward: Nov 26. Wt. 121#. General health good: Occasionally becomes disturbed & scolds vigorously.

Dec 1st. Attacked nurses & other patients. Struck Mrs. Asperg. Dec 25 Trans. to C 5.

Feb 28 1901. Wt. 105½. General health good: Takes regular exercise: At times very much disturbed: Talks to himself. Expresses delusions of persecution freely.

Mar. to June 1901 May 20 No change in mental or physical condition, Wt. 120#

June to Sept. June 6 visited by lady friends. no change, no weight.

Sept. to Dec. Is unoccupied, takes regular out door exercise, general health good, sits about the ward and does not interest herself in her surroundings, at times becomes very irritable and expresses many delusions, is inclined to be somewhat violent, talks in an incoherent manner, Nov. 15 Wt. 122#

Dec. to Feb 1903. No change. Patient visited by a friend Dec. 28th 1901. Wt 124#.

Personal and Medical History of

Personal and Medical History of Ingebor Tallefson.

Whole No. 5656
No. of Year, 19.
Residence, Chatfield, Minn.
Insane Relatives, none.
Date Admission, September 10 1900.
Cause Exciting, Sunstroke.
Admitted by Dr. A.F. Kilbourne hour, 3 PM.
Cause Predisposing, unknown.
How Sent, Ex. Farrington, Sheriff Fillmore Co.
Form, Acute Mania (delusional)
Sex, female. Age, 53 yrs.
Accompanying Bodily Disorder, none mentioned.
Civil Condition, widowed
Suicidal or not, not.
Children, 4.
Date of this Attack, July 3 1900.
Age Youngest Child, 24 yrs.
Duration, 2 mos. 7 days.
Occupation, housewife (husband was a farmer)
No. of Attack, 1st
Degree Education, Common school.
No. of Admission, 1st
Profession, Religion, Lutheran.
Age First Attack, 53 yrs.
Habits, Not intemperate.
Time of Leaving,
Nativity, Norway (Parents born in Norway)
Time in Hospital,
Physicians Committing, H. Phillips & Frank Love.
Result,
Correspondents, L.L. Finneseth. (Sand Fountain, Minn.

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* 9/12/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
somewhat confused & sluggish
MEMORY, Past Events,
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,
Indifferent.
DELUSIONS, Systematized, Transitory, Special Subjects,
of persecution.
HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, Began first about 2 mos. ago.
ONSET, Gradual or Sudden, Sudden.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
negative.
Father, dead.
Paternal Relatives,
Mother, Living 80 yrs. of age.
Maternal Relatives,
Brothers and Sisters, 3
4 Children Well.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Typhoid 10 yrs. ago.
HABITS, Drinking and Smoking, drank much coffee
HEADACHES, often VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Fair Constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5 PRESENT WEIGHT, — USUAL WEIGHT, NUTRITION, good
WOUNDS, Abnormalities and condition of Skin, skin normal.
TONGUE, Coatings or Promptness of Movement, coated - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal - responses poor.
SIGHT, good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, exaggerated. Other Reflexes, elbow - mist.
ARTICULATION, Slurred, Hesitating, Slow, 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,
Color and Appearance,

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

GYNECOLOGICAL EXAMINATION, Laceration of perineum - cystocele - rectocele - lacerated cervix. leucorrhoea.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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). Admitted in good physical condition. Is quite fleshy - very quiet in behavior - careless in appearance - obstinate in a great many ways. Has to be forced to go to meals - Son says she probably had a sunstroke to which her trouble might be attributed. Delusions of persecution.

Personal and Medical History of Ingebor Dollefsond.

1900

This patient was brought here by Sheriff deputy E.K. Blixrud, attended by S.L. Fosseseth (sons) in apparently good physical condition with the following history: No history of consanguinity nor heredity: No intemperance on patient nor parents: First symptoms of insanity manifested July 3' 1900. Began by making the household imagined some one was going to injure him & carry him away: Disease appears increasing. Not variable: Has delusions on a great many subjects: Is disposed to injure others: Habits filthy & destructive: No previous premonitions noted: No severe diseases nor injuries to head: No confinement nor restraint employed: Has been treated by several physicians without success. On personal examination talks incoherently. On admission put upon Infirmary G.H.& Rpt. Complexion dark: Hair brown: eyes gray: Skin normal: Eruption on back: Several bruises on body, legs & arms: Is clean: Has 13 upper & 7 lower teeth: all in bad condition: Behavior quiet: Talks fairly well & is very anxious to go home!

Sept 10 to Sept 25 Summary 14 day record by Dr. Heyerdale: First night out of bed all night. Stood with back against the door: has hallucinations, delusions & incoherence of speech: During first week Temp. 98⅘ - 100⅘ Pulse 74 to 108: Resp. 19-22. Appetite good: bowels quite regular: after second night slept well: May quiet: talks incoherently: pulls hair down: resists when taken to dining room, after which, lowers, the eats: Sept. 13 up and dressed: Sept. 15 Visited by son: out of bed greater part of night: Sept. 16 Did a little work in dining room: During 2nd week P. R. normal: Appetite poor: bowels somewhat constipated: May quiet: does not converse: slept well: resisted when taken to meals: If allowed to do so will wander about and aimlessly: Oct. Appetite poor: Fed by nurse: Bowels constipated require laxatives: Sleeps poorly: Does not care to go out of doors: Does not speak English: Is resistive & sometimes very noisy: often requires sleeping doses: Very difficult to manage: Trans. to C. - Oct. 29. Sept. 15 & 30 Visited by son & daughter. Oct. 28 by relatives. Nov. 26 by son. Nov. 17. Wt. 170#.

Dec - Feb 28 1901 General health & appetite good: Bowels regular: Sleeps well. Takes outdoor exercise: Is clean & neat. At times extremely noisy. resistive Given 20 gr. trional 3x day: General condition improved.

Jan 4 1901. Visited by son. Tres 26. Vaccinated: Mch 3. Wt. 141#.

Mar 1 - June 1 - 1901 No change in mental or physical condition. May 18 visited by son and friend; May 30 visited by daughter. May 29 Wt. 127#

June to Sept. Usually noisy at night, habits dirty, careless in appearance, July 10 visited by daughter, is noisy, violent and resistive most of the time

Personal and Medical History of

1901

strikes other patients occasionally, requires holding very often; physically is losing; was taken with slight emesis Aug. 29 taken to Inf. and put on light diet; Sept. 2 visited by son; Sept. 5 by daughter; was given liquid diet: occasionally fed mechanically; has lavage of stomach: was taken home Sept. 5, 1901

Dec to Feb 1903 Patient is noisy most of the time: does not speak or understand English. Talks incoherently to herself. Does not menstruate. bowels regular: appetite good: does no work but exercises. Usually requires hypnotics. Nov. 12th Visited by son. Nov. 27th Wt 122#

Personal and Medical History of Celia Thronson

Whole No. 5661
Residence, St. Paul, Minnesota.
Date Admission, September 17, 1900
Admitted by Dr. O.C. Heyerdale hour, 7 P.M.
How Sent, E.W. Bazille Dep. Ramsey Co.
Sex, female Age, 17.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, None.
Degree Education, Common school.
Profession, Religion, Methodist.
Habits, Not intemperate.
Nativity, Norway (Parents also born there)
Physicians Committing, Arthur Swenny & C.A. Gneiss
Correspondents, Magnus Thronson 347 St. Lawrence St. St. Paul, Minn.

No. of Year, 24
Insane Relatives, None
Cause Exciting, unknown.
Cause Predisposing, unknown.
Form, Acute Mania
Accompanying Bodily Disorder, Uncleanness
Suicidal or not, Not.
Date of this Attack, Sept. 13, 1900
Duration, 4 days.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 17 yrs.
Time of Leaving, Dec. 21, 1900
Time in Hospital, 3 mon. 4 days.
Result, Discharged Recovered. Apr. 30, 1901.

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Sept. 19, 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick.
MEMORY, Past Events, good.
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,
Normal.

DELUSIONS, Systematized, Transitory, Special Subjects,
Religious delusions - also thinks she is sick.
HALLUCINATIONS, of hearing.
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, Only a short time.
ONSET, Gradual or Sudden, Sudden.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, 45 - well.
Paternal Relatives, healthy.
Mother, 50 well.
Maternal Relatives, healthy
Brothers and Sisters, 3 sisters 1 brother
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Pneumonia when 2½ years old.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches. Vertigo.
OCCUPATION, Healthy or not, Housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Regular. Irregular. Constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 9 PRESENT WEIGHT, 113. USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, Skin normal.
TONGUE, Coatings or Promptness of Movement, Coated, prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size large - response 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, exaggerated. Other Reflexes, elbow & wrist present.
ARTICULATION, Slurred, Hesitating, Slow, good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Normal
ARTERIES,
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,

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical.
Expansion good.
B. sounds normal.
EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Genitals normal - Leucorrhoea
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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 been quiet & tractable since first day or two when she refused to be bathed but finally submitted. She also threw down her tray and acted stubborn - since has caused no trouble - Physical condition good. Patient has a fair common school education.

Personal and Medical History of Celia Thronson.

1900

This patient was brought here by Sheriff's deputy W.H. Lamb, attended by Magnus Thronson (father) in fair physical condition, with the following history: No consanguinity, heredity nor intemperance in patient nor parents: First symptoms of insanity manifested Sept 13 1900. became irrational, violent & destructive: Disease appears increasing: Not variable: Derangement now manifested by screaming, violence & disturbed conduct: Disease not variable: No rational intervals: Attacked patient at city hospital: Habits filthy & destructive: No peculiarities previously manifested: During last six months has been sick a great deal: Has been at city & co. hospital: Restraint & sedative treatment employed:
On personal examination is restless: morose: sleepless: violent: scratches face: constantly attempts to escape.
On admission put up on Infirmary W (G.H.M. Cpt. Complexion dark: Hair light brown: eyes gray: Skin in normal condition: Small scars on back, right hand & nose: both elbows bruised: has vermin: Very dirty: Has 15 upper & 16 lower teeth: Resisted being bathed: Has delusions.)

Sept 15-19 (Summary 14 da. record by Dr Heysedale) Hypodermic given on admission: slept about six hours the first night: Temp. Pulse & Resp. about normal: appetite good: bowels regular: Sept. 21 medicine given: noisy at times: expressed hallucinations & delusions. Sept 26 threw tray at heater and broke dishes: Slept well that night: promised she wouldn't do anything of the kind again: rested during day in bed: slept well at night thereafter:

Sept. 18 Up and dressed: did not seem very well: went to bed again: quiet, intelligent, agreeable: Second week temp. pulse & resp. normal: appetite good: bowels regular: medicine three times daily: slept well. Sept 30 Up and out of doors: Sept. 19. Threw tray on floor at breakfast time said God told her to do it. Sept. 29 Put on ward: General health improved: menstruates regularly: Sleeps fairly well. Oct. 30 Up on ward: assists with work. At times somewhat disagreeable. Dec 21. Allowed to go home-

Personal and Medical History of

Personal and Medical History of Kerstí Hakanson

Whole No. 562
Residence, Jackson Co. Minn
Date Admission, Sept. 18. 1900
Admitted by Dr. O.C. Heyerdahl hour, 1 p.m.
How Sent, C. H. Dunbar J.P. Jackson Co.
Sex, female Age, 53
Civil Condition, married
Children, six
Age Youngest Child, nine
Occupation, housewife - husband farmer.
Degree Education, common school
Profession, Religion, Lutheran
Habits, temperate so far as known
Nativity, Sweden - parents also.
Physicians Committing, Frank R. Hanson & Jos. H. Dudley
Correspondents, Morten Hakanson, Dundee, Minn. (husband)

No. of Year, 25
Insane Relatives, brother
Cause Exciting,
Cause Predisposing, heredity
Form, (acute) Mania with delusions
Accompanying Bodily Disorder,
Suicidal or not, not suicidal. Disposition to injure others
Date of this Attack, Sept. 12. 1900
Duration, since Sept. 12.
No. of Attack, Not 1st.
No. of Admission, 1st.
Age First Attack, 51
Time of Leaving, Sept. 19 1900.
Time in Hospital, 1 day.
Result, Dischg. unimproved Feb 6. 1901.

EXAMINATION ON ADMISSION BY DR. Heyerdahl *Date of* Sept 19 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
seems quite clear & quick.
MEMORY, Past Events,
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert.
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 Dulness, Silliness, Loss of Will Power, Slight Melancholy, or Exaltation.

HISTORICAL.

LENGTH INVASION, About 2 yrs.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, dead
Paternal Relatives, healthy.
Mother, living - well.
Maternal Relatives, healthy.
2 Brothers and 1 Sisters,
10 children 6 living 4 dead.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Always very sick after confinement.
HABITS, Drinking and Smoking, excessive Coffee drinker
HEADACHES, Often VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, poor Appetite, poor and Bowels, constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft PRESENT WEIGHT, 150 # USUAL WEIGHT, NUTRITION, Quite good.
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, White coating - very prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation,
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, present. Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
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,

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 the 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). In fair physical condition. Speaks no English so information obtained from daughter. Is quiet & tractable & answers quickly & quite well - Remained in hospital only over one night. On following day was taken home again by daughters.

Personal and Medical History of Hersh Hakanson

1900

This patient was brought here by M. B. Dunn, attended by Emma Hakanson in fair physical condition, with the following history: No history of intemperance known. nothing known as to consanguinity: Brother residing at Lennon Falls is insane: First symptoms of insanity manifested ~~two~~ year and a half ago: attacks have occurred periodically since then lasting from a few hours to a day. First symptoms of present attack manifested Sept. 12, 1900 - by hallucinations and violence at times - Disease appears increasing - in variable with rational intervals. Derangement now manifested by thinking his husband intimate with other woman: Imagines herself persecuted: Sees ghosts: thinks arm and leg broken - is disposed to injure others: not suicidal, filthy nor destructive: Extremely religious: reads Bible constantly: no injury to head nor nervous disease known. Has not been confined nor restrained: Has been quieted by bromides:
On personal examination:- Great agitation: very talkative on many subjects: Incoherent. On admission put upon Infirmary Ward. (F. H. N. Rpt.) Complexion dark: hair brown part gray: eyes gray: condition of skin normal: mark on right groin like a burn: no scars: a few small bruises on arms: dirty: behavior quiet: has delusions.

Sept. 18 to Oct. 3rd (Summary Notes 14 day record by Dr. Heyerdahl) Resisted somewhat on admission: Slept all night. Temp. 100⅖ at 5 a.m. Sept. 16 Appetite fair: expresses some delusions: rested during morning: visited by daughters + taken home in afternoon by them.

Discharged

Personal and Medical History of

Personal and Medical History of Bertha Fischer

Whole No. 5665

Residence,

Date Admission, Sept. 19. 1900

Admitted by Dr. L. A. Linton hour, 7 pm.

How Sent, Judge of Probate Hennepin Co.

Sex, female Age, 29 yrs.

Civil Condition, single

Children, —

Age Youngest Child, —

Occupation, dressmaker

Degree Education, common school

Profession, Religion, Methodist Episcopal

Habits, not intemperate

Nativity, Germany - Parents also. Resident of State + County for nine years

Physicians Committing, Chas Northrop + F. Jones.

Correspondents, Mrs. Mary Fischer 1511½ 4th St. S. Mpls. (or Hellen Fischer)

No. of Year, 28

Insane Relatives, paternal aunt

Cause Exciting, unknown.

Cause Predisposing, heredity

Form, Chr Melancholia

Accompanying Bodily Disorder, uterine troubles

Suicidal or not, not suicidal

Date of this Attack, 5 years ago

Duration, 5 years

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 24 years.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Haydale *Date of* Sept. 25 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
somewhat confused at times

MEMORY, Past Events,

Recent Events, fair. Special Subjects,

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

REASONING POWER, Ordinary Subjects,

Special Subjects, fair.

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
somewhat 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 Dulness, 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, one sister.

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

HABITS, Drinking and Smoking, appear good.

HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo - fainting spells.

OCCUPATION, Healthy or not, dressmaker

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

Sleep, Appetite, and Bowels, Good / Good / Regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal.

TONGUE, Coatings or Promptness of Movement, Coated - prompt.

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

SIGHT, has worn glasses.

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

HEARING, fair - better in Right ear.

COORDINATION, Arms, Legs, good Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands.

PATELLAR REFLEX, present. Other Reflexes, Knee - wrist.

ARTICULATION, Slurred, Hesitating, Slow, slow.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, None Strength, Sounds, Size, Fair / N.

Apex Beat, N. Regularity, regular.



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.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion good.
Breath sounds normal.

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Normal.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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). On admission physical condition rather poor - emaciated. Mentally depressed - at times talks quite rationally + answers questions well - occasionally incoherent for a few moments. Is quiet + of a gentle disposition - has rather weak intellect - Has probably overworked + married a great deal - Mental trouble a mild form of melancholia.

Personal and Medical History of Bertha Fischer

1900

This patient was brought here by A W Phillips - deputy Sheriff attended by Mrs Samuel, in fair physical condition with the following history: No history of intemperance or consanguinity in patient or parents: paternal aunt insane: first symptoms of insanity manifested about five years ago - by hysterical weeping, "ideas that people are wronging" - disease appears increasing, variable: worse during menstrual periods. derangement now manifested by incessant and incoherent talking, sleeplessness, wandering from home - Results control at times by Striking - Could under mild treatment: not disposed to injure others except by Striking when opposed in her wishes: not suicidal, filthy nor destructive - no previous peculiarities, severe disease or head injury. Has been mildly restrained at home: cause of disease unknown - Has uterine trouble - painful menstruation - Has received no special treatment of late years. On personal examination - talked incoherently: unsteady walked around refused to submit to oral examination. Somewhat emaciated in body: manner quiet and composed: On admission but upon Infirmary Ward (U. H. N. Rpt.) Complexion dark: hair brown: eyes brown: skin normal: no marks, scars or bruises: clean. has a tendency to goitre. Has four upper and nine lower teeth + several roots: quiet: Has delusions:

Sept. 19 to Oct. 4. - (Summary Nurse's 14 day Record) On admission had some incoherence of speech - expressed some delusions - Slept well the first night with aid of hypodermic: Temp. during first week 98-100: pulse 48-106: Resp. 15-20. appetite fair. bowels somewhat constipated. medicine three times daily: Slept well during first week: Sept. 27 up and dressed: very quiet and pleasant: talked quite sensibly: Somewhat depressed: physical condition poor: During second week condition same as above: Assisted with dining room work.

Nov 20 & 21 1900 Visited by mother & on Dec 24 by sister. Dec 30 Assists with ward work: Is neat: Sleeps well: Takes occasional Cathartics: Expresses some delusions: appetite good: Takes out door exercise. Attends chapel: Jan 1. Visited by mother Jan 11 1901 Trans. to 33. Very quiet & has little to say to anyone: Seems melancholy & dull & stupid. Jan 13 Visited by mother. Jan 14 by sister. Somewhat depressed mentally. Feb 26 Visited by mother Feb 26 Wt. 106 lbs. General health good. Vaccinated: Apr 23 1901. Appetite good: General health good: Bowels regular Sleeps well: Takes out door exercise: Assists with work. Visited today by mother who took her home.

June to Sept 1901 June 6 received on D1; talks incoherently and is quite resistive, June 8 visited by friend, June 30 by mother: sleeps fairly well: bowels regular; appetite fair: July 18 menstruated: complained of pain and cramps, July 31 taken home by mother. Feb. 6. 1902 received on Inf. W. bathed and put to bed: very resistive: put in seclusion in P.M.: converses in German: sleeps well: appetite good: bowels regular: Feb. 9 up on ward: excited for several days resistive and inclined to be violent: bruised and cut nurses finger by closing door on it: Feb. 20 visited by mother: Feb. 20 has improved is agreeable: Feb. 27 Wt. 100 lbs: Mar. 10 patient rather stupid; is resistive and stubborn; menstruating; fought with Mary Merrill: Mar 11 visited by mother: Apr. 6 was put to bed menstruating Apr. 13-17 visited by mother: May 5 patient in bed short time seemed weak: May 8 visited by mother: June 2 Wt. 98#. June 1st. 1902 menstruating: is somewhat weak and has lost some in weight was put to bed for few days: given cathartic: is resistive and talks to herself a good deal June 29 was visited by mother and taken home on trial Dec to Feb 1903. Wt about 96# July 27th Visited by mother also on Sept 18th, Jan 6th, Nov 23rd, and Feb 11th.

Personal and Medical History of

Personal and Medical History of Minnie Smith

Whole No. 5666

Residence, St. Paul, Minn.

Date Admission, Sept. 20, 1900

Admitted by Dr. H.C. Heyerdale hour, 7 pm.

How Sent, C.W. Bazille, judge of Probate Ramsey Co.

Sex, female Age, 27 years

Civil Condition, married

Children, -

Age Youngest Child, -

Occupation, Housekeeper - husband waiter.

Degree Education, Common School

Profession, Religion, Lutheran

Habits, not intemperate

Nativity, Minnesota, Parents Germany - Resident of State 27 yrs. of county, 17 yrs.

Physicians Committing, Louis A. Nelson & V.J. Hawkins.

Correspondents,

No. of Year, 2nd

Insane Relatives, none

Cause Exciting, ulcer of Stomach

Cause Predisposing, ulcer of Stomach

Form, Melancholia delusional

Accompanying Bodily Disorder, ulcer of Stomach

Suicidal or not, not

Date of this Attack, Six weeks ago

Duration, Six weeks

No. of Attack, 1

No. of Admission, 1

Age First Attack, 27 years.

Time of Leaving, Jan. 7 1901

Time in Hospital, 3 mos. 18 da.

Result, Discha. Recovered Apr. 30 1901

EXAMINATION ON ADMISSION BY DR. Heyerdale Date of Sept 26 1900

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, good.

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, good.

Special Subjects,

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 - Cancer of stomach

Paternal Relatives, living - Rheumatic

Mother, living Rheumatic

Maternal Relatives,

Brothers and Sisters, 8/
No children.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Typhoid 7 yrs. ago. Rheumatism.

HABITS, Drinking and Smoking, Drinks some beer.

HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo.

OCCUPATION, Healthy or not,

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

Sleep, Appetite, and Bowels, for last few weeks.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in PRESENT WEIGHT, 87# USUAL WEIGHT, NUTRITION, poor.

WOUNDS, Abnormalities and condition of Skin, normal.

TONGUE, Coatings or Promptness of Movement, slight whitish coat. prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, unequal - large - Left eye hurt when a child. Miposis normal.

SIGHT, good.

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

HEARING, impaired on Right

COORDINATION, Arms, good Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands.

PATELLAR REFLEX, present. Other Reflexes, Mist jerk

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Mod. mitral regurgitation.

Apex Beat, Regularity, regular.



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

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion good.
Breath sounds normal

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Enlarged ducts of glands of Bartholine - Offensive leucorrhoea cervicitis

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 admitted in poor physical condition & emaciated. Has an ulcer of stomach. An acquaintance says she has led a dissipated life for some time. Mentally clear - answers questions well. Admits that name is fictitious. Says she does not wish her mother to know where she is. As yet she has expressed no delusions.

Personal and Medical History of Minnie Smith.

1900

This patient was brought here by Sheriff's deputy attended by Mrs. John Bruns, in poor physical condition with the following history: History of consanguinity, but does not remember. Last parents or grandparents were related: no history of heredity in patient or parents. First symptoms of insanity manifested two weeks ago by delusions. Disease appears increasing, variable with irregular rational intervals. Derangement now manifested by wandering about nights with the delusion that her room is filled with children and frogs and cats. Not disposed to injure others, not suicidal, filthy nor destructive: no previous pronounced, acute disease or head injury: has not been restrained or confined: ulcer of stomach is supposed cause of disease: nothing known as to treatment: On personal examination, has had family trouble and parted from her husband three years ago. On admission put upon Infirmary Ward (St. H. N. Rpt.) complexion dark: hair brown: eyes gray: skin hot and dry: no marks: scar on left foot caused by burn: said to have gastric ulcer: right knee bruised: clean: has 14 lower and 15 upper teeth: quiet: talks intelligently.

Sept 29 to Oct. 5. (Summary 14 day record by Dr. Heyerdale) Slept well first night: During first week temp. 99⅖ to 100⅘ Pulse 80-100: Resp. 20-24: Appetite poor: bowels regular: medicine 3 times daily: slept well: expressed delusions in talking: rested during day: vomited: vomited 9 a.m. on examination found to have ulcer of stomach: liquid diet given: remained in bed during 2nd week. Temp. pulse & resp. normal: liquid diet given: medicine given regularly: bowels regular: slept well: quiet: somewhat depressed: frequently asked to be sent home: said she was improved physically: did not feel nausea nor pain in stomach as at first.

Oct. 15 Neat. Assists with work: Expresses no delusions: Physical condition fair. Takes regular outdoor exercise: Bowels regular: Sleeps well. Talks very rationally & intelligently: Seems somewhat depressed. Nov 30, 1900. Has improved slightly. Jan. 7. No change.

Jan 7 Allowed to go home today.

Discharged.

Personal and Medical History of

Personal and Medical History of Charlotte Roache

Whole No. 5672
Residence, St. Paul, Ramsey Co.
Date Admission, Sept. 28. 1900
Admitted by Dr. L. G. Linton hour, 7 30 p.m.
How Sent, C. W. Bazille, J. of P. Ramsey Co.
Sex, female Age, 55
Civil Condition, widowed
Children, two
Age Youngest Child, 36
Occupation, Cook - Husband laborer.
Degree Education, uneducated
Profession, Religion, Methodist (Colored)
Habits, Not intemperate
Nativity, Near Nashville Tenn. Parents also Tennessee.
Physicians Committing, Chas F. Denny & Finley C. Spates
Correspondents, Elizabeth Roache, (daughter) 454 Rondo St St Paul.

No. of Year, 35
Insane Relatives, none known
Cause Exciting, Uterine Tumor
Cause Predisposing, previous attack
Form, Acute Mania (Religious delusions)
Accompanying Bodily Disorder, Large Myo-fibroma of uterus.
Suicidal or not, Threatened but never attempted suicide
Date of this Attack, Sept. 22. 1900
Duration, one week
No. of Attack, has had several
No. of Admission, 1st
Age First Attack, 54
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Hoyerdale *Date of* Sept 29 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear. quick.
MEMORY, Past Events, good.
Recent Events, do. Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert.
REASONING POWER, Ordinary Subjects,
Special Subjects, good
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Slightly 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 Dulness, 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).
No history
Father, Dead. Killed by overseer in South
Paternal Relatives,
Mother, Dead.
Maternal Relatives,
Brothers and Sisters, One child
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Paralysis - Small pox.
HABITS, Drinking and Smoking, good.
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches Vertigo
OCCUPATION, Healthy or not, Cook
Detail Date, Duration, and Character of Previous Attack, if any,
none
Sleep, Appetite, and Bowels, good good Constipated.

Re Charlotte Roache

See letter of Elizabeth L. Bean, 89 Iglehart St. St Paul, Minn. relative to actions and conduct of patient necessitating her return. (letter dated Feb 6/1901)

since her return home from Hospital, she has not ceased one day showing that she was mentally unbalanced. She got home Dec 21 last; walked the streets from noon till 5 30 p.m. that night, she told of mistreatment of nurses, telling how they abused her - that Dr. Aradella(?) gave her she had a large amount of money - she had strange delusions Eg. she was to be Queen of this country; God intended she should reform the World. On Jany 26, she took a religious streak "God telling her to do certain things - Acted queerly when talked to about these things, flourishing a knife &c - on Sunday morning she took a hand bell, fruit, cake &c & acted strangely during services. On monday night, shouted & prayed until she fell in a dead faint - claimed she had been poisoned &c - subsequently put herself under Surgical treatment.

Chas

July 23/1901

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

Peculiarities in Shape,

GYNECOLOGICAL EXAMINATION, Fibroma of uterus.

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

Give condensed statement of the 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). Admitted in good physical condition considering that she has a large fibroma of uterus. Mentally clear. Feels well. memory good. Has had no education but talks well. worries because not here & very anxious to go home. Has some delusions in regard to daughter also of a religious nature.

Personal and Medi

Whole No. 5672

Residence, St. Paul, A

Date Admission, Sept. 28 1900

Admitted by Dr. L. G. Linton hour, 7:30 p.m.

How Sent, C. W. Bazille, J. of C. Ramsey Co.

Sex, female Age, 45

Civil Condition, widowed

Children, Two

Age Youngest Child, 26

Occupation, Cook - Husband Laborer.

Degree Education, uneducated

Profession, Religion, Methodist (Colored)

Habits, Not intemperate

Nativity, Near Nashville, Tenn. Parents also Tennessee.

Physicians Committing, Chas S. Denny & Emily C. Spates

Correspondents, Elizabeth Roache, (daughter) 454 Rondo St. St Paul.

Cause Exciting, Uterine Tumor

Cause Predisposing, previous attack

Form, Acute Mania (religious delusions)

Accompanying Bodily Disorder, Large Myo-fibroma of uterus.

Suicidal or not, Threatened but never attempted suicide

Date of this Attack, Sept. 22. 1900

Duration, One week

No. of Attack, has had several

No. of Admission, 1st

Age First Attack, 54

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Skyrdale *Date of* Sept 29 1900

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, good.

Recent Events, do. Special Subjects,

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

REASONING POWER, Ordinary Subjects,

Special Subjects, good

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Slightly 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 Dulness, 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 Dead. Killed by overseer in South

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

Brothers and Sisters, One child

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
paralysis - Small pox.

HABITS, Drinking and Smoking, good.

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches - Nervous

OCCUPATION, Healthy or not, Cook

Detail Date, Duration, and Character of Previous Attack, if any,
none

Sleep, good Appetite, good and Bowels, constipated.

RECEIVED OCT 1 ROCHESTER STATE HOSPITAL

St Paul
Oct. 12, 1900

Dr. A. F. Kilbourne:
Dear Sir:

Mrs. Roache has gone three and four weeks, yes longer before she shows any signs of mental trouble.

She would have spells of crying, grieving because people seem to be against her trying to do her injury such as poisoning, locking in jail and stealing her food and money. I was ill at St Joseph Hospital three weeks in Sept., and my mother got it in her head that some friends of ours had hidden me away from her. She would go to Dr. Denny's office, all confused, asking I am not anxious to keep her down there and as soon as she is in condition to leave please inform me But she has to be watched closely for she may not show sign for a month, just as soon as her bowels are allowed to go several days without taking medicine she will go to pieces.

The people for whom she last worked were Mr & Mrs. L. F. Sohrill 886 Laurel Ave,

Respectfully
Elisabeth Roache
454 Rondo St.

Expansion good.
Breath sounds normal

Volume,
Peculiarities in Shape,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Fibroma of uterus.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, good.

BOWELS, Present Condition,

Give condensed statement of the 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). Admitted in good physical condition considering that she has a large fibroma of uterus. Mentally clear - Talks well - memory good. Has had no education but talks well - worries because kept here & very anxious to go home - Has some delusions in regard to daughter also of a religious nature.

Personal and Medi

Whole No. 5672

Residence, St. Paul, Ramsey Co.

Date Admission, Sept. 28. 1900

Admitted by Dr. L. G. Linton hour, 7 30 p.m.

How Sent, C. M. Bazille, J. of P. Ramsey Co.

Sex, female Age, 55

Civil Condition, widowed

Children, Two

Age Youngest Child, 26

Occupation, Cook - Husband Laborer.

Degree Education, uneducated

Profession, Religion, Methodist (Colored)

Habits, Not intemperate

Nativity, Near Nashville, Tenn. Parents also Tennessee.

Physicians Committing, Chas F. Denny & Finley C. Spates

Correspondents, Elizabeth Roache, (daughter) 454 Rondo St. St Paul.

Insane Relatives, none known

Cause Exciting, Uterine Tumor

Cause Predisposing, previous attack

Form, Acute Mania (Religious delusions)

Accompanying Bodily Disorder, Large Myo-fibroma of uterus.

Suicidal or not, Threatened but never attempted suicide

Date of this Attack, Sept. 22. 1900

Duration, One week

No. of Attack, has had several

No. of Admission, 1st

Age First Attack, 54

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Guyerdale *Date of* Sept 29 1900

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, good.
Recent Events, do. Special Subjects,

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

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

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Slightly 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 Dulness, 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).
No history
Father, Dead killed by overseer in South

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

Brothers and Sisters,
One child

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
paralysis - Small pox.

HABITS, Drinking and Smoking, good.

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches Vertigo

OCCUPATION, Healthy or not, Cook

Detail Date, Duration, and Character of Previous Attack, if any,
none

Sleep, good Appetite, good and Bowels, constipated.

and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 10 in PRESENT WEIGHT, 189 lbs USUAL WEIGHT, NUTRITION, good.

WOUNDS, Abnormalities and condition of Skin, normal.

TONGUE, Coatings or Promptness of Movement, clear - prompt.

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

SIGHT, wears glasses.

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

HEARING, fair

COORDINATION, Arms, good. Legs, do. Grasp,

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

PATELLAR REFLEX, absent Other Reflexes, Met - elbow.

ARTICULATION, Slurred, Hesitating, Slow, good.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Mitral regurgitant - Sounds weak
Apex Beat, Regularity, Regular.



ARTERIES,
Slightly sclerotic.

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion good.
Breath sounds normal

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

GYNECOLOGICAL EXAMINATION, Fibroma of uterus.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, good.

BOWELS, Present Condition,

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,

Give condensed statement of the 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). Admitted in good physical condition considering that she has a large fibroma of uterus. Mentally clear - Talks well - memory good. Has had no education but talks well - worries because sent here & very anxious to go home - Has some delusions in regard to daughter also of a religious nature.

Personal and Medi

Whole No. 5672

Residence, St. Paul, Ramsey Co.

Date Admission, Sept. 28. 1900

Admitted by Dr. L. G. Linton hour, 7 30 p.m.

How Sent, C. W. Bazille, J. of P. Ramsey Co.

Sex, female Age, 55

Civil Condition, widowed

Children, Two

Age Youngest Child, 26

Occupation, Cook - Husband laborer.

Degree Education, uneducated

Profession, Religion, Methodist (Colored)

Habits, Not intemperate

Nativity, Near Nashville, Tenn. Parents also Tennessee.

Physicians Committing, Chas. F. Denny & Farley & Sparks

Correspondents, Elizabeth Roache, (daughter) 454 Rondo St. St. Paul.

Insane Relatives, none known

Cause Exciting, Uterine Tumor

Cause Predisposing, previous attack

Form, Acute Mania (Religious delusions)

Accompanying Bodily Disorder, Large Myo-fibroma of uterus.

Suicidal or not, Threatened but never attempted suicide

Date of this Attack, Sept. 22. 1900

Duration, One week

No. of Attack, has had several

No. of Admission, 1st

Age First Attack, 54

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Guyerdale *Date of* Sept 28 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Clear - quick.

MEMORY, Past Events, good.

Recent Events, do. Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

alert.

REASONING POWER, Ordinary Subjects,

Special Subjects, good

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Slightly 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 Dulness, 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).

No history

Father, Dead Killed by overseer in South

Paternal Relatives,

Mother, Dead.

Maternal Relatives,

Brothers and Sisters, 4 One died

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

Paralysis - Small pox.

HABITS, Drinking and Smoking, good.

HEADACHES, VERTIGO, OR CONVULSIONS, Headaches - Vertigo

OCCUPATION, Healthy or not, Cook

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

none

Sleep, Appetite, and Bowels, good good Constipated

and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 10 in. PRESENT WEIGHT, 189 lb. USUAL WEIGHT, NUTRITION, good.

WOUNDS, Abnormalities and condition of Skin, normal.

TONGUE, Coatings or Promptness of Movement, clear - prompt.

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

SIGHT, wears glasses.

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

HEARING, fair

COORDINATION, Arms, good. Legs, do. Grasp,

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

PATELLAR REFLEX, absent Other Reflexes, Mict - elbow.

ARTICULATION, Slurred, Hesitating, Slow, good.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Mitral regurgitant - Sounds weak

Apex Beat, Regularity, Regular.

ARTERIES,

Slightly sclerotic.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

Chest symmetrical Expansion good - 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, Fibroma of uterus.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, good.

BOWELS, Present Condition,

Give condensed statement of the 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). Admitted in good physical condition considering that she has a large fibroma of uterus. Mentally clear - Feels well - memory good. Has had no education but talks well - worries because sent here & very anxious to go home - Has some delusions in regard to daughter also of a religious nature.

Personal and Medical History of Charlotte Roache

1900

This patient was brought here by Julius Newmann, attended by Elizabeth Roache, in good physical condition with the following history:- No history of intemperance, none known as to heredity: nothing known as to consanguinity: Symptoms of insanity have been manifested during the past 12 months, in attacks lasting one week or more: First Symptoms of present attack manifested on Sept. 22nd, 1900. by depression + Suicidal tendencies and threatening to strike her daughter: disease appears increasing: Variable with irregular rational intervals - melancholia: Derangement now manifested by mental depression, - mind bewildered, - talks to herself: Once has shown disposition to injure her daughter. Has threatened suicide at times during past 12 months but never attempted it: not filthy nor destructive: no peculiarities noticed previous to one year and a half ago: Has large supposed fibroma of uterus which is supposed cause of disease: Has received general treatment with galvanism to growth: Has not been confined or restrained. On personal examination: There is a slight mental confusion + day which is greatly increased during her depressed intervals. On admission (G. H. N. Rpt) put upon Infirmary ward: Colored woman: Black hair + eyes: Skin normal: no marks or scars. a few dark places on back: clean. Has 6 upper + 11 lower teeth + a few roots: quiet. talk: intelligently

Sept. 22 (Summary 14 da record by Dr Heyerdal) Sept. 22 - Oct 4 Temp. pulse + resp. about normal. Appetite good
to occasional cathartics given. On admission was quiet in manner
Oct. 14 except that she constantly asked why she was brought here. Restless a few hours the first night + for several nights afterward. Up + dressed on 30th. + commenced assisting with work. Very discontented + constantly asking to go home: quite agreeable + very quiet. During second week appetite good: Refused medicine after first few days: Bowels regular: Slept well at night: Took regular out door exercise. Assisted with work: Cannot understand why sent here.

Oct 30 Neat. Assists with work: Frequently has homesick spells. Takes out door exercise General health good: Nov 8 Attempted to escape while out walking.

Nov 30. Quite depressed. Asks to be sent home: Walks up + down hall.

Dec 31. Allowed to go home on trial. Jan 30 Returned - (See letter attached) Was very much disturbed at home + expressed religious delusions. Very quiet here. Talks freely + says there is no reason why she should be here.

Feb 28 Wt. 195#. Of late very quiet but stubborn + obstinate. Does no work: gives cathartics: Refuses out door exercise: Refuses to go to chapel - Vaccinated.

Personal and Medical History of

Mar. to June 1901 Mar. 17 patient in good general health, has large fibroid tumor of the uteris, refuses to have operation, bowels constipated, has many delusions of persecution. thinks that people in the hospital are to blame for her being here, at times scolds some. May 29 Wt. 196#. June to Sept. Patient does some work on the ward, refuses out door exercise, is resistive when attempts are made to bathe her or change her clothing, is noisy and sings at times Aug. 19 Wt. 190#.

Sept. to Dec. Is very disagreeable on the ward, has little or nothing to do with those about her. does some crude simple embroidery, at times is noisy and sings religious songs. does not like to take out door exercise, at times scolds and is inclined to be violent when baths are given. Nov. 15 Wt 194#.

Dec to Feb 1903 No change. Wt about 210#.

Personal and Medical History of Rachel Hidden

Whole No. 5674

Residence, Waconia Dodge Co, Minn.

Date Admission, Sept. 29. 1900

Admitted by Dr. Kilbourne hour, 7:30 P.M.

How Sent, Transferred from Fergus Falls.

Sex, Female. Age, 51 yrs.

Civil Condition, Single

Children, Three.

Age Youngest Child,

Occupation, none

Degree Education, none

Profession, Religion, None.

Habits, Bad.

Nativity, Canada.

Physicians Committing, –

Correspondents,

No. of Year, 37

Insane Relatives, Brother

Cause Exciting, Epilepsy

Cause Predisposing, Heredity

Form, ~~Epileptiform Insanity~~ Epileptic Dementia.

Accompanying Bodily Disorder, Epilepsy

Suicidal or not, not.

Date of this Attack, 1865

Duration, 35 yrs.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 16 yrs.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Reynolds *Date of* Oct 4 1900

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Very fair

Recent Events, " Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert - quite correct.

REASONING POWER, Ordinary Subjects, Very fair

Special Subjects,

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 8 PRESENT WEIGHT, 127# USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, Skin normal.

TONGUE, Coatings or Promptness of Movement, Clear

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. Size Normal. Responds do

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, present Other Reflexes, none.

ARTICULATION, Slurred, Hesitating, Slow, good.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, No 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, Slight laceration of perineum - rectocele - cystocele - external haemorrhoids - Cochial Lipoma.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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 admitted in fair physical condition. Mentally her condition is practically unchanged since leaving here.

Personal and Medical History of Rachel Holden

Personal and Medical History of

1901

This patient was returned from the Fergus Falls Hospital, at her own request. by Miss Lyon. No accompanying history. She was transferred to Fergus Falls from here on February 14' 1899- for her previous history see Vol 3. Fol. 4. No. 365.

Sept 9 On admission put upon Infirmary. (Gtn. Opt) Complexion dark: hair gray. eyes brown: Skin in normal condition: is clean: no marks, scars nor bruises Has 7 upper + 9 lower teeth. Behavior quiet: Has delusions.

Sept 9 to Oct. 14 Admitted on Inf. Ward (Summary 14 da record by Dr Heysdale) Appetite good: Bowels regular: Quiet + agreeable on ward: Sleeps well at Night: Takes out door exercise: Sept 20 had a convulsion. Oct 1 Dressed + up on ward. Oct 5. Had two convulsions. Irritable afterward- Generally agreeable but occasionally scolds. Takes out door exercise: Not changed in any way since leaving here. Oct 11 Trans. to D'.

Oct 7 + Nov 1. Convulsions. Nov. 19 Trans. to D 3. Nov. 28 Wt. 127#. Dec. 7 Had a convulsion. Fell bruising left side of head + eye. Jan 31 Had a convulsion fell injuring head. Feb 24. Vaccinated successfully. Feb 28 Put on Course of trional 10 gr. 3x day. This seems to control convulsions: more quiet. Does not scold so much. Attends chapel + amusements: Neat + Clean: Goes riding + walking. Mch 4. Wt. 133#.

June to Sept. June 10 convulsion; June 20 fought one of the patients; July 21 again fought patient; July 25 convulsion in falling received bruise and slight cut over right eye; July 28 convulsion; Aug. 23 struck a patient with the broom; is very disagreeable and extremely noisy at times, is neat and clean, takes out door exercise, Sept. 1st. Wt. 128#.

Sept. to Dec. Sept. 8-14-26 had convulsion; Sept. 17 complained of severe pain in left side; slight attack of pleurisy; plaster applied; Oct. 19 up on ward Nov. 13-14-15 had convulsion: Nov. 30 Wt. 128 1/4#.

Dec to Feb 1902 Patient has frequent convulsions. Receives frequent falls in this way often bruising and cutting her face; is very disagreeable; noisy and restless preceding and following her convulsions. Scolds a great deal: does no work but attends amusements and takes exercise; General health fairly good. sleeps well: eats well: Dec 1st Wt 129. At her best is rather silly and feeble minded. Answers simple questions readily and intelligently.

Personal and Medical History of Ada Huebner.

Whole No. 5675
Residence, St. Paul, Minnesota.
Date Admission, October 9th 1900.
Admitted by Dr. O.C. Heyerdale hour, 7 P.M.
How Sent, Ex. Bazille J. of P. Ramsey Co.
Sex, female Age, 38 yrs.
Civil Condition, single
Children, —
Age Youngest Child, —
Occupation, Housework (father a contractor)
Degree Education, Common school.
Profession, Religion, Not a church member.
Habits, not intemperate
Nativity, Germany (Parents also born there)
Physicians Committing, A. L. Whitcomb & Wm. Archibald
Correspondents, Chas. F. Huebner 1081 Arcade St., St. Paul, Minn.

No. of Year, 31.
Insane Relatives, none.
Cause Exciting, unknown.
Cause Predisposing,
Form, Acute Melancholy (defective)
Accompanying Bodily Disorder, unknown.
Suicidal or not, attempted - morphine - croton oil.
Date of this Attack, 2 mos. ago.
Duration, 2 mos.
No. of Attack, 2
No. of Admission, 1 here - at City Hospital, St. Paul.
Age First Attack, 35 yrs.
Time of Leaving, Feb. 9' 1901.
Time in Hospital, 4 mos.
Result, Discharged - Improved - May. 1' 1901

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Oct 10' 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
very clear - quick.
MEMORY, Past Events, good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert - correct.
REASONING POWER, Ordinary Subjects, seems very good.
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
very slightly 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 Dulness, 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, 68 - (feeble)
Paternal Relatives, history negative.
Mother, died - cardiac trouble.
Maternal Relatives, history negative
2 Brothers and 5 Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
none
HABITS, Drinking and Smoking, good.
HEADACHES, VERTIGO, OR CONVULSIONS, none
OCCUPATION, Healthy or not, housework.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, good/ good/ constipated

Personal and Medical History of Ada Huebner.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 2 in. PRESENT WEIGHT, 113 lbs. USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, Club foot R. Left somewhat so.
TONGUE, Coatings or Promptness of Movement, prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, unequal - large & irregular. fair response to light - non response to accomodation.
SIGHT, poor
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, nystagmus. strabismus.
HEARING, quite good.
COORDINATION, Arms, Legs, poor. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands. slight of tongue & facial muscles.
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, good.
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,

GYNECOLOGICAL EXAMINATION, uterus enlarged. cervix soft. closed. leucorrhoea. vagina cyanotic. appears to be pregnant - has not menstruated since July 10. external Haemorrhoids.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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). In rather poor Physical condition. mentally seems very rational & talks clearly - says she has never had any education nor advantages. Owing to eye trouble, has never been able to study or read - yet she is quite intelligent & talks well. Says she has had a hard time in life has always lived at home, & has been abused by step-mother. Does not express any delusions. Says she has attempted suicide owing to shame of her condition - admits being 3 Mos. pregnant. So deformed physically - Club-footed atrophied hands & arms. mental derangement acute melancholia of a mild form. As to low mental grade due to lack of opportunity & education. Seems naturally bright & quick.

Personal and Medical History of Ada Huebner.

1900

This patient was brought here by Sheriff's deputy Hanson attended by Mrs. C. F. Huebner (mother) in fair physical condition, with the following history: No consanguinity, heredity nor intemperance none: First symptoms of insanity manifested three years ago, have been almost constant since: Was at City Hospital in St. Paul & was temporarily helped. About two months ago attempted suicide by use of morphine: Disease appears increasing: Is variable: Derangement now manifested by nymphomania, mind seems to dwell constantly upon sexual intercourse: Not disposed to injure anyone: No filthy nor destructive habits manifested: Before accession of disease sexual passions predominant: No severe diseases nor head injuries since two years old: No treatment pursued no confinement employed, except at City hospital: No further facts noted on personal examination. (On admission put

Oct 9. upon Infirmary Wrist. Complexion dark: hair brown: eyes gray: Skin normal: has ulcer on great L. toe. Is dirty: R. eye crossed: hands & feet deformed: Has 14 upper & 10 lower teeth: Is quiet: Talks intelligently: Says she is pregnant.)

Oct 9 to Oct 23 Summary 14 da. Record by Dr. Kilpatrick. Admitted on Infirmary. During first week temp. pulse & resp. normal. Appetite good: Tongue grim: Bowels regular: Large toe very sore due to ingrowing nail: Bi-chloride compresses applied: Sleep good: up & dressed ab Oct 10th. Oct. 13 Toe continues very sore: Local anaesthetic applied & nail removed: Bichloride compresses applied: Quite restless until night of 15th. Second week. Temp. pulse & resp. normal. Appetite good: medicine grim & occasional cathartic: Slept well at night: Toe improved. Nov. 20 No change: Occasionally disagreeable about going to bed & getting up: Dec. 30, 1900 Up on ward: Appetite good: Bowels regular: Talks intelligently: Neat: very quiet: Converses freely: Complains of nausea due to pregnant condition: Has Rheumatism in bed part of time: Does not feel well enough to be about on ward.

Feb 9. Taken to City Gen. Hospital St Paul by Dr Linton.

Discharged.

Letter received from Dr. A.B. Ancker Apr. 21. states that patient gave birth to female child on Apr. 20. No change mentally. Dr. Kilbourne wrote recommending that she be sent to Faribault.

Personal and Medical History of

Personal and Medical History of May Dorn.

Whole No. 5676
Residence, St. Paul, Minn.
Date Admission, October 11 1900.
Admitted by Dr. E. J. Warnans hour, 7 P.M.
How Sent, E.W. Bazille & A.P. Ramsey Co.
Sex, female Age, 23 yrs.
Civil Condition, married
Children, one.
Age Youngest Child, 3 yrs.
Occupation, housewife.
Degree Education, common school.
Profession, Religion, not a church member.
Habits, confirmed alcoholic(?)
Nativity, New York (Parents also born there)
Physicians Committing, J.J. McNamara & Lt. Penny
Correspondents, Mrs. E. M. Banker, 814 Raymond Ave. St Anthony Park, Minn. (mother)
husband John Dorn see Vol. 45 Fol. 217 No. 5517.

No. of Year, 39.
Insane Relatives, maternal uncle.
Cause Exciting, Ill usage.
Cause Predisposing, Hereditary degeneracy.
Form, Subacute mania (hysterical)
Accompanying Bodily Disorder, none known.
Suicidal or not, attempted to cut throat.
Date of this Attack, One year ago.
Duration, one year.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 22 yrs.
Time of Leaving, 3rd July 1901.
Time in Hospital, 8 mos 22 ds
Result, Recovered: Discharged Nov 27/1901

EXAMINATION ON ADMISSION BY DR. Meyerdale *Date of* Oct. 12 1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick.
MEMORY, Past Events,
Recent Events, Good. Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert - correct.
REASONING POWER, Ordinary Subjects,
Special Subjects, good.
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
normal at present.

DELUSIONS, Systematized, Transitory, Special Subjects,
apparently none.

HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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. was nervous.
Paternal Relatives,
Mother, Living. appendicitis
Maternal Relatives, uncle died apoplexy.
Brothers and Sisters,
Child,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Fell from barn 40 ft. - when five years old. Striking on head.
HABITS, Drinking and Smoking, good.
HEADACHES, VERTIGO, OR CONVULSIONS, Headaches.
OCCUPATION, Healthy or not, housework.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Good Appetite, Good and Bowels, Reg.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 8 in PRESENT WEIGHT, 90 lbs USUAL WEIGHT, NUTRITION, good
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, slight coat. 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, good Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands.
PATELLAR REFLEX, exaggerated. Other Reflexes, elbow + wrist present.
ARTICULATION, Slurred, Hesitating, Slow, good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, accentuated Sounds, Size,
Apex Beat, Regularity,
ARTERIES,
normal.
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical. Expansion good. hyperresonance - asthmatic



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 haemorrhoids uterus retroflexed: cervix congested. leucorrhoea. cervix slightly lacerated.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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). Talks rationally + clearly - expresses no delusions. Seems very nervous + has probably received little discipline. Has had a very sad married life. Has been separated from her husband for two years. He was brutal + deserted her + she says attempted to dispose of child. Threw it on street car track. Acute melancholia is nearest type of insanity.

Personal and Medical History of May Dorn.

1900

This patient was brought here by sheriffs deputy, Jno. A. Moak, attended by her mother with the following history:- Patient in fairly good physical condition. No consanguinity. Maternal uncle insane. History of intemperance noted. First symptoms of insanity manifested one year ago by despondency, irritability, attempts at self destruction. Dsease increasing, is variable. Derangement now manifested by thinking that her people are conspiring against her: works herself into a violent rage: has attempted suicide by cutting throat. Not disposed to injure others. No filthy nor destructive habits. No peculiarities previously shown. Patient received injury to head when 5 yrs. old. No confinement nor restraint employed. Medical treatment pursued. On personal examination hereditary degeneracy with uterine trouble as a complication, found to be cause of disease.

Oct 11 On admission put upon Infirmary West. (G.H.N. Rpt.) Complexion fair hair brown: eyes blue: skin in normal condition: A few small scars on feet and one on head caused by a fall. Is clean: third toes on both feet short. Has 11 upper + 12 lower teeth: Behavior quiet. Talks intelligently.)

Oct 11 to Oct. 25 (Summary 14 da. record by Dr. Reynolds) Received on Infirmary. Talked very readily + rationally. Temp. pulse + resp. normal during first week: appetite good: Medicine given t.i.d. Bowels regular with occasional cathartics: Slept well at night: quiet + agreable during day: Talked sensibly + intelligently: up + dressed on Oct. 17th. Has asthma. Second week - Little change. Tonics, medicine for asthma + occasional cathartics given. Bowels regular. Intelligent + agreable, Assisted with ward work.

Oct 30 Visited by friends. Nov 1 - Feb 28, 1901 Neat: quiet: agreable: Assists with work: Also does fancy work. Sleeps well: appetite good. Bowels regular: Occasionally goes to bed for a day or two + Complains of some pain: Somewhat Hypochondriacal: Has some pain when menstruating. Feb 26 Menstruated: Feb 28. Wt. 126#

Mar. to June 1901 Mar. 6 trans. to A 2 West, no change, May 30 Wt. 95#.

June to Sept. July 3 Patient in good general health, has occasional attacks of asthma neat in habits and appearance, bright and cheerful, seems perfectly well mentally very agreeable on ward, does not express any delusions, assists with ward work, takes regular out door exercise, July 3 went home this A.M.

— Discharged. —

Personal and Medical History of

Personal and Medical History of Mary Quinnihan

Whole No. 5677
Residence, Washington Co. Minn.
Date Admission, October 12' 1900.
Admitted by Dr. O. G. Hayerdale hour, 7 P.M.
How Sent, F. J. Wilson J of P. Wash. Co.
Sex, female Age, 60 - 75.
Civil Condition, widowed.
Children, One.
Age Youngest Child, 45 yrs.
Occupation, farmers wife.
Degree Education, none.
Profession, Religion, Catholic.
Habits, unknown.
Nativity, Ireland (Parents also born there)
Physicians Committing, E.O.B. Freligh G.H. Watier
Correspondents, J. Quinnihan Oak Park. Stillwater Minn.

No. of Year, 40
Insane Relatives, unknown.
Cause Exciting, Cerebral haemorrhage.
Cause Predisposing, unknown.
Form, Senile dementia.
Accompanying Bodily Disorder, Cerebral haemorrhage.
Suicidal or not, not.
Date of this Attack, some yrs. ago.
Duration, years.
No. of Attack, 1st
No. of Admission, 1st here.
Age First Attack, ?
Time of Leaving,
Time in Hospital,
Result,

See letter 1/10/02 from Frank Berry - Stillwater Minn
Dayhig I Ref had been appointed Guardian

EXAMINATION ON ADMISSION BY DR. Hayerdale *Date of* Oct. 13' 1900

MENTAL CHARACTERISTICS.

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

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

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,
ILLUSIONS,
The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 - old age.
Paternal Relatives,
Mother, does not know about her.
Maternal Relatives,
Brothers and Sisters, 7 Well. 1 soon 45 yrs old.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Has had smallpox & some fever - does not know what.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not,
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, Bowels,

Personal and Medical History of

4p/397 3677
M Mary Quinnehan
Copy of Order for Hearing Petition of T.M. Quinnehan
for appointment of said petitioner or some other suitable person as guardian for said Mary Quinnehan insane; served and service admitted November 2nd 1900
(Papers filed with commitment papers.)

ACTERISTICS.

SUAL WEIGHT, NUTRITION, fair.
te coating.
- normal response to accom - poor.
eye
t in R. eye. partial.

Grasp,
Other Reflexes, elbow & wrist.

TREMORS, Hands, Tongue, Facial Muscles, General, none
PATELLAR REFLEX, present
ARTICULATION, Slurred, Hesitating, Slow, normal.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, good Size, N.
Apex Beat, N Regularity, irregular

ARTERIES,
Sclerotic.

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest symmetrical
Expansion fair
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,

Jan 27/1901 GYNECOLOGICAL EXAMINATION, External Genitals normal; uterus retroverted. hard (?) hypertrophied hypertrophies about vaginal orifici, which bleed at touch: has something of the appearance of a maligant involvement.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character,
BOWELS, Present Condition,

Give condensed statement of the 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).
Admitted in fair physical condition - Mental condition one of senile dementia
Is a person of meagre education

Personal and Medical History of Mary Quinnihan

Whole No. 5677

Residence, Washington Co. Minn.

Date Admission, October 12' 1900.

Admitted by Dr. O. C. Heyerdale hour, 7 P.M.

How Sent, F. T. Wilson J. of P. Wash. Co.

Sex, female Age, 60 - 75.

Civil Condition, widowed.

Children, one.

Age Youngest Child, 45 yrs.

Occupation, farmers wife.

Degree Education, none.

Profession, Religion, Catholic.

Habits, unknown.

Nativity, Ireland (Parents also born there)

Physicians Committing, E.O.B. Freligh G.H. Mattier

Correspondents, T. Quinnihan Oak Park. Stillwater, Minn.

See letter 1/7/02. from Frank Berry Stillwater minn saying I he had been appointed Guardian

No. of

Insane

Cause

Cause

Form,

Accom

Suicid

Date

Durati

No. of Attack, 1st

No. of Admission, 1st hos.

Age First Attack, ?

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Oct. 13' 1900

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Rather poor.

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

REASONING POWER, Ordinary Subjects, poor

Special Subjects,

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or Dulness, 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 - old age.

Paternal Relatives,

Mother, does not know about her.

Maternal Relatives,

Brothers and Sisters, 3 Well. 1 son 45 yrs old.

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

Has had smallpox + some fever - does not know what.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

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

Sleep, Appetite, Good Fair and Bowels,

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1 PRESENT WEIGHT, 106½ USUAL WEIGHT, NUTRITION, Fair.

WOUNDS, Abnormalities and condition of Skin, normal.

TONGUE, Coatings or Promptness of Movement, prompt - white coating.

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

SIGHT, fair in L. eye. poor in R. eye

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, cataract in R. eye. partial.

HEARING, Good ~~in R. ear~~

COORDINATION, Arms, good. Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, none

PATELLAR REFLEX, present Other Reflexes, elbow + wrist.

ARTICULATION, Slurred, Hesitating, Slow, normal.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, N.

Apex Beat, Regularity, irregular



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,
Sclerotic.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical
Expansion fair
breath sounds normal

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

Albumen, Sugar,

Casts and Crystals,

June 27/1901 GYNECOLOGICAL EXAMINATION, External Genitals normal; uterus retroverted. hard (?) hypertrophied hypertrophies about vaginal orifice, which bled at touch: has something of the appearance of a malignant involvement.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character,

BOWELS, Present Condition,

Give condensed statement of the 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).

Admitted in fair physical condition - Mental condition one of senile dementia
In a person of meagre education

Personal and Medical History of Mary Quinnihan.

1900

This patient was brought here by sheriff's deputy Dr. P. Alvig attended by Mrs. M.A. Young, in fair physical condition, with the following history: First symptoms of insanity date from a paralytic stroke some years ago: Disease appears increasing; not curable: Patient now entirely irresponsible: wanders about: not disposed to injure anyone: Habits filthy & destructive: No previous peculiarities known: No information concerning heredity, consanguinity nor intemperance in patients parents. Has been confined to room: county farm: city hospital: Has been given sedative treatment. On personal examination entirely irresponsible talk incoherent. On admission put upon Inf. N. (G.H.N.Rpt. complexion
Oct 1st dark: eyes gray, hair gray: Skin normal: Scars on face & body from smallpox. Is clean: has 3 upper & 3 lower teeth: Behavior quiet. Is rather confused.)

Oct 1st to Oct 4 (Summary 14 da. record, Dr. Heyerdale) Oct 1st admitted on Infirmary: Given bath & put to bed: Talk incoherent & expressed many delusions & hallucinations: Restless & out of bed. Temp. pulse & resp. normal: appetite good: bowels regular. Medicine given regularly: up on ward on Oct. 15th. Walked about hall aimlessly. Called to door: thinks she hears voices about her. A case of senile dementia: Has cataract of R. eye: At times somewhat noisy & scolds. Complains of pain in shoulder: Liniment applied daily.
Second week: Appetite good: Medicine given: Bowels regular: noisy & out of bed at night. Complains of some pain in back & shoulder. Probably rheumatism. Trans. to D3 Oct 20 Oct 24 In bed during day with pain in back: up Oct. 25th Nov. 28 Wt. 106#. Quite meddlesome & troublesome
Jan 5 1901. Vaccinated. Jan 30 - Feb. 6 Sick in bed with cold: Medicine given:
Feb 17. Pushed against wall by another patient - & right eye & head slightly bruised. Feb 18 Trans to B'. Appetite fair: Bowels regular: Sleeps well. Untidy: expresses delusions: At times talks a great deal to herself. Does not seem to realize where she is. Wt. 109#
Mar 1 June 1 No change in mental or physical condition; takes no exercise; does no work. May 28 Wt. 118#. June to Sept. 1901
Condition both mentally and physically remains about the same; wanders about the ward aimlessly knocking at the doors and imagines that some one is talking to her; at times is quite noisy, stubborn and violent; slaps and scratches other patients; at times has hysterical spells of crying; at times talks quite intelligently; has to be dressed and undressed by the nurses, Aug. 31 Wt. 116#.
Sept. to Dec. Oct. 18 face became swollen, had a number of teeth extracted; was put to bed; Oct. 21 up on ward, Nov. 30 Wt. 119#.
Dec to Feb 1903 No change. Wt. 108# Patient very feeble: Oct 6th fell causing deep cut in little finger of left hand which was dressed. Patient seems

Personal and Medical History of

to be failing in ability to walk. Appetite poor: bowels regular. does not sleep well. Is at times quite noisy: Talks to herself a great deal: Is entirely incoherent: Never gives intelligent answers to questions. Is quite childish. Nov. 25th Wt 130#.

Personal and Medical History of

Whole No.	No. of Year,
Residence,	Insane Relatives,
Date Admission,	Cause Exciting,
Admitted by hour,	Cause Predisposing,
How Sent,	Form,
Sex, Age,	Accompanying Bodily Disorder,
Civil Condition,	Suicidal or not,
Children,	Date of this Attack,
Age Youngest Child,	Duration,
Occupation,	No. of Attack,
Degree Education,	No. of Admission,
Profession, Religion,	Age First Attack,
Habits,	Time of Leaving,
Nativity,	Time in Hospital,
Physicians Committing,	Result,
Correspondents,	

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

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,	HISTORICAL.
	LENGTH INVASION,
MEMORY, Past Events,	ONSET, Gradual or Sudden,
Recent Events, Special Subjects,	HEREDITY (Question concerning Insanity, Consanguinity, Epil-
PERCEPTIVITY, Alert or Dull, Correct or Illusive.	epsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
	Father,
REASONING POWER, Ordinary Subjects,	Paternal Relatives,
Special Subjects,	Mother,
Own Mental State,	Maternal Relatives,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,	Brothers and Sisters,
	PROMINENT DISEASES (especially Typhoid Fever, Sunstroke,
	Head Injuries, and Surgical Operations),
DELUSIONS, Systematized, Transitory, Special Subjects,	
	HABITS, Drinking and Smoking,
	HEADACHES, VERTIGO, OR CONVULSIONS,
HALLUCINATIONS,	OCCUPATION, Healthy or not,
ILLUSIONS,	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 Dulness, Silliness,	Sleep, Appetite, and Bowels,
Loss of Will Power, Slight Melancholy, or Exaltation.	

Examined for photographs.
all in that can be taken
except.
1 Heimke
2 Raymond
3 Gasahl.