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

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August 20, 2018

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Respectfully,

Egbert Tilden Chambers.

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Almquist	Stellena ad. Corlnie	137	Have before: has been in other hospitals
Anderson	Jennie	165	
Anderson	Anna #2	357	

Bindleman	Ora	65	
Broadhag	Pauline	81	Recom'd
Bierbaum	Christina E. W	157	
Bertrand	Cathie J.	233	heretofore as "Catha Jones" - Feb-5/89 - Feb 5/89
Bolt	Eliza	317	3d admission fee.

Cosgrave	Jennie	5	
Christianson	Olena	61	2nd ad.
Connors	Mary	73	
Carpenter	Eliza Jane	121	
Cole	Bell	141	Has been in Poorhouse Nelsville Wis
Cole	Barbra (Barbara)	193	Confined at St. Peter for 5 Years
Carroll	Ellen	221	
Conlin	Nora G.	253	9th ad.
Cooper	Eliza A.	261	
Carlson	Hannah	273	
Chase	Rebecca	301	(Hannah Jones-Harrison House - 9th)
Cook	Melissa F	389	

Doherty	Julia	169	(Has been treated at St Joseph's Hospl)
Darcy Mary	Elizabeth	209	
Duhamel	Louise	365	was in C & County Hospital before Consumption
Dills	Jessie	373	

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

Elle	Catherine	89	has been in C & C Hosp. St. Paul.
Erickson	Emma	97	In California (1892): In Fergus Falls (1895)
Earl	Julia	329	was at Jamestown, N. Dak, hospital.

Farrell	Margaret or Margate	109	
Faulhaber (al. Maggie Berry)	Margaret	185	Steve twice before.
Fretteim	Inga A.	353	5th admission
Foley	Mary	377	

Griffith	Annie A.	113	
Gould	Mabel C.	145	
Galloway	Bernice (Colored)	241	
Goddard	Martha A.	257	2nd ad.
Golish	Wilhelmina	337	

Hendry	Kate	69	
Hallond	Hannah	117	
Hammer	Hannah	129	
Hass	Mary	245	
Haugen	Annie Marie	325	
Hofmeister	Caroline	369	

Joyce	Hannah	229	here before – also at Detention	Hospital
Jacobs	Jessie	381		

Kaisen	Mary	#	
Kult	Josephine	77	
Kelliher	Mary	259	(has been at St Joseph's Hospital)
Kjelset	Ellen	341	

Livingston	Ida G.	17	2nd ad.
Lawrence	Ellen	29	
Lathrop	Cordelia A	53	
Lange	Katie	205	was at St Luke's Hospital
Luxa	Mary	305	has been in "City Lock up" : also at "Poor Farm"
Littlefield	Emma	333	
Larson	Mary #3	149	

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Morisette	Elizabeth	101.	Was at St Peter (1884)
Meyers	Anna M	125	Recommd (Rec before May 1-95 to Sept 25/95)
Martin	Mary	213	Has been in C+C Hospital St Paul.
Murphy	Mary Jane	314	
Mulcare	Mary	313	
Meyers	Margaret A.	321	
Moody	Ida S.	314	2nd admission.

Mchean	Elsie	45	
Mc Grath	Annie #2	393	2nd admission.

O'Brien	Johannah al Josephine	133	3rd Commt.
Ogilsbee	Mary	173	
Obery	Tillie	177	
Olson	Ella	385	Was at St Peter: Tuscaloosa, Ala. & Detention Hosp: St Paul

Paukratz	Bertha	237		
Peterson	Mary	281		
Quinn	Sarah	57		
Quinn	Bridget	225	here twice before — also at St Peters	
Quinette	Clarinda	289		

Rose	Ella	1	
Rheinhart	Mary	297	from City Hospital St. Paul
Rameker	Mary	see	slip attached in case-book.

Schmitz	Elizabeth	9		
Schramm	Eunice A.	71		
Stone	Margaret	75		
Swanson	Sarah	37		
Snyder	Emma	49		
Swanson	Emma	85		
Swisse	Jennie	93		
Simms	Sarah	153	3d Commt. (was also at St. Peter Transferred from that hosp. to this)	
Schmidt	Wilhelmina	187	(Brotka, Frank Seymour, Committed Today)	4-9/33
Stroup	Mary A	189	has been at St. Peter Hospital	
Sullivan	Laura B.	197	Here before	
Stummel	Ella	201		
Swanberg	Emma	265		
Shiverick	Emily G.	293		
Simmons	Josephine	309		
Smith	Nellie H.	345	was at Mineral Lake Wash.	

Sawyer	Judith K.	361	

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Trustdell Truesdell	Fannie Frances E	217	See before Apl 16/95 – Mar 27/1900	

Vincent	Mrs. Mary	33	
Van Dyk	Frances	161	(was in hospital at Neuremberg Holland)
Vaughn vaughan	Sarah A	277	

Williams	Anna	13	
Wallace	Michael Wm	105	
Whited	Laura M	285	

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Personal and Medical History of

Personal and Medical History of

Personal and Medical History of Ella Rase

Whole No. 5780

Residence, Mayville, Houston Co. Minn.

Date Admission, October 19 1900

Admitted by Dr. O. C. Heyerdale hour, 4th PM.

How Sent, L. Budahl J. of P. Houston Co.

Sex, female Age, 28 yrs.

Civil Condition, Married.

Children, none.

Age Youngest Child, -

Occupation, Laborer.

Degree Education, Common school.

Profession, Religion, Roman Catholic.

Habits, Not Intemperate (Father drank)

Nativity, Ohio. Parents born in Ireland.

Physicians Committing, W. Browning - D. C. Rhines.
Became resident of State Co. 20 yrs ago.

Correspondents, David Hynes (bro.) Caledonia - 7 mi. East - in country. Taken out of State.

No. of Year, 43

Insane Relatives, Uncle - paternal. - Cousin (double)

Cause Exciting, Poor health.

Cause Predisposing, unknown,

Form, Acute Melancholia (delusions)

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, Threatened.

Date of this Attack, One year ago.

Duration, One year.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 27 yrs.

Time of Leaving, Mch 14 1901 -

Time in Hospital, 5 mo. 5 da -

Result, Discharged Improved - May 11 1901

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Oct. 20 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear - somewhat sluggish.

MEMORY, Past Events, Very fair.

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, fair.

Special Subjects,

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
says she has been dosed with medicines + it has injured her. Also thinks she has been persecuted.

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 a year.

ONSET, Gradual or Sudden,

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

Father, died - Cancer of stomach - a hard drinker

Paternal Relatives, 2 uncles 1 Cousin insane

Mother, died - after operation.

Maternal Relatives, Healthy.

2 Brothers and 2 Sisters, well.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says not.

HABITS, Drinking and Smoking, drank much tea.

HEADACHES, VERTIGO, OR CONVULSIONS, frequent dizzy spells of late.

OCCUPATION, Healthy or not, Housework.

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

Sleep, fair Appetite, fair and Bowels, Quite regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 2 in. PRESENT WEIGHT, not taken. USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, whitish coating - prompt.

TONGUE, Coatings or Promptness of Movement,

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 - slight of tongue.

PATELLAR REFLEX, present. Other Reflexes, elbows - wrist.

ARTICULATION, Slurred, Hesitating, Slow, hesitating.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, strong n.

Apex Beat, Regularity, Regular

ARTERIES,
normal.

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,
Chest symmetrical + well developed.
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,

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. Mentally depressed + expresses many delusions of persecution; also about medicine given her. Refused to take medicine at home of late. Condition probably one of acute melancholia with delusions. She seems to have been a woman of very fair intelligence. Is extremely nervous + somewhat hysterical + emotional in manner.

Personal and Medical History of Ella Rose

1900

This patient was brought here by sheriff's deputy N.H. Forsyth attended by Mrs. Neal Gavin with the following history:- No consanguinity: Paternal uncle + one cousin insane: Father intemperate: First symptoms of insanity manifested one year ago: by religious mania: Disease decreased: So variable + rational for two or three weeks + then worse for a few days: Derangement now manifested by religious delusions: Says someone has taken her soul from her: Is disposed to injure others: Has threatened suicide: No filthy nor destructive habits: Before accession of disease was easily offended + displayed a violent temper: Never was very strong: Was confined for a few days at commencement of disease: also received treatment from local physicians for a short time: On personal examination very quiet leaned against sister as if asleep: Answered questions.

Oct 19 On admission put upon Infirmary (G.A.R. Cpt. Complexion dark: hair brown: eyes blue: skin hot + dry So clean: Has 9 upper + 14 lower teeth: Behavior quiet: Talks intelligently (but does not converse freely.)

Oct 19 (Summary 14 do. Record by Dr. Heyndale) Admitted on Infirmary, given bath + put to bed: Nervous + expressed delusions about herself: said she was sick: was very resistive Temperature, pulse + respiration normal: Medicine prescribed but generally refuses it. Sleeps well at night. Very languid in manner, sleeps during day. Thinks she is sick - is very discontented. In an impaired physical condition

o up on ward all week - very quiet. Second week. Temp. pulse + respiration normal. Appetite good: Refuses medicine: Bowels regular: Sleeps well: Quiet on ward: Has very little to say + lounges about most of time.

Oct 30. Neat: very quiet: At times quite depressed: Does not often converse with other patients: Very languid in manner: General health good.

Jan 17. Given electrical treatments. Feb 28. Vaccinated. Wt 117½ lbs. Mch 10 Bd with grippe: getting along very nicely: Mch 18 up on ward: Assists with work + has improved somewhat mentally of late: Physically very well: Takes outdoor exercise: Is quiet: Converses intelligently: Appetite good: Writes many letters to husband: Mch 24 Visited by Husband + taken home -

Discharged

Personal and Medical History of

Personal and Medical History of Jennie Cosgrove.

Whole No. 5681
Residence, St. Paul, Minnesota.
Date Admission, October 19 1900.
Admitted by Dr. L.A. Linton hour, 7 PM.
How Sent, E.W. Bazille J of P. Ramsey Co.
Sex, female Age, 33 yrs.
Civil Condition, married
Children, Three
Age Youngest Child, one year.
Occupation, Housewife (husband a janitor)
Degree Education, Common school.
Profession, Religion, Not a church member.
Habits, Not intemperate.
Nativity, Norway (Parents also born there)
Physicians Committing, C. F. Denny + Haldor Sneve
Correspondents, Chas Cosgrove. Seville Flats - Kent + Selby Ave. St Paul, Minn

No. of Year, 44
Insane Relatives, none known
Cause Exciting, Ill-health following childbirth.
Cause Predisposing, unknown
Form, Acute Melancholia with delusions.
Accompanying Bodily Disorder, ill health generally.
Suicidal or not, Threatened.
Date of this Attack, Sept 1. 1900
Duration, about 6 weeks.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 33 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Oct 20/1900

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.
REASONING POWER, Ordinary Subjects,
Special Subjects, Fair
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
depressed.
DELUSIONS, Systematized, Transitory, Special Subjects,
of persecution. Says she has not been well treated.
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, many headaches
OCCUPATION, Healthy or not, housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Fair Appetite, Good and Bowels, Constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1 PRESENT WEIGHT, 106 USUAL WEIGHT, NUTRITION, fair.
WOUNDS, Abnormalities and condition of Skin, Skin normal -
TONGUE, Coatings or Promptness of Movement, Clear - prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal. size large - responses good.
SIGHT, fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, fine of tongue + hands.
PATELLAR REFLEX, present. Other Reflexes, elbow + wrist present.
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, No Murmurs, Strength, Sounds, good Size, N -
Apex Beat, N. Regularity, regular
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,

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, Cervicitis - lacerated eroded + hypertrophied cervix. profuse thick 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 fair physical condition Seems to have a slight cold. Talks well. has a good memory + seems fairly well educated. Expresses some delusions especially of persecution. Says she has been abused + badly treated by her husband.

Personal and Medical History of Jennie Cosgrove.

1900

This patient was brought here by sheriffs deputy Hanson attended by husband, in fair physical condition, with the following history: No history of consanguinity, heredity nor intemperance in patient nor her parents. First symptoms of insanity manifested about Sept. 1/1900 had an attack of excitement & talked loudly. Disease appears increasing in variable. Derangement now manifested by delusions of persecution. Spirits people with devils have united to persecute her by looks, talk & acts: calls to them to stop it. No filthy nor destructive habits. No previous peculiarities. No severe diseases nor injuries to head. Confined in County

Oct 19 jail three days. No treatment pursued. On personal examination talked quite rationally: pale & careworn in appearance: says people are banded against her. On admission put upon Infirmary. Gen. Rpt. Complexion dark: hair brown: eyes brown: skin in normal condition. No marks, scars nor bruises. So clean. No teeth except artificial upper plate. Talks intelligently.

Summary 14 day record by Dr Heysdale. Admitted to Infirmary bathed & put to bed.

Oct 19 to Nov 3 Very quiet in behavior. Slept 8 hours during night. During first week temperature about normal. Appetite fair. Bowels regular with occasional cathartics. In bed all week. Slept poorly at night. Complained of pain in chest. Has severe cold: coughs & expectorates a good deal. Up on morning of 22 quite weak & went back to bed. Very melancholy & expresses some delusions of persecution. During second week temp. pulse & respiration normal. Appetite only fair. Cathartics required & medicine for cold. Also occasional hypnotics. Up on ward during day. Quite disturbed latter part of week & had many delusions of persecution. Nov 20 Neat in habits. Very much depressed: wanders aimlessly about ward or stands in corner. Occasionally asks to go home. Appetite rather poor: sleep fair. Bowels constipated. Nov 30 Visited by husband. Dec 30 Visited by husband. Up on ward. Appetite good. Has extra diet. Sleeps well. Expresses delusions. Takes regular outdoor exercise. Quiet Feb 4 Visited by husband. Feb 9/01 Somewhat destructive at times & when disturbed. is somewhat noisy. Feb 28/01 Vaccinated. Wt. 112#. Mar. to June 1901 Apr. 14 trans. to B. 3, patient is very melancholy, seldom converses, receives regular gynecological treatment three times a week and takes medicine regularly. May 29 Wt. 108#. June to Sept. Does not assist with ward work, no change, July 19 visited by husband, very melancholy, cries, now and then attempts to run away. Aug. 29 Wt. 109#. Sept. to Dec Oct. 2 visited by husband Oct. 4 improved, taken home by husband.

Personal and Medical History of Jennie Cosgrove

1901 Nov. 6 returned, assists with ward work, quiet and agreeable, takes out door exercise, general health good, somewhat melancholy, very quiet. Nov. 29 Wt. 127#.

Dec to Feb 1903. No change Wt 110 #.

Personal and Medical History of Elizabeth Schmitz

Whole No. 5682
Residence, 223 Western Ave., St. Paul, Minn.
Date Admission, October 19 1900
Admitted by Dr. L.A. Linton hour, 7 PM
How Sent, E.W. Bazille J. of P. Ramsey Co.
Sex, female Age, 24 yrs.
Civil Condition, married
Children, Two.
Age Youngest Child, Two years.
Occupation, housewife
Degree Education, Good.
Profession, Religion, Catholic
Habits, Intemperate
Nativity, Germany (Parents also born there)
Physicians Committing, W.S. Miller + Omachel
Correspondents, Michael W. Schmitz c/o G. Sommers + Co. St. Paul.

No. of Year, 45
Insane Relatives, Brother was at Oshkosh.
Cause Exciting, Intemperancy + Degeneracy.
Cause Predisposing, Probably heredity.
Form, sub acute mania due to intemperance and excesses.
Accompanying Bodily Disorder, ~~none mentioned~~
Suicidal or not, not.
Date of this Attack, one year ago.
Duration, one year.
No. of Attack, 1st.
No. of Admission, 1st
Age First Attack, 24 yrs
Time of Leaving, Nov 12 1900.
Time in Hospital, 24 days.
Result, Dischg. Recovered Feb 5 1901

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Oct. 22 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, gradual
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, died - some lung trouble
Paternal Relatives, negative
Mother, living - well.
Maternal Relatives, negative
Brothers and Sisters, well.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Erysipelas when young.
HABITS, Drinking and Smoking, drank much beer - at time became intoxicated daily
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, normal

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 PRESENT WEIGHT, 115½ USUAL WEIGHT, NUTRITION, good.
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, fair - wears spectacles
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, good - Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, fine of tongue - present of hands -
PATELLAR REFLEX, present. Other Reflexes, elbow - wrist
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, Genitals normal. cervix + uterus hypertrophied: endometritis - cervicitis - erosion - leucorrhoea profuse - excoriation about genitals.
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 Appetite good. Seems somewhat nervous. Admits drinking a great deal of intoxicating liquor. denies other charges indicated on commitment papers. Is bold + loud in manner but acts rationally + does not express any delusions.

Personal and Medical History of Elizabeth Schmitz.

1900

This patient was brought here by Sheriff's deputy A. Lawton attended by Michael Schmitz in fair physical condition with the following history.- No history of heredity given but one brother insane: not consanguinity known. Patient intemperate: First symptoms of insanity manifested one year ago: commenced to visit colored men: Disease appears increasing & variable,-worse before menstruating. Derangement now manifested by nymphomania (nymphalia) Not disposed to injure anyone. No filthy nor destructive habits: No previous peculiarities manifested: No severe diseases nor injuries to head: No confinement nor restraint employed: No treatment pursued.
On personal examination no further facts learned-
On admission put upon Infirmary (Gen'l Rpt. Complexion normal hair brown: eyes blue: small mark under left eye: Says husband struck her: Right leg bruised & scratched. Is dirty: Has 14 upper & (four front) & 15 lower teeth: Is dirty: Talks intelligently.)

Oct. 19 (Summary by Dr Reynolds - 14 days record) Received on Infirmary: Quiet. Slept about 3 hrs. during night. Talked very intelligently: Expresses no delusions: Says she has been drinking intoxicating liquors & is very nervous. Temp. pulse & resp. normal- Medicine given T.D.D. also hypnotics. Appetite good: Bowels regular.

Oct 23rd. up & dressed on ward. Rather boisterous & disagreeable: Slept well at night Took out-of-door exercise. Second week - Appetite good: Bowels regular: Medicine given - & hypnotics for sleep. Up & about on ward: Takes regular exercise: Is more cheerful: Talks intelligently: Expresses no delusions. Occupies herself with fancy work etc. Nov 11 Shows no change except that she is less nervous: Takes regular exercise: Appetite good: Sleeps well at night More quiet & agreeable Nov 17 Was taken home by husband.

Discharged.

Letter from husband Jan 16 1901- states that for two weeks after going home she was very nervous after that fully recovered & attended to work

Personal and Medical History of

Personal and Medical History of Anna Williams.

Whole No. 5685
Residence, Brownsville, Minn.
Date Admission, October 20 1900.
Admitted by Dr. O.C. Heyerdale hour, 4 P.M.
How Sent, L. Budahl Sup't. Houston Co.
Sex, female Age, 31 yrs.
Civil Condition, married
Children, 3.
Age Youngest Child, 3½ mos.
Occupation, Housewife (Contractor's wife)
Degree Education, Can read & write.
Profession, Religion, Catholic.
Habits, Not intemperate.
Nativity, Minn. Parents born in Ireland.
Physicians Committing, D.C. Rhines & W.E. Browning.
Correspondents, Thos. Williams (husband) Brownsville, Minn.

No. of Year, 48
Insane Relatives, Mother + maternal aunt.
Cause Exciting, unknown.
Cause Predisposing, heredity
Form, ~~Chr~~ Melancholia (Hysterical)
Accompanying Bodily Disorder, pain in head, neck + chest.
Suicidal or not, Not.
Date of this Attack, 3½ yrs ago.
Duration, 3½ yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, about 28 yrs.
Time of Leaving, October 15 - 1901.
Time in Hospital, 11 mos - 25 ds
Result, Improved -
Discharged by B of C April 14 - 1902

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Oct 22 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick
MEMORY, Past Events, seems 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,
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 - Remittent fever.
Paternal Relatives, negative history
Mother, living - insane
Maternal Relatives, maternal aunt insane
Brothers and Sisters, brothers well. Sister died Consumption. 3 children
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
had spasms when young.
HABITS, Drinking and Smoking,
~~Nervous~~
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, fair fair irregular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5 PRESENT WEIGHT, 100,# USUAL WEIGHT, NUTRITION, poor.
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.
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, absent.
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,
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, Genitals normal anteversion of uterus. endometritis. Cervix eroded & congested.
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 nervous & thinks herself more keenly afflicted than any human being. Complains of pain in head back, chest, sides &c. but upon examination nothing found. No doubt has hypochondriacal Mental calibre, Probably always below average.

Personal and Medical History of Anna Williams.

1900

This patient was brought here by Sheriff G.N. Blexrud, attended by her husband Thos. Williams, in poor physical condition, with the following history:- No consanguinity; heredity nor intemperance in patient nor parents: First symptoms of insanity manifested 3½ yrs. ago by pain in top of head: getting worse all the time: Not variable. Derangement now manifested by pain in stomach & over chest to neck: Fears going insane: Not disposed to injure anyone: No peculiarities previously manifested: No filthy nor destructive habits: Maternal aunt died in hospital & brother mentally deranged: Patient has been subject to no severe diseases nor injuries to head: No confinement nor restraint employed: Has received medical treatment: On personal examination is poorly nourished; restless movements of hands: moans most of time with pain.

Oct 10 On admission put upon Infirmary list (Gitt Dpt. Complexion dark: hair & eyes brown: skin in normal condition: Small scar on left leg below knee: So dirty: Has 7 loose & 12 upper teeth & several roots: One toe (2nd) on R. foot deformed. So very nervous.)

Oct 10 to Nov 4 (Summary 14 da. record by Dr. Reynolds) Admitted on Infirmary. Did not sleep well during night. Very hysterical: Hypnotics & tonic given: Appetite good: Bowels regular: Temp. pulse & Resp. normal during first week: Remained in bed. Complained a great deal of various pains in back & chest. Examined repeatedly but no definite cause found. Second week. Temp. pulse & resp. normal. appetite good. Tonics given t.i.d. & occasional hypnotics: Bowels regular: Sleeps well. Complains constantly. More or less hysterical in manner: Thinks she is growing rapidly worse: Moves hands over chest & back. Says she cannot help it. Says she cannot control herself. Nov 8 Transf. to C3: Nov 21 Wt 104. Given elec. treatments Dec 1. Mobd: Complains of pain in chest & back also limbs: Bowels constipated: cathartics given: Sleep fair: Very much agitated mentally: Says she will die: Very nervous & restless Dec 18. Trans. to Infirmary: Dec 30. Remained in bed: Still complains of pain: expresses many delusions: untidy: quite restless: given eggnogs & regular diet: bowels constipated: Takes medicine Jan 5 1901. Sat up in chair: very melancholy: Constantly asks to see priest because going to die. Jan 17 - Feb 10. given electrical treatments Feb 6 Escaped when taken up for electrical treatment. brought back a couple of hours later. same day attempted to pick screen lock. Given cold baths in morning for tonic effect. Nov 27 Shows a slight mental improvement Assists with ward work: Talks quite intelligently Attempted to escape by climbing over transom into nurses room today. Discovered

Personal and Medical History of

1901

by nurse Feb 28 Vaccinated. Wt. 103½#. Mch 1 - Up on ward: assists with work: Neat in habits: Complains of some pain in side: Very much improved of late: Neat in habits. Talks intelligently Anxious to be sent home: Trans. to B2. Mch 25. Has improved both mentally & physically: Talks intelligently but still seems to have some delusions. Sent home today Mar. to June 1901 Mar. 29 patient returned from home, bathed and put to bed, caused a great deal of trouble while being returned from home, was very vulgar and vile in her language, struck the nurse and fought desperately, after arriving at the institution she was very quiet and intelligent and gave us no trouble whatever. May 29 Wt. 106½#.

June to Sept. General health good, rather quiet and agreeable, assists with the ward work, occupies herself by reading, menstruates regularly July 28 Wt. 113½#

Sept to Dec. Sept. 28 trans. to B3, Oct. 16 taken home by husband and sister in law.

Discharged.

Personal and Medical History of Ida C. Livingston

Whole No. 5687
Residence, Faribault, Minn.
Date Admission, October 22 '1900.
Admitted by Dr. L. A. Linton hour, 4 P.M.
How Sent, James Hunter J. of P. Rice Co.
Sex, female Age, 34 yrs.
Civil Condition, Single
Children, –
Age Youngest Child, –
Occupation, School-teacher
Degree Education, High school graduate.
Profession, Religion, M. E. Church.
Habits, Temperate.
Nativity, Rice Co. Minn. (Parents born in New Hampshire)
Physicians Committing, W. H. Robilliard & L. M. Mayland.
Correspondents, Rose Livingston, Faribault, Minn.

No. of Year, 50
Insane Relatives, Mother & grandmother.
Cause Exciting, Chronic Irritation of sexual organs.
Cause Predisposing, Heredity.
Form, Chr. Melancholia
Accompanying Bodily Disorder, Lumbago - Constipation.
Suicidal or not, not.
Date of this Attack, 1892.
Duration, 8 yrs.
No. of Attack, has had attacks periodically since leaving here
No. of Admission, 2nd
Age First Attack, 26 yrs.
Time of Leaving, August 23 - 1901
Time in Hospital, 10 mos - 1 Day
Result, Improved —
Discharged by Board of Control
Feby 26 - 1902

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Oct 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.
REASONING POWER, Ordinary Subjects,
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,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, living well.
Paternal Relatives,
Mother, dead.
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Pneumonia, Nervous Prostration, Scarlet Fever, Oöphorectomy 5 yrs. ago.
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework last 6 yrs.
Detail Date, Duration, and Character of Previous Attack, if any,
Here in 1892.
Sleep, Appetite, and Bowels, poor Variable constipated

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 PRESENT WEIGHT, 129½ USUAL WEIGHT, NUTRITION, poor.
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.
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, R. 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,
Color and Appearance,

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

GYNECOLOGICAL EXAMINATION, Normal except oöphorectomy. performed 6 yrs ago.
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). Quiet & rational but extremely nervous in manner & behavior. Sleeps poorly requiring hypnotics. Says she came back to hospital because she had used up all her will power & thought this the best place for her.

Personal and Medical History of Ida C. Livingston.

1900

This patient was brought here by sheriffs deputy Rose Livingston, in good physical condition, with the following history:- No consanguinity known: Grandmother & mother insane: No intemperance in family: First symptoms of insanity manifested in 1894 when patient was in this hospital from Apr 17/1894 to Apr 30/95 See Vol. N Fol. 65 No. 3687. She was discharged much improved but has had periodical attacks ever since: Insomnia - very much frightened even at her own foot-steps: Disease appears increasing: is variable, attacks appearing at monthly periods: Derangement now manifested by complaining that her folks are filthy &c. Not disposed to injure anyone: No filthy nor destructive habits: Before accession of disease manifested peculiarities on religious & by increased sexual passions especially during her monthly periods: No severe diseases nor injuries to head: No confinement nor restraint employed:- Before leaving hospital has been given sedatives at time of wakeful periods. On personal examination found that patient suffers from lumbago and constipation.

Oct 2nd On admission put upon Inf. [G.N.R. Apt. Complexion normal: Hair brown: eyes blue: Skin normal: Is clean: Is upper & Is lower teeth - scar on abdomen from operation. Talks intelligently.]

Oct 2nd to Nov 5 [Summary 14 da Record by Dr Reynolds] Admitted to Infirmary - Very quiet & intelligent & depressed & very nervous: Didnot sleep during night: Hypnotics given: Medicine given t.i.d. Hot baths given occasionally at bed-time: Oct 28 Up & dressed on ward: Takes outdoor exercise: Agreeable on ward altho depressed. Temp. pulse & Resp. normal - Appetite good: Bowels regular

Oct 30. Visited by sister ~~Oct~~ 30. Neat. Up on ward: Takes outdoor exercise. General health good: very nervous & hysterical & hypochondriacal Nov 11 were transferred to A3. Quite weak mentally yet talks sensibly & rationally. Nov 16 Wt. 129# Takes regular electrical treatments

Dec 23. Refuses nourishment: very melancholy: At times very nervous & somewhat hysterical: Usually assists with work Jan. 98 More active & cheerful. Does some sewing for Nurse. Feb 3-11. In bed with attack of grippe. Feb 26 Vaccinated. Wt. 119#.

May to June 1901 Apr. 8 visited by sister Rose who took her to the city to spend the night. she also visited her on 9-10-11. Patient is generally quite well physically, and mentally is rather confused does not know just what to do or say, misconstrues statements that are made, at times becomes very much depressed and melancholy. May 30 Wt. 121 1/2 #.

June to Aug Aug. 20 No change, visited by sister and taken home by her.

— Discharged —

Personal and Medical History of

Personal and Medical History of Eunice A. Scramm,

Whole No. 5689

Residence, Owatonna, Minn.

Date Admission, Oct. 26 1900.

Admitted by Dr. O. C. Heyerdale hour, 5 PM.

How Sent, W.A. Eggleston Jos P. Stule Co.

Sex, female Age, 57 yrs.

Civil Condition, married.

Children, Four.

Age Youngest Child, 13 yrs.

Occupation, Housewife.

Degree Education, Moderate.

Profession, Religion, Universalist.

Habits, not intemperate.

Nativity, Penna. (Father Penna - Mother Ky.)

Physicians Committing, John Johnson & J.R. Hatch.

Correspondents, C.W. Scramm (Husband) Owatonna. Minn. 3/4 mi. north
Telephone D.J. Ames - Row 74. Owatonna (a friend)

No. of Year, 52.

Insane Relatives, None.

Cause Exciting, uterine disease

Cause Predisposing, neurotic temperment.

Form, Chr. Melancholia

Accompanying Bodily Disorder, Uteri. chorea.

Suicidal or not, Not.

Date of this Attack, Feb. 1899.

Duration, 1 yrs. 8 mos.

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 55 yrs.

Time of Leaving, Oct. 28.

Time in Hospital, 2 d.

Result, Died - Chronic Nephritis.

EXAMINATION ON ADMISSION BY DR. Heyerdale *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, ——— PRESENT WEIGHT, ——— USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin,

TONGUE, Coatings or Promptness of Movement,

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

SIGHT,

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

HEARING,

COORDINATION, Arms, Legs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

ARTERIES,

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds,

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 Eunice A. Scranton.

1900.

This patient was brought here by Sheriffs deputy D.J. Ames, attended to by Dr. G.W. McCurdy, in poor physical condition, with the following history:- No history of consanguinity heredity nor intemperance in patient nor parents: First symptoms of insanity manifested in Feb. 99 by extreme nervousness with tendency to incoherence: Disease appears increasing & variable: Derangement now manifested on no particular subject. Not disposed to injure anyone: No filthy nor destructive habits: Years ago was subject to uteri chorea & for last six or seven years has had complete procidentia. No confinement nor restraint employed: Has received the usual treatment for this class of patients. On personal examination is extremely restless & talkative (incoherent except when under influence of Hyoin or other drugs.

Oct 26 On admission put upon Infirmary West (Gen. N. Rpt. Complexion dark: Hair light brown: eyes blue: skin normal: Several small bruises on legs: Is clean: Very nervous with choreic movements: Has 7 loose teeth None in upper jaw: Very resistive & incoherent.)

Oct 26 (Dr Heyndall) Admitted on Infirmary at 7:30 P.M. Temp. 108. Pulse 130 Resp. 30. Bathed & put to bed with great difficulty: Very resistive & restless: Has constant choreic movements of arms & legs. Is somewhat delirious in manner: Requires constant watching to keep her in bed. Slept at short intervals during night. Out of bed much when awake. Has a great many small bruises on limbs: Seems to partly understand what is said to her: Oct. 27 Is weaker this morning 5 A.M. T. 99⅘. P. 136 R. 38. 6. P.M. T. 101⅘. Pulse too rapid to count. Took oat-meal & milk during day: Drank a great deal of water. Hypodermic given night of 26th. Maker, very restless: Several bruises on forehead & one on R. shoulder not noticed on admission. Seems to be failing rapidly. Urinalysis showed large amount of albumen. Oct. 28 Temp. 106⅘. Became weaker respirations rapid & labored. Died at 7:50 A.M. Bruises due to restlessness, striking herself against wall & bedstead.

Died.

Personal and Medical History of

Personal and Medical History of Mrs. Margaret Stone

Whole No. 5691
Residence, St. Paul, Minn.
Date Admission, October 30th 1900
Admitted by Dr. L. A. Littau hour, 7 P.M.
How Sent, Ex. Bazille J. of P. Ramsey Co.
Sex, female Age, 36 yrs.
Civil Condition, divorced.
Children, one.
Age Youngest Child, 15 yrs.
Occupation, housewife.
Degree Education, high-school.
Profession, Religion, Episcopal.
Habits, unknown.
Nativity, Newyork (Parents nativity unknown)
Physicians Committing, Arthur Sweeny & A.B. Ancker.
Correspondents, Fred Shaft, Merchants Hotel St. Paul, Minn.

No. of Year, 54.
Insane Relatives, unknown.
Cause Exciting, Syphilis.
Cause Predisposing, unknown.
Form, General Paresis.
Accompanying Bodily Disorder, unknown
Suicidal or not, not.
Date of this Attack, About one year ago.
Duration, one year
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 35 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Nov. 1 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,

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 3½in PRESENT WEIGHT, 88 USUAL WEIGHT, NUTRITION, poor.

WOUNDS, Abnormalities and condition of Skin, normal.

TONGUE, Coatings or Promptness of Movement,

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

SIGHT,

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

HEARING,

COORDINATION, Arms, could not Test Legs, do. Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

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, Cervicitis, endocarditis, uterus + cervix 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). Physical condition poor. Talks incoherently - says nothing sensible. Does not seem to understand the simplest sentences. Asked to put out tongue but gave no evidence of understanding

Personal and Medical History of Mrs Margaret Stone

1900

This patient was brought here by Sheriff's deputy Frank Shaft attended by Mrs. W. Irish (nurse) in poor physical condition with the following history:- No information concerning consanguinity, heredity nor intemperance in patients nor parents: First symptoms of insanity manifested about one year ago by hallucinations. Disease appears increasing: Not variable. Derangement now manifested by general incoherence, singing, laughing, crying, shouting + by insomnia: No disposition shown to injure anyone: No filthy nor destructive habits: No peculiarities previously manifested: Has syphilis: Has been confined at City + County hospital since August 2nd 1900. Has received usual treatment On personal examination is incoherent, noisy, restless + difficult to keep in bed.

Oct 30. On admission put upon Infirmary West. (G.H.N. Rpt. Complexion dark: hair black, part gray: eyes brown: Skin in normal condition: Small scar on lower part of back: eruption on face Small bruises on legs + arms: Is clean: Has 15 upper + 14 lower teeth: Is quite disturbed + incoherent.)

Oct 30 to Nov 14 (Summary 14 da. Record Dr Heyerdale) Admitted on Infirmary, bathed + put to bed. Quite resistive: Slept 6 hrs. out of bed + noisy when awake: On admission temp. 100. Normal next day: Pulse + respiration somewhat accelerated: Appetite fair: given milk + liquid diet. Hypnotics given occasionally: Medicine t.i.d. + occasional cathartics. Bowels regular. Fed by nurse: Does not understand what is said to her. + will not answer questions: Seems very weak + demented.

Second week. Appetite good: fed by nurse: medicine t.i.d. Bowels regular Is somewhat resistive + out of bed frequently: Sleeps well: Improved somewhat latter part of week. Dressed + up on ward on the 10th. Still incoherent. Nov 22. Visited by friends Nov 26 Very noisy, profane + vulgar at times. Dec. 30 Up on ward: Takes medicine Appetite good. Sleeps well: Thinks people steal her things. Dec. 31 Visited by two men. Mental condition slightly improved. Jan 1- Somewhat improved Trans. to A3. Jan. 4. Somewhat disturbed: expresses her delusions freely + talks in a loud, vulgar manner Trans. to Infirmary west.

Feb 10 1901. Very noisy at night + more or less disturbed during day: Takes out door exercise untidy: very disagreeable toward others: occasionally strikes other patients: requires hypnotics. Feb 7. Wt. 107#.

Mar-June. Still takes iodide of potassium three times per day 200 drops. May 6 was struck by Ida Nelson, slight gash cut on right side of forehead - No change in physical or mental condition. May 29 Wt. 97#

Personal and Medical History of

June to Dec. 1901 Patient is indifferent to surroundings but will answer questions at times fairly sensibly at other times rather disconnectedly, takes out door exercise, does no work, neat in appearance, habits clean: Nov 22 Wt. 104½#.

Dec. to Feb. 1903. Patient is untidy in appearance + dirty in habits Exercises but does no work: Gen'l health fairly good: Sleeps well. Appetite fair: At times talks incoherently to herself: sometimes uses profane language: At other times is quite quiet and pleasant. Does not converse and does not readily answer questions. Dec. 1st Wt 107#.

Personal and Medical History of Belle Lawrence (colored)

Whole No. 5693
Residence, St. Paul, Minnesota.
Date Admission, November 5' 1900.
Admitted by Dr. O.C. Heyerdale hour, 7 P.M.
How Sent, Co. Bayille J. of P. Ramsey Co.
Sex, female Age, 27 yrs.
Civil Condition, married
Children, one.
Age Youngest Child, 8 yrs - dead.
Occupation, Housecuife (Husband R.R. porter.)
Degree Education, Common school
Profession, Religion, methodist.
Habits, not intemperate. (?)
Nativity, Indiana. (Father U.S. Mother N Carolina)
Physicians Committing, Eugene Hubbell - also Donald.
Correspondents, Husband - Shadrack Lawrence

No. for Year, 56
Insane Relatives, Grandfather + aunt.
Cause Exciting, unknown.
Cause Predisposing, Previous attack + heredity
Form, Acute Melancholia with delusions -
Accompanying Bodily Disorder, none mentioned
Suicidal or not, not.
Date of this Attack, ? (recent.)
Duration, ?
No. of Attack, 2nd
No. of Admission, 1st
Age First Attack, 26 yrs.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Nov. 7 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick.
MEMORY, Past Events, Apparently good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert. Correct.
REASONING POWER, Ordinary Subjects, fair
Special Subjects, fair
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Seems quiet + 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).
Grandfather, Aunt insane.
Father, living - does not know where
Paternal Relatives, does not know much about them.
Mother, dead.
Maternal Relatives, does not know about them
2 Brothers and 3 Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None.
HABITS, Drinking and Smoking, Drank beer to excess several years ago - used to smoke.
HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo.
OCCUPATION, Healthy or not, Would not give it
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. 5½ in. PRESENT WEIGHT, 112 # 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.
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, absent.
ARTICULATION, Slurred, Hesitating, Slow, good.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, N. aortic diuresis
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, Genitals normal. uterus retroflexed. cervicitis 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 in good physical condition. Quiet in manner + behavior. Seems very reticent - avoids other patients + remains by herself. Does not converse freely but answers questions. Would not tell what work she had been engaged in. Answers questions very sensibly. Seems quite intelligent + to have a fair education.

Personal and Medical History of Belle Lawrence

1900

This patient was brought here by Sheriffs deputy Hanson attended by Mrs. Elizabeth Kelly + J. H. Hanlin in fair physical condition, with the following history:- No history of consanguinity. Grandfather + Aunt insane: No history of intemperance: First attack of insanity came on in Winter of 99+1900. lasting 5 months. shown by religious mania: Disease appears increasing, is variable: Derangement now manifested on subject of religion + by refusal to eat on Sundays: Not disposed to injure anyone: No disposition to filthy nor destructive habits shown: Before accession of disease showed religious impressions: No severe diseases nor injuries to head sustained. Never confined nor restrained but has received medical treatment

Nov 5 On personal examination is loquacious, talk rambling: refuses to eat. On admission put upon Infirmary West G.H.N. Rpt. Complexion dark: hair black: eyes brown. Is clean: Has 15 upper + 16 lower teeth: Behavior quiet: Talks intelligently) Summary of 14 da. record (by Dr. Heyerdahl Patient quiet + well behaved: First med

Nov 5 to Nov. 19 slept well: appetite good. Temp. pulse + resp. about normal: Given tonics: bowels record regularly: appetite good: Remained in bed five days. after that up on ward: Began menstruating on Nov. 8th, Nov. 11 Expresses delusions: thinks it is a sin to eat on sunday. Record work: Temp. pulse + respiration normal: Slept well: Appetite good: bowels regular: sings + talks loudly: Expresses some religious delusions: Nov. 18 Refused nourishment. Nov. 30 Converses quite readily: Expresses delusions: General health good: Takes outdoor exercise: Dec 30 up on ward: Appetite good: bowels regular: sleeps well: expresses delusions: Thinks she must not eat on sunday, lately calls one of other days Sunday + fasts accordingly.

Jan 9 Disturbed - fought nurses biting + kicking. Jan. 11 Trans. to C.

Jan 30 Since last note has been quiet + agreeable. Assists with work: especially sewing: Takes no exercise. Feb. 26 Vaccinated.

Mch 3 Wt. 108#. Mar- June. No change in mental or physical condition. May 31 Wt. 106½#. June to Sept. 1901 Is at times violent; takes out door exercise; is a good worker on the ward; attends no amusements. Has delusion that she must neither eat or work on the Sabbath.

Sept. to Dec. Nov. 23 Wt. 116#.

Dec to Feb 1903 Patient is usually quiet: rarely converses: generally answers questions: eats well. menstruates regularly: takes exercise: assists with the work. Attends Chapel and amusements: Clean in habits but careless in appearance. Nov. 27th Wt. 113#.

Personal and Medical History of

Personal and Medical History of Mrs Mary Vincent

Whole No. 5695
Residence, St. Paul, Minn.
Date Admission, November 8 1900
Admitted by Dr. O. C. Heyerdale hour, 7 PM
How Sent, E.W. Bazille J. of P. Ramsey Co.
Sex, female Age, 24
Civil Condition, married
Children, four.
Age Youngest Child, eleven months.
Occupation, housewife.
Degree Education, common school.
Profession, Religion, Roman catholic
Habits, not intemperate
Nativity, Minn. Parents also born in Minn.
Physicians Committing, A.B. Aucker & A.W. Dunning.
Correspondents, Isaac Vincent, New Canada, Minn.

No. of Year, 58
Insane Relatives, none.
Cause Exciting, unknown.
Cause Predisposing,
Form, Sub Acute Melancholia
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, not.
Date of this Attack, several years ago.
Duration, several years
No. of Attack, 1st continuous.
No. of Admission, 1 here. at City & Co Hospital.
Age First Attack, about 21 yrs.
Time of Leaving, Feb 28 1901
Time in Hospital, 3 mos. 20 dys.
Result, Dischg. recovered Apr 30 1901

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Nov 19 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick
MEMORY, Past Events, Apparently good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert - correct.
REASONING POWER, Ordinary Subjects, fair.
Special Subjects, fair
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
seems depressed.
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,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, drinks some.
Paternal Relatives,
Mother,
Maternal Relatives,
7 Brothers and Sisters, 1 bro. at this hospital at one time - 4 children.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Surgical operation - repair of cervix.
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, good Appetite, good and Bowels, constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. PRESENT WEIGHT, 98½ # USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt slight coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal.
SIGHT, fair - eyes weak.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, good - Legs, fair Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands & tongue.
PATELLAR REFLEX, present - exaggerated Other Reflexes, elbow - wrist.
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, no Murmurs, Strength, Sounds, weak Size, n.
Apex Beat, n. Regularity, regular.
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,

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. cervix shows repair of extensive lateral laceration, some leucorrhoea - floating kidney.
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 apparently good physical condition. Talks intelligently & rationally - Eats & sleeps well. Says she is very sick & is failing each day. Wants priest to see her. These expressions seem to be show the main trend of her thoughts at present associated with a mild melancholia.

Personal and Medical History of Mrs. Mary Vincent.

1900

1 This patient was brought here by sheriff's deputy Hanson attended by husband, Isaac Vincent, in fair physical condition, with the following history: No consanguinity, heredity nor intemperance in patient nor parents: First symptoms of insanity manifested two or more years ago by extreme melancholia, patient has been in the City & Co. hospital St. Paul. Disease appears stationary: is not variable. Derangement now manifested by melancholia & on subject of religion & bodily ailments. Not disposed to injure anyone: No filthy nor destructive habits: No peculiarities previously: No severe diseases nor injuries to head: Has been at City & Co. hospital as above stated: Treatment pursued:- rest, nourishment & medication. On personal examination demeanor quiet. Surgical Sept 27 1900
On admission put upon Infirmary. Complexion dark: eyes gray: hair dark brown: skin normal: Bruises on back & abdomen: Is clean: Has 16 upper & 15 lower teeth. Behavior quiet: talks intelligently.)

Nov 8. (Summary by Dr. Harperdale) Admitted on Infirmary given bath & put to bed: quiet in behavior slept 6 hours during night. During first week. Temp. about normal: Pulse 78-100. Resp. 18-20. Appetite very good: Bowels regular: Took medicine. During second days complained of pain in back & abdomen: seemed somewhat weak: Slept well during night. Awake most of third night. Talks very intelligently Dressed & up on ward on the 17th Complained of pain in side: Very hysterical & hypochondriacal: Thinks she is about to die: Constantly asks to see Priest. Slept well at night. During second week Temp, Pulse & respiration about normal: appetite fair: malt & cod liver oil given after meals. Cathartics given. Complained more or less of pain in back & abdomen. Seems to have some difficulty in walking, probably due to remaining in bed so long. Sleeps well at night. Continues to think that she is about to die & constantly asks to see priest - Nov 29 Visited by priest: no change. Dec 5 Visited by priest: In good general health: Appetite fair. Bowels regular: Is hypochondriacal: expresses some delusions:
Jan 17 - Feb 10. Given electrical treatment. Feb 28 Improved very much of late: Assists with work: Takes outdoor exercise: Converses intelligently: Appetite good: Bowels regular: Visited by husband & went home with him.

Discharged.

Personal and Medical History of

Personal and Medical History of Sarah Swanson.

Whole No. 5696
Residence, Cannon Falls, Minn.
Date Admission, November 8' 1900
Admitted by Dr. O.C. Heyerdale hour, 7:30 P.M.
How Sent, Axel Haller & apo Goodhue Co.
Sex, female Age, 84.
Civil Condition, widowed.
Children, Six.
Age Youngest Child, forty one yrs.
Occupation, housewife.
Degree Education, Common school.
Profession, Religion, Lutheran.
Habits, Not intemperate.
Nativity, Sweden Parents also born there.
Physicians Committing, D. Jacking & Lk. Mayland.
Correspondents, Frank Swanson (son) Cannon Falls, Minn. (Lives in town)

No. of Year, 59
Insane Relatives, None.
Cause Exciting, Unknown.
Cause Predisposing, "
Form, Senile dementia.
Accompanying Bodily Disorder, Partial loss of feeling in lower extremities.
Suicidal or not, Not.
Date of this Attack, Two years ago.
Duration, 2 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 80 yrs.
Time of Leaving, Dec 7th. 1900
Time in Hospital, 1 month: 16 Ds.
Result, Died: Chronic nephritis
remains removed by Sm.

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* 11/14 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Incoherent.
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,
Somewhat exalted.

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, — PRESENT WEIGHT, — USUAL WEIGHT, NUTRITION, good.
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, "
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - normal.
SIGHT, Seems quite good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING,
COORDINATION, Arms, In bed - could not get Legs, do Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
normal.
ARTERIES,

LUNGS, Chest, Symmetry, Expansion,
Breath Sounds,
Chest Asymmetrical
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, Small - Sp. g. Reaction, Color and Appearance,
Albumen, Large amount Sugar,
Casts and Crystals, Epithelial cells & large amount of pus.

GYNECOLOGICAL EXAMINATION, Genitals normal. uterus atrophied. cystocele.

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). Case one of delirium probably due to kidney trouble. Speaks only Norwegian. talk incoherent. Lies with thighs & legs flexed & evidences great pain when thighs are extended. Mental condition one of senile dementia

Personal and Medical History of Sarah Swanson

1900

This patient was brought here by Sheriff P.P. Lundquist attended by son, Frank Swanson & Dr P.A. Allen, in good physical condition, with the following history:- No history of consanguinity, heredity nor intemperance known. First symptoms of insanity manifested two years ago, by incoherent talk & destruction of property. Disease appears stationary; is variable but no rational intervals. Derangement now manifested by dementia. Not disposed to injure anyone. Habits filthy & destructive. No previous peculiarities mentioned. No severe diseases nor injuries to head sustained. Has been locked in room two days & has received treatment from Dr Brady of Cannon Falls - no results. On personal examination speech is incoherent. There is partial loss of feeling in lower extremities.

On admission put upon Infirmary Diet (G.H.N. Rpt. Complexion fair hair light. eyes blue. Skin in normal condition. scar on chin. Is dirty. Both limbs swollen. tumor on R. leg above knee. Teeth all out. Behavior maniacal. Does not speak English.)

Nov 8. Summary by Dr Haycraft. Admitted on Infirmary given bath & put to bed. Very much disturbed & very dirty. Has large fatty lipoma on right leg above knee. Feet badly swollen. Remained awake during night after given hypodermic. Nov 9 Temp. Normal, Pulse 118° Temp 99. On liquid diet. Slept quite well during night with aid of hypnotic.

Nov 10. Temp about 100. Pulse 70-120. Resp 15-22. Took fair amount of liquid nourishment. Sat up ½ hour in afternoon. Pulse intermittent & somewhat weak. Awake during night, at times noisy. Does not talk English but seems to be incoherent in her own language. During rest of week Temp. about 100 Pulse 116°. Resp. 22. Took fair amount of liquid diet. Bowels regular. Hypnotics given for sleep. Dirty in habits. Very noisy at times. Rested quite well at night. Very feeble. Lies with thighs flexed upon body; seems unable to straighten them. During 2nd week. Temp. dropped from 100 to normal. Pulse about 100, Resp. about normal. Took nourishment well. medicine given t.i.d. Cathartics given, bowels regular. Hypnotics given. Very dirty in habits & very feeble. Sore on foot treated with boracic acid - due to pressure. Sleeps well at night. Remains constantly in bed. Dec. 6 Shows no marked change. Temp. about normal. Pulse slightly accelerated. Resp. about normal. Very dirty in habits. requires a great deal of care & attention. Incoherent in talk. Drinks a great deal of water & has a good appetite. Her vitality is low & it is noticed that small sores form quickly wherever there is any point of contact. Is noisy & restless at times. Dec 6 - 19 Continued much the same. sat up in chair part of time until the 19th. After Dec. 19 failed gradually fed by nurse. Required a good deal of attention. Died at 10 AM. on Dec. 20th.

Personal and Medical History of

At 9 AM. on 19th telegraphed son. "Mother failing rapidly, probably will not live" Later in day telegraphed him of her death & asked what arrangements he wished made. & upon his instructions she was buried here

Died

Personal and Medical History of Mary Kaiser

Whole No. 5703

Residence, 550 Blair St. St. Paul

Date Admission, Nov. 20. 1900

Admitted by Dr. L. A. Linton hour, 7½ pm.

How Sent, Ed. Bazille, J. of P. Ramsey Co.

Sex, female Age, 33

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Laundress

Degree Education, Common School

Profession, Religion, St. Agnes (Roman Catholic?)

Habits, Not intemperate

Nativity, Germany. Parents also. Resident of State since 1885

Physicians Committing, H. Rickett & Wm D. Kelly.

Correspondents, Fred Kaiser (father)

No. of Year, 66

Insane Relatives, —

Cause Exciting, unknown

Cause Predisposing, "

Form, Delusional Insanity Chronic Mania

Accompanying Bodily Disorder, none mentioned

Suicidal or not, not suicidal

Date of this Attack, Two weeks ago

Duration, 2 weeks

No. of Attack, 2nd ?

No. of Admission, 1st

Age First Attack, 30 yrs.

Time of Leaving, Dec. 1st 1900.

Time in Hospital, 1 yr. 1 mo 4 da.

Result, Dischg. Recovered Apr. 30 1901

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Nov 21/1900

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,

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

normal.

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS, of hearing. hears voices especially in church. also sees people -

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).

negative history.

Father, living.

Paternal Relatives, says well

Mother, living

Maternal Relatives,

4 Brothers and 5 Sisters, well.

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

none.

HABITS, Drinking and Smoking, good.

HEADACHES, VERTIGO, OR CONVULSIONS,

occasional vertigo

OCCUPATION, Healthy or not, Laundress.

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

Sleep, Appetite, and Bowels, Constipated.

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6 in. PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, fair.

WOUNDS, Abnormalities and condition of Skin, normal.

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

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal - size normal responses 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, slight of tongue

PATELLAR REFLEX, exaggerated Other Reflexes, elbow & wrist present.

ARTICULATION, Slurred, Hesitating, Slow, good.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, No Murmurs, Strength, Sounds, Size, fairly strong

Apex Beat, Regularity, regular.

ARTERIES,

normal

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,

GYNECOLOGICAL EXAMINATION, Rectocele - cystocele - retroflexion of uterus. cervicitis leucorrhoea. urethral caruncle.

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. Talks mixing up + freely. Says for the last 3 yrs. has heard voices about her house which would follow her when she moved into other houses. Says she frequently saw people who vanished in a moment. especially an old man whom she imagined was trying to kill her. Also has delusions regarding father - on one occasion ran from house.

Personal and Medical History of Mary Larsen.

1900

This patient was brought here by Dep. Sheriff Hanson attended by Mrs. L. Agnider in fair physical condition with the following history: No history of consanguinity or intemperance in patients parents. Nothing known as to heredity. Symptoms of insanity manifested during past three years. First symptoms of present attack manifested two weeks ago. Disease appears increasing. Variable with rational intervals. Derangement now manifested by delusions, hallucinations & desire to be married. No disposition to injure others, not suicidal, filthy or destructive. Has shown previous peculiarities: no severe disease or injury to head. Has not been confined or restrained. Has received no treatment. Cause of disease unknown. On personal examination:- No further facts obtained: On admission put upon Infirmary Ward. Complexion dark. Hair brown: eyes brown: Skin normal: no marks or scars: Left ankle bruised & sprained: rather dirty. Small growth under left knee, resembling wart. Has 14 upper teeth - one gold crowned: 14 lower teeth. Is quiet: talks intelligently.

Nov. 20, 1900 (Summary 14 da. Record by Dr Heyerdale) Received on Infirmary ward. Left foot & ankle inflamed & swollen. States that she sprained ankle running in street in St. Paul. Slept 3 hours first night. First week. Temp. Pulse & respiration normal. Appetite good. Bowels regular. Foot & ankle bandaged & patient kept in bed on account of it. Very quiet. In good physical condition. Expresses a great many delusions & thinks that certain people are conspiring to do her harm; especially a certain old man who appears every now & then with the intention of harming her. The Second week appetite fair, bowels regular: cathartics given. Temp. pulse & respiration normal. Slept quite well at night. On November 29 dressed & up on ward. Foot & ankle treated daily. Quiet & agreeable on ward. Dec. 5 awoke nearly all night. Dec. 7 In bed part of time - flax seed poultices kept on ankle. Slept well at night. Appetite good: Bowels regular. Talks intelligently Dec. 11 Went home on trial.

Discharged

Personal and Medical History of

Personal and Medical History of Elsie Mc Lean.

Whole No. 5711
Residence, Lake City, Minn.
Date Admission, December 1 1900.
Admitted by Dr. L. A. Liston hour, 7.45 P.M.
How Sent, M. Kennedy Sheriff Wabasha Co.
Sex, female Age, 23 yrs.
Civil Condition, single.
Children, none.
Age Youngest Child,
Occupation, housewife.
Degree Education, Common school.
Profession, Religion, Congregationalist.
Habits, not intemperate.
Nativity, Minn. Father France Mother Ohio.
Physicians Committing, W. F. Wilson - J. C. Adams
Correspondents,

No. of Year, 75
Insane Relatives, none.
Cause Exciting, unknown.
Cause Predisposing, heredity suspected.
Form, ~~Puberscent~~ Insanity
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, not.
Date of this Attack, 5 yrs. ago.
Duration, 5 yrs.
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 18 yrs.
Time of Leaving, 11th February 1901
Time in Hospital, 2 mos. 10 Ds.
Result, ~~Recovered~~ Improved. — Discharged Jan 30/1901.

EXAMINATION ON ADMISSION BY DR. Liston Date of Dec'r 1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear - quick
MEMORY, Past Events, Good
Recent Events, Special Subjects, do.
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,
Religion
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, 5 yrs.
ONSET, Gradual or Sudden, gradual.
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, no history living - not well - does no work.
Paternal Relatives,
Mother, living - not well - does no work.
Maternal Relatives,
3 Brothers and 3 Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Scarlet fever.
HABITS, Drinking and Smoking, Good
HEADACHES, VERTIGO, OR CONVULSIONS, Occ'l.
OCCUPATION, Healthy or not, Assists with housework.
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Reg'r

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 4½ in. PRESENT WEIGHT, 108 lbs. 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.
SIGHT, good.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good.
COORDINATION, Arms, normal Legs, do. Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, fine of hands.
PATELLAR REFLEX, present - ~~elbow~~ & wrist Other Reflexes, elbow & wrist present.
ARTICULATION, Slurred, Hesitating, Slow, slow.
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Faint murmurs - aortic & mitral regurgitation.
Apex Beat, Regularity, Sounds strong. Size normal apex beat normal position Irregular.
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, Genitals normal. uterus retroflexed.

MENSTRUATION,
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). Patient probably delusional but will not talk about them. Is bright & cheery on ward & assists with all kinds of work. Has shown no melancholic tendencies nor desire to be alone as reported. Says was not happily situated at home - feels she was not understood - not sympathized with. Father & mother seem to be hypochondriacal - do no work. Family has chiefly on contributions of friends. The main article of diet being bread. Patient is anaemic. When asked regarding scientific discoveries mentioned in papers, said she did not wish to talk about them.

Personal and Medical History of Elsie McLean.

1900

This patient was brought here by Sheriff G.G. Dickman attended by J.B. & Mrs. McLean, in fair physical condition with the following history:- No history of consanguinity, heredity nor intemperance given: First symptoms of attack manifested about 5 years ago, by melancholia & desire to be alone: Disease appears increasing: Is variable. Derangement now manifested on the subject of religion: Thinks she has a special commission from God & has made a scientific discovery of great importance. These delusions are worse in cloudy weather: Believes she can influence the forces of nature, as the barometer. Is disposed to injure others: Habits filthy & destructive: No peculiarities previously manifested: No severe diseases nor injuries to head: No treatment pursued: Never confined nor restrained in any way. On personal examination appeared indifferent to dress & personal looks: Says she neglects herself because other things are more important & there is not time for everything.

On admission put upon Inf. W (G.H.N. Rpt. Complexion light: hair light brown: eyes brown. Skin in normal condition: No marks, scars nor bruises: Is dirty: Has 11 upper & 12 lower teeth: Talks intelligently.

Dec 1 to Dec 15 (Summary 14 da. Record by Dr Heyerdale) Admitted on Infirmary & put to bed: Was menstruating: Slept well during night. First week. temp. pulse & respiration normal most of time Appetite good: Given malt & Cod liver oil. Bowels regular: Dec 2 up & dressed on ward: Expresses some delusions Thinks she is able to control the weather. Slept well during first week. up on ward each day. Quiet in behavior but said she was somewhat nervous: Habits neat but somewhat careless in appearance: During second week. Temp. from normal to 100°. Pulse & respiration varied slightly. Appetite good: Given malt & cod liver oil regularly. Bowels regular: Slept well: Quiet: Took regular exercise.

Dec 30 1900. Up on ward: Very active: Sleeps well: Appetite good: Takes medicine 3 x day: Attends amusements & chapel: Menstruates regularly. Jan 14 Very inquisitive: Interferes with treatment of other patients: Trans. to A3. Jan 26-27 '01. Visited by mother & brother:

Feb. 7 & 8 In bed with a cold. Feb. 11 Allowed to go home.

Letter from father on Apr 12 says patient has improved since leaving hospital but delusions still remain - Thinks she causes buds & leaves to grow.

Personal and Medical History of

Personal and Medical History of Emma Snyder

Whole No. 5714

Residence, St. Paul. Minnesota.

Date Admission, December 5' 1900.

Admitted by Dr. L. A. Linton hour, 7.45 P.M.

How Sent, E.W. Bayliss & of P. Ramsey Co.

Sex, female Age, 34.

Civil Condition, married

Children, none

Age Youngest Child, —

Occupation, Housewife.

Degree Education, Common school

Profession, Religion, Not a church member.

Habits, unknown.

Nativity, Wisconsin (Father Ohio - Mother Penn.)

Physicians Committing, W. Richeson + E.W. Buckley.

Correspondents, George Snyder. 433 Mt Ida Ct. St Paul. Minn.)

No. of Year, 1st

Insane Relatives, none

Cause Exciting, Uterine disease

Cause Predisposing, unknown

Form, Recurrent Mania with delusions Acute Mania

Accompanying Bodily Disorder, None mentioned

Suicidal or not, not.

Date of this Attack, 6 wks. ago.

Duration, 6 wks ago.

No. of Attack, 2nd

No. of Admission, 1 hm. at Oshkosh 10 yrs ago

Age First Attack, 24 yrs.

Time of Leaving, October 30 - 1901.

Time in Hospital, 10 mos 25 ds.

Result, Improved: Discharged Feb 26 - 1902 by Board

EXAMINATION ON ADMISSION BY DR. Linton Date of Dec. 6' 1900

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, good

Recent Events, good Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

REASONING POWER, Ordinary Subjects,

Special Subjects, good

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal at present. has spells of depression.

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

HALLUCINATIONS, of sight.

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 - dropsy. Cardiac trouble - drank

Paternal Relatives, Grandmother hysterical

Mother, living.

Maternal Relatives, 1 sister paralyzed (2 strokes)

Brothers and Sisters, (1 bro. 1 sister dead) 1 bro. drinks

No children.

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

none.

HABITS, Drinking and Smoking, good.

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, housework.

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

10 yrs ago

Sleep, Appetite, and Bowels, good good regular

Personal and Medical History of

PHYSICAL CHARACTERISTICS.

HEIGHT, — PRESENT WEIGHT, 110# 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, 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, absent. Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, good.

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, 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, Retroflexion - cervicitis - leucorrhoea.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Variable.

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).

Personal and Medical History of Emma Snyder.

1900

This patient was brought here by sheriffs deputy Hanson attended by her husband in fair physical condition, with the following history: No consanguinity heredity nor intemperance known in family: First symptoms of insanity manifested ten years ago + patient was in the Oshkosh Wis. Hospital for Three months: First symptoms of present attack manifested about six weeks ago by sleeplessness: disease appears increasing: Is variable: Derangement now manifested by delusions: Patient not disposed to injure anyone: No filthy nor destructive habits: No information concerning previous peculiarities: No severe diseases nor injuries to head: No confinement nor restraint employed No treatment pursued. On personal examination is nervous, has delusions with sane intervals.
On admission put upon Inf. W. (G.H.W. Rpt. Complexion light. hair brown: eyes brown: Skin in normal condition: Scar on L. shoulder: Is clean: Several scratches on lower R. leg. Gash on first R. finger. Has 11 lower Teeth: Upper set false;
Dec. 5 (Summary 14 da. record by Dr. Reynolds) Admitted on Infirmary + put to bed. Slept 3rd during night. During first week temperature, pulse + respiration normal. Appetite good. Bowels regular: Given medicine regularly. Quiet + agreeable during day + slept well at night. Took outdoor exercise: Assisted with work: Neat in habits + appearance. Very rational + answers questions intelligently. Second week ~~Temp~~. pulse + respiration normal. Very little change manifested. Actions + talk rational. Appetite good: Bowels regular.
Dec 30 1900 Up on ward: Quiet: intelligent: Appetite good: Assists with work: neat: Menstruates regularly: Jan 15 1901. Much disturbed during day + somewhat so at night. Threw rug on floor + hid pin in flowerpot: unable to find either: Jan. 18 Much disturbed + hysterical: Says while fully conscious of actions is not able to control herself + thinks someone is continually urging her to do things. Feb 3 Mans to C. Very quiet + agreeable. Feb 5 Menstruated: Feb. 14 Becoming more disturbed: Talks very volubly + sings + whistles a great deal: Takes off clothing + pulls hair down. Feb 21. Still in spell: Destruction to clothes. Threw false teeth on floor breaking them. Trans. to C 3,
Feb 27. Quieting down some: More rational + agreeable. Inclined to be violent during day: Held by hr. by nurses. Much more quiet afternoon. Takes outdoor exercise. Mr. 10 5-7 Mch 13 Visited by sister: Agreeable + pleasant on ward. Talks intelligently. Taken home in afternoon.
Aug. 30, 1901 patient received on A. 2 bathed and put to bed, quiet in behavior, converses

Personal and Medical History of

intelligently, Aug. 31 became quite disturbed mentally.
Sept. to Dec 1901 Sept. 1st tran. to infirmary West being very much disturbed, Sept. 22 much improved, assists with ward work, at times disagreeable, tran. to D. 2 West. Oct. 24 tran. B. 3 West. Oct. 30 patient returned to her home.

Discharged.

Personal and Medical History of Cordelia H. Lathrop.

Whole No. 5715
Residence, Hastings. Minn.
Date Admission, December 11th 1900
Admitted by Dr. E. J. Watson hour, 7.30 PM.
How Sent, Thos. P. Moran & of D. Dakota Co.
Sex, female Age, 63 yrs.
Civil Condition, married
Children, 7
Age Youngest Child, 28 yrs.
Occupation, housewife
Degree Education, Fair
Profession, Religion, Methodist
Habits, Not intemperate.
Nativity, Ill. (Father N.Y. Mother Indiana)
Physicians Committing, Am. Asst + Dr. Van Cappellen
Correspondents, E.R. Lathrop. Hastings. Minn. (Husband & Patient). (Diag) Pernicious Anaemia
See, Statement of D.A.M. asst, to file with papers.

No. of Year, 78
Insane Relatives, None.
Cause Exciting, unknown.
Cause Predisposing, Previous attack
Form, Paranoia
Accompanying Bodily Disorder, Anaemic + nervous
Suicidal or not, not.
Date of this Attack, ?
Duration, ?
No. of Attack, 2nd
No. of Admission, 1st
Age First Attack, 38 yrs.
Time of Leaving, December 16th 1900
Time in Hospital, — 5 days.
Result, Died

EXAMINATION ON ADMISSION BY DR. Lustrom *Date of* Dec 12/1900

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, Seems good
Special Subjects, " "
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal
DELUSIONS, Systematized, Transitory, Special Subjects,
Jealous of women of congregation over which husband presided.
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, 2 years
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Tuberculosis — died of pneumonia
Paternal Relatives,
Mother, Died in Childbirth
Maternal Relatives, Mother's brother died of tuberculosis
Brothers and Sisters, one brother died of Convulsions
Children — 4 girls — 3 boys.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), None
Typhoid
HABITS, Drinking and Smoking, good habits
HEADACHES, VERTIGO, OR CONVULSIONS, vertigo
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels,
Sleeps well: Eats well: bowels regular

Personal and Medical History of Cordelia H. Lathrop.

The Daily Bulletin
ROCHESTER, DECEMBER 17, 1900

MRS. LATHROP DEAD.

The Wife of "Elder Lathrop" Laid to Rest.

Mrs. Cordelia Lathrop, wife of Rev. E. R. Lathrop, passed away at the State Hospital in the city Sunday morning at six o'clock. She had been here less than a week and the news of her approaching demise came as a shock to the members of her family. Her husband hastened to her bedside and was here to witness the entrance of the beloved wife into her eternal rest. For several years she has been mentally deranged on some subjects, but it was only a week ago that her affliction assumed such form that she could not remain with her loved ones. She was not supposed to be in a serious condition physically and the sudden dissolution was not dreamed of. The cause of death was anæmia.

Cordelia Jackson was born at Terra Haute, Indiana, in March, 1838. Her marriage to E. R. Lathrop occurred in August, 1855, and the following year they came to Olmsted county to reside. During 1872 and '73, Mr. Lathrop was pastor of the First Methodist church of Rochester. Since then he has been pastor of a number of prominent Methodist churches throughout the state.

For about nine years his home was at Hastings. Retirement from the ministry was made necessary by his wife's illness and he has spent this long period in faithful devotion to her whom he had vowed to cherish in sickness or in health. He was assisted in this loving service by their only surviving daughter, Ella Lathrop. One other child lives to mourn, he being John Lathrop of Pendleton, Oregon.

So long as it was possible, the retired minister and the devoted daughter cared for the afflicted wife and mother, sacrificing their own comfort, rest and peace of mind without hesitancy. It was only upon the advice of their physician that they gave her into other hands for treatment. But the best of skilled attention could not change the ordered course of human events, and after a brief stay here, the veil which had clouded her mind, was removed by the entrance of her spirit into the Eternal Home.

The funeral services were held in the Methodist church of the city at 2:30 o'clock this afternoon, conducted by Rev. Frank Doran. The remains were laid to rest in Oakwood cemetery beside her three children who were buried there years ago.

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 150 lbs USUAL WEIGHT, NUTRITION, fair (apparently)
and condition of Skin, anaemic.
omptness of Movement, prompt: rotated slightly
Response to Light, and Accommodation, Yes : Yes :
glasses. —
t, Arcus Senilis, or other troubles, Normal
good
good Legs, good Grasp, Otherwise good.
ue, Facial Muscles, General, hands, none; tongue slight tuna; facial muscles general, none
present Other Reflexes, absent
d, Hesitating, Slow, good
Paretic, Sad, Etc.
th, Sounds, Size,
ity, aortic ite - mitral re - string fairly. run to left - regular
tuna
, Expansion, Chest Symmetry
food: Rales
also dullness.
Quantity, Sp. g. Reaction, Color and Appearance,
Sugar,
als,
HINATION, Papillary vaginitis
AMINATION,
Blood, 75 plastics, Haemoglobin, Red Corpuscles 866000 - Poikilocytosis
SLEEP, Present Amount and Character,
BOWELS, Present Condition, very Constipated

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).

Patient in a very anaemic condition: all mucous membranes very pale: that of vagina + cervix has a pale yellow color. Examination reveales no lesions, unless the jealousy referred to leads to calls such: said that the lady members of her husbands congregation were very attentive to him. Examination showed bowels in very bad condition: rectum and colon were packed with hard faecal matter: High enema ordered. —

Personal a

Whole No. 5715

Residence, Hastings. Minn.

Date Admission, December 11th 1900

Admitted by Dr. E. J. Watson hour, 7.30 PM.

How Sent, Thos. P. Moran J. of P. Dakota Co.

Sex, female Age, 63 yrs.

Civil Condition, married

Children, 7-

Age Youngest Child, - 28 yrs.

Occupation, housework

Degree Education, Fair

Profession, Religion, Methodist

Habits, Not intemperate.

Nativity, Ill. (Father N.Y. Mother Indiana)

Physicians Committing, A.M. Adsit + Dr. Van Cappellen

Correspondents, E.R. Lathrop. Hastings. Minn. (Husband of patient)

(Diag) Pernicious Anaemia.

See, Statement of Dr. A. M. Adsit, made with papers.

Cause Predisposing,

Form, Paranoia

Accompanying Bodily Disorder, Anaemic + nervous

Suicidal or not, not.

Date of this Attack, ?

Duration, ?

No. of Attack, 2nd

No. of Admission, 1st

Age First Attack, 38 yrs.

Time of Leaving, December 16th 1900

Time in Hospital, — 5 days.

Result, Died

EXAMINATION ON ADMISSION BY DR. Linton Date of Dec 12/1900

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, Recent good
Special Subjects, " "
Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Jealous of women of congregation over which husband presides.

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, 2 years

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, died of Pneumonia - Tuberculosis

Paternal Relatives,

Mother, Died in Childbirth

Maternal Relatives, Mother's brother died of tuberculosis

Brothers and Sisters, one brother died of Convulsions
Children - 4 girls - 3 boys.

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

HABITS, Drinking and Smoking, good habits

HEADACHES, VERTIGO, OR CONVULSIONS, vertigo

OCCUPATION, Healthy or not, housework

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

Sleep, Appetite, and Bowels,
Sleeps well: Eats well: bowels regular

...ir.
...DUT
...ne, everything
...Come quick
...but new, up-
...l line of Xmas
...trade.
...argains:
LAS GOODS!
XMAS GOODS!
...line of handkerchiefs and
...is large and prices the low-
...of albums, fancy cellulaid
...and kid mittens, muffs, silk,
...ing sacques, underskirts, etc.,
...losing out prices.
...s, and they will go at
...yard up.
...in a dress pattern for a
...grain you ever had.
...king shirts, night gowns,
...t prices. Come before
...ore,

Personal and Medical History of Cordelia A. Lathrop.

PHYSICAL CHARACTERISTICS.

...ft 4 PRESENT WEIGHT, 150 lbs USUAL WEIGHT, NUTRITION, fair (apparently)

...S, Abnormalities and condition of Skin, anaemic.

...NGUE, Coatings or Promptness of Movement, prompt: coated slightly

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

SIGHT, uses glasses.

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

HEARING, good

COORDINATION, Arms, good Legs, good Grasp, otherwise good.

TREMORS, Hands, Tongue, Facial Muscles, General, hands, none; tongue slight tremor; facial muscles: general, none

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, Aortic Murmurs + regurgitation - mitral regurgitation - Sounds, strong fairly: Size enlarged: apex beat down + left - regular

ARTERIES,

some atheroma

LUNGS, Chest, Symmetry, Expansion,

Breath Sounds, - Chest Symmetry Expansion good: Rales in right apex: also dullness.

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, papillary vaginitis

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin, Red Corpuscles 766,000 - Poikilocytosis

SLEEP, Present Amount and Character,

BOWELS, Present Condition, very 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 a very anaemic condition: all mucous membranes very pale: that of vagina + cervix even a pale yellow color. Examinations reveales no delusions, unless the jealousy referred to should be called such. Said that the lady members of her husband's Congregation were very attentive to him. Examination showed bowels in very bad condition: rectum and colon were packed with hard faecal matter: high enema ordered. -

Personal and Medical History of Cordelia H. Lathrop.

1900

This patient was brought here by Sheriff H.H. Hyland attended by Mrs. Graves in poor physical condition, with the following history. No consanguinity, heredity nor intemperance in family. First symptoms of insanity manifested about 25 years ago - by jealousy of husband - imagines "clans" are working against her. Disease appears increasing. Disease is not variable. Not disposed to injure anyone. No filthy nor destructive habits. No severe diseases nor injuries to head. No confinement nor restraint. On personal examination is anaemic, nervous, easily excited. Dec 11 On admission put up on Irg. W. (G.H.N. Rpt. Complexion fair, hair gray, eyes gray, Condition of Skin normal; no marks or scars, except small bruise on hand: no hernia. Is clean: has 6 lower teeth and an upper plate. Is quietly behaved; some delusions apparent.) —

Dec 17 Notes by Dr. Linton. Patient admitted Dec 11. in Evening: bathed and put to bed: ate supper: quiet in behavior, though inclined to be disagreeable: talked of being jealous of husband: lower limbs quite dropsical: skin very pale lemon yellow: very anaemic: expectorated a great deal: greenish expectoration: Complained of having abscess of lung. Examination showed only slight dullness in right apex, and sputum showed no tubercular bacilli. Complained of no pain. On first night, did not sleep any; during 2d day, talked quite intelligently and seemed quite bright: slept at short intervals: During 2d night, became nauseated and sleeping dose given. On 13th, pulse began to grow weaker: Complained of feeling tired: refused breakfast: bowels not having moved, high enema was given and free movement, consisting of hard, blackened feces was obtained. Tepid bath given all afternoon, to reduce temperature, which had risen from 99.8 (at time of admission) to 104 2/5. From this time on to time of her death (on Evening of 16th), patient lay in a semi comatose condition. Did not talk after the 1st day; though turned open eyes, when spoken to. On day of 14th, had a chill: seemed so nauseated for last 3 days, that she could not retain either nourishment or medicine. She was given tonics & stimulants during the time. On night of 13th, became nauseated, and, in attempting to get out of bed, fell and bruised left eye. Her temperature during the time, varied from 99.8 to 104 3/5: Pulse from 92 to 124. Resp. 20 to 40.

During last few days, became restless and moaned a good deal, as though in pain, refusing or not taking nourishment or medicine. Slept very poorly. The afternoon of 15th, blood smears were made, and blood-count showed red corpuscles reduced to 561 000: abnormal red blood-cells were found under microscope. Diagnosis of Pernicious Anemia was made.

Patient Expired at 1245 a.m. on the 16th =

Her husband had been advised by telephone of her condition and came to the Hospital and was with her, at the time of her death. He made all arrangements for the disposition of the remains, which were buried in the Rochester Cemetery. (see notice attached page 54.) —

Dead —

Personal and Medical History of

Personal and Medical History of Sarah Quinn

Whole No. 5771.
Residence, Wheatland, Rice Co. Minn.
Date Admission, 20th December 1900
Admitted by Dr L. A. Linton hour, 5 PM.
How Sent, James Hunter, Jof P. Rice County
Sex, Female Age, 28
Civil Condition, single
Children, -
Age Youngest Child, -
Occupation, Servant-Girl
Degree Education, Common school
Profession, Religion, Catholic
Habits, probably good; no intemperance
Nativity, Scott Co. Minn; parents born in Ireland
Physicians Committing, F. C. Fleshen & J. M. Ross
Correspondents, Wm Quinn (father) Vesli, Rice Co. Minn (Wesely)

No. of Year, 84
Insane Relatives, none on either side
Cause Exciting, don't know; said she lost money
Cause Predisposing, not stated
Form, Delusional mania acute mania
Accompanying Bodily Disorder, none mentioned
Suicidal or not, not -
Date of this Attack, about 4 months ago
Duration, about 4 months
No. of Attack, 1
No. of Admission, 1
Age First Attack, 27+
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Linton *Date of* Dec 21/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear; Quick;
MEMORY, Past Events,
Recent Events, appears good Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert; Illusive
REASONING POWER, Ordinary Subjects, fair
Special Subjects, poor
Own Mental State, does not appreciate
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
normal

DELUSIONS, Systematized, Transitory, Special Subjects,
Religious delusions; also thinks she smokes what she calls "Rose Moss" —
HALLUCINATIONS, of sight and 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. (statements of patient)
LENGTH INVASION, must have been gradual, according
ONSET, Gradual or Sudden, sudden, according to history
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption). None
Father, Living
Paternal Relatives,
Mother, Dead
Maternal Relatives,
Brothers and Sisters, one brother
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), None

HABITS, Drinking and Smoking, Inveterate Smoker; is reported destitute when unable to get tobacco.
HEADACHES, VERTIGO, OR CONVULSIONS, vertigo
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Did not sleep well; restless; Reams: appetite good: bowels regular -

Personal and Medical History of Sarah Quinn

Winona Minn. July 26 1900

M. D. A. P. Kilbourne

Sir I want to know if there is a girl in the Asylum by the name of Amy Quinn or if you know of any person of that name in any of the Asylums. Any Quinn would be 30 or 35 years old I would be very thankful for the Information is she a patient or helper

M Kain
64 E. 5th St
Winona Minn

...TERISTICS.

...L WEIGHT, NUTRITION, good

...t.

...: size normal: respond to L^t accomth.

Grasp, ...ches tests, good.

...ue: Facial muscles general, none

...her Reflexes, Arms + wrist

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, but quite rigid; uterus retroverted and slightly prolapsed: cervicitis. Leucorrhoea
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Poorly; restless.
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). Thinks she has unusual power, at certain times; E.g. On Easter Sunday, when she attends Church, for the purpose of decorating the altar, the altar becomes decorated by the simple waving of the right hand. She also thinks she has painted and covered several churches with what she calls "Rose Moss". She also claims to have seen her mother translated after the death, and at the same time, she saw God, who descended from Heaven & conversed with her. The death of her mother came when Miss Quinn was but 5 years old.

Personal and Medical History of Sarah Quinn

Whole No. 5771.
Residence, Wheatland, Rice
Date Admission, 20th Decem
Admitted by Dr. L. A. Linton
How Sent, James Hunter,
Sex, Female A
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Servant-
Degree Education, Common
Profession, Religion, Catholic
Habits, Probably goo
Nativity, Scott Co. Minn; Par
Physicians Committing, F. C. Fles
Correspondents, Wm Quinn

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loss of money
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entioned
ths ago
nonths

EXAMINATION ON AI

of Dec 21/1900

MENTAL ACTIVITY, Clear or Co
Clear;

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

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

REASONING POWER, Ordinary Subjects, fair
Special Subjects, poor
Own Mental State, does not appreciate

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
normal

DELUSIONS, Systematized, Transitory, Special Subjects,
Religious delusions; also thinks she smokes what she calls "Rose Moss"

HALLUCINATIONS, of sight and 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.

ONSET, Gradual or Sudden, Insidious, according to statements of patient & gradual, according to history

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

Father, Living
Paternal Relatives,
Mother, Dead
Maternal Relatives,
Brothers and Sisters, one brother

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

HABITS, Drinking and Smoking, Inveterate Smoker; is reported as suffers when unable to get tobacco.
HEADACHES, VERTIGO, OR CONVULSIONS, vertigo
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Did not sleep well; restless; dreams: appetite good: bowels regular —

Personal and Medical History of Sarah Quinn

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6 PRESENT WEIGHT, 121½ lbs USUAL WEIGHT, NUTRITION, Good
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: respond to light & accomdn.
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Good
COORDINATION, Arms, Good Legs, Good Grasp, Romberg test, good.
TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor of hands & tongue: facial muscles & general, none
PATELLAR REFLEX, present Other Reflexes, Arms & wrist
ARTICULATION, Slurred, Hesitating, Slow, Good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, None — Fairly strong — normal
Apex Beat, Regularity, regular 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, Sym: Good
Breath Sounds, Normal

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

GYNECOLOGICAL EXAMINATION, External genitals normal — hymen intact, but quite rigid: uterus retroverted and slightly prolapsed: cervicitis. Leucorrhoea
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Poorly; restless.
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). Thinks she has unusual power, at certain times; E.g. On Easter Sunday, when she attended Church, for the purpose of decorating the altar, the altar becomes decorated by the simple waving of the right hand. She also thinks she has "planted" and covered several churches with what she calls "Rose Moss". She also claims to have seen her mother translated after Death, and at the same time, she saw God, who descended from Heaven & conversed with her. The death of her mother came when Miss Quinn was but 5 years old.

Personal and Medical History of *Sarah Quinn*

1900

This patient was brought here by Deputy J.B. Thompson, attended by Wm Quinn, in good physical condition and with following history. There is no history of consanguinity, and none of insanity, on either side. This is first attack; first symptoms manifested about four months ago; said "there was something wrong with her head". Disease appears increasing; is variable & with rational intervals; these periods are variable but constant. Derangement now shown by insomnia; is restless; has fear of injury. Is not disposed to injure others, nor suicidal; no filthy or destructive habits. Did not, in particular, show any previous peculiarities. There is no history of intemperance & so. nor of any severe disease or head injury. She has not been restrained or confined. Dont know cause of the disease; said to be "loss of money". Was treated by Doctor for about 6 weeks; slept better; then refused to take the medicine. On personal Examination, she exhibited restlessness, hallucinations, delusions impressions, and violent temper, if irritated.

Dec 20 On admission, was put upon Infy Ward (G.H.N. R'pt. Complexion dark; hair brown; eyes blue; condition of skin normal; no marks, scars or bruises noted; is rather dirty; has ten upper and seven lower teeth and most of them in a bad condition. Behavior quiet; has delusions.

Dec 20 (Summary 14 da Record by Dr Keyerdale) Dec 20. Admitted on Infirmary put to bed. Expressed many delusions: slept well. First Meal - Temp. 98 - 99. Pulse & respiration slightly accelerated. Appetite good. Hypnotics given first three nights. Occasional cathartics given Dec 22 Up & dressed on ward: Agreeable & quiet in manner: Neat in habits & appearance: Seems cheerful: Expresses many delusions: Assists with ward work. Second week Temp about normal. Pulse slow. Respiration 17 - 23. Appetite good: bowels regular. Up on ward each day: Slept well during night. Assists with ward work. Neat & quiet. Expresses delusions. Dec 29 Menstruating

Jan 7 1901. Agreable & quiet on ward. Answers questions intelligently: Talks very little: Assists with ward work. Sleeps well. General health good: Takes outdoor exercise: Expresses some delusions of persecution. Vaccinated. Wt. 113½. Remains in good physical condition: Talks much to herself.

Mar - June. 1901 Patient eats and sleeps well, general health good: does no work refuses out of door exercise: attends no amusements: quiet in manner: seldom converses but will briefly answer questions put to her. May 1st visited by father. May 31 Wt. 103½ #. June to Sept. Is quiet; does no work; is quite restless walks up and down the ward; laughs to herself; answers questions intelligently; clean but rather careless; Sept. 1 Wt. 105½ #.

Sept. to Dec. Sept. 16 - Oct. 15 menstruated; quite troublesome about throwing water about in the wash room and destroying plants; Nov. 26 visited by father and brother. Nov. 30 Wt. 101½ #.

Dec 1 to Feb 1903 General health good: sleeps well: appetite good: does no work: occasionally exercises. Is quite restless: walks up and down the ward aimlessly: Very delusional: rarely volunteers conversation:

Personal and Medical History of

but will answer questions at times. Habits and appearance neat. Dec 1st Wt 106#.

Personal and Medical History of Alena Christianson

Whole No. 5723.

Residence, Wolpho Township, Minn.

Date Admission, 24th December 1900.

Admitted by Dr. A. J. Kilbourne hour, 8 P.M.

How Sent, J. S. Washburn, Jo ft, Mower County

Sex, Female Age, 19.

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Domestic (Father's farmer)

Degree Education, Common School

Profession, Religion, Lutheran —

Habits, — probably good —

Nativity, Mower County, Minn: parents born in Norway.

Physicians Committing, E. A. Washburn Rodgers & J. E. Duginan

Correspondents, None mentioned in papers: Proof of residence made by C. O. Christianson

No. of Year, 86.

Insane Relatives, Mother's brother & brother have been insane and father was intemperate —

Cause Exciting, menstrual derangement.

Cause Predisposing, first attack & heredity

Form, Acute Melancholia

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Not: threatens to kill sister & to injure others.

Date of this Attack, one week ago

Duration, — one week —

No. of Attack, 2nd (one, a year ago)

No. of Admission, 2nd

Age First Attack, 18 years

Time of Leaving, 19th April 1901.

Time in Hospital, 3 mos 26 ds

Result, Recovered: Discharged Apr 19/1901.

EXAMINATION ON ADMISSION BY DR. Heyerdale Date of Dec 28/1900

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events,

Recent Events, Seems good Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State, very quiet

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any delusions

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, a few days

ONSET, Gradual or Sudden, Sudden

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

Father,

Paternal Relatives,

Mother, and brother have been insane

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
gives no history of such

HABITS, Drinking and Smoking, Good

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework

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

how how

Sleep, Appetite, and Bowels, Constipated

Personal and Medical History of Alena Christianson

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, fair physical

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt; thick white coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal; Size normal; Response to light, good. to accommodation, Yes.

SIGHT, good

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

HEARING, Good

COORDINATION, Arms, Good Legs, Good Grasp,

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

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, Genitals normal; hymen intact; uterus retroflexed; Cervicitis; 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, very fair physical condition; is very quiet and seems depressed & melancholy; answers questions readily & talks very intelligently.

Personal and Medical History of Alena Christianson

1900

This patient was brought here by B.O. Christianson attended by N.N. Johnson, in fair physical condition & with following history. There is no consanguinity: but history of insanity, as mother's brother, and brother have been insane. This is not first attack; one occurred one year ago, lasting four months, when she was treated at this (Rochester, Minn.) hospital & was apparently cured. First symptoms of this attack manifested one week ago; began talking incoherently. Disease appears increasing; not variable; no rational intervals; She seems about the same, all the time. Derangement now shown in that she talks incoherently and is quite violent, at times. Threatens to kill her sister: Has not shown a disposition to injure others, but has made threats: not suicidal: no filthy or destructive habits. No peculiarities previously shown. Her father was intemperate. No history of any severe disease, convulsions, or head-injury. Has been restrained or confined, as stated, a year ago for 4 months in Hospital. Supposed cause of the disease is menstrual derangement. Has had no treatment. On personal Examination, she is incoherent in remarks & slightly emotional. She requires care & treatment, while under legal restraint. (Records shew patient was here before, and this the 2nd Commitment; (See No 5473. Vol 42. fol 89.): from Dec 22/99: went home Mar 22/1900 and discharged Sept 22/1900. Recovered). ———— - - ————

Dec 22 On admission, was put upon T.W. (G.H.N.R'pt. Complexion dark; hair brown; eyes gray; Condition of skin normal: marks none; several small cuts on left hand. Is dirty: has 15 upper & 13 lower teeth. Behavior quiet: Talks intelligently).

Dec 24 to Jan 8 Summary 14 da record by Dr Heyerdale - Restless & destructive: Hyp natics given for sleep: Temp. pulse & resp. normal: & regular diet. On second day very restless & noisy: Slept well during night. Remainder of week up & dressed on ward: Quite noisy & destructive: Second week temp. pulse & resp. normal: Appetite quite good: Bowels moved regularly: Slept well: Quiet & agreable: up each day: Quiet, neat. Talks little. Takes out door exercise: Improving rapidly

Jan 10 1901. Had sore throat. Tonsils swollen & inflamed: put to bed. Supposed with severe tonsilitis. In bed until Jan 16th. Highest temp. 101⅘. pulse & resp. not high at any time. Able to take fair amount of nourishment but at times with difficulty. Given Monsels solution; gargles & spray.

Jan 29. Trans. to A2. Has had electrical treatments: Feb 7. Careless in appearance. Very quiet. Has done little work: Feb 10 Refused to work said she was sick: Throat sore occasionally Feb 28 but 106th Vaccinated: Mch 6 Visited by friends: Mch 27. Trans. to A3,

Apr 5 Visited by sister: Tonsils removed by Dr Heyerdale, Apr. 19. Visited by brother & taken home. In good general health. Very quiet & not inclined to work.

Discharged

Personal and Medical History of

Personal and Medical History of Ora Bindleman

(Correct name Bideman)

Whole No. 5724

Residence, St Paul, Minnesota

Date Admission, 26th December 1900.

Admitted by Dr. E. J. Warnow hour, 7.30 P.M.

How Sent, E.W. Cazille, J. of P. Ramsey County

Sex, Female Age, 32 years

Civil Condition, married

Children, one

Age Youngest Child, Three years

Occupation, Housewife (husband, Salesman)

Degree Education, Common School.

Profession, Religion, Episcopal

Habits, probably good; not intemperate

Nativity, Ohio: parents born in U.S. -

Physicians Committing, E.A. Borchardt & C. Eugene Riggs

Correspondents, James J. Bideman, 227 E 6th St. St Paul.
In Kingsley Saddlery Co.

No. For Year, 87 -

Insane Relatives, not known

Cause Exciting, unknown

Cause Predisposing, not stated

Form, Melancholia Acute

Accompanying Bodily Disorder, Poor physical condition

Suicidal or not, Suicidal, and propensity active.

Date of this Attack, Last September

Duration, about 3 months

No. of Attack, 1st -

No. of Admission, 1st -

Age First Attack, 31 last

Time of Leaving, May 8th 1902

Time in Hospital, 1 year 4 mos 12 ds

Result, Died: pulmonary tuberculosis.

* See letter of Mrs Lucinda Long (mother) Cordova Kentucky 2/7/1901

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Dec 29/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear, but somewhat sluggish

MEMORY, Past Events, Seems good.

Recent Events, Special Subjects,

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

REASONING POWER, Ordinary Subjects, Special Subjects, } Good

Own Mental State, Depressed & melancholy

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed & irritable

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,

ILLUSIONS,

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

Paternal Relatives,

Mother, living - well.

Maternal Relatives,

Brothers and Sisters, Three children 2 dead: 1 living

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

HABITS, Drinking and Smoking, no

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 fair constipated

Personal and Medical History of Ora Bindleman

HH/65
57 nt
no

M Ora Bindleman

Copy of Order for Hearing Petition of James J. Bideman for appointment of ____ as guardian for said Ora Bideman insane; served and ~~service admitted~~ Dec 31/1900 Rm

(Papers filed with commitment papers.)

Hearing for Monday 19th May '02 at 10. am

ACTERISTICS.

SUAL WEIGHT, NUTRITION, fair

ite Coating

al

good Grasp, —

TREMORS, Hands, Tongue, Facial Muscles, General, of hands, present.

PATELLAR REFLEX, Exaggerated Other Reflexes, Elbow + wrist

ARTICULATION, Slurred, Hesitating, Slow, Slow

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,
Normal

ARTERIES,
normal

Symmetrical
LUNGS, Chest, Symmetry, 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, Genitals normal: slight prolapse of uterus: retroflexion cervicitis, erosion and cystic degeneration of uterus: 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 fair physical condition. Is irritable & fretful & cannot understand why she cannot go to her home in St Paul. At first, patient was violent & struck at nurses: patient has evidently been a woman of some education.

Personal and Medical History of Ora

Whole No. 57 Ref
Residence, St Paul, Minnesota
Date Admission, 26th December 1900.
Admitted by D. E. J. Warnow hour, 7.30 P.M.
How Sent, E. W. Bazille, J. of P. Ramsey County
Sex, Female Age, 32 years
Civil Condition, married
Children, one
Age Youngest Child, Three years
Occupation, Housewife. (husband, Salesman)
Degree Education, Common School.
Profession, Religion, Episcopal
Habits, probably good; not intemperate
Nativity, Ohio: parents born in U.S. —
Physicians Committing, E. T. Borchardt & C. Eugene Riggs
Correspondents, James J. Bideman, 227 E 6th St. St Paul.
The Kenauth Saddlery Co.

No. of Year, 0,
Insane Relatives,
Cause Exciting,
Cause Predisposing,
Form, Melancholia
Accompanying Bodily Disorder, Poor Eyesight
Suicidal or not, Suicidal, and propensity
Date of this Attack, Last September
Duration, about 3 months
No. of Attack, 1st —
No. of Admission, 1st —
Age First Attack, 31 past
Time of Leaving, May 8th 1902
Time in Hospital, 1 year 4 mos 12 ds
Result, Died: pulmonary tuberculosis.

* See Letter of Mrs Lucinda Lang (mother) Cloverdale Kentucky 2/15/1901

EXAMINATION ON ADMISSION BY DR. Heyndale *Date of* Dec 29/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear, but somewhat sluggish
MEMORY, Past Events, Seems good.
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Correct & alert
REASONING POWER, Ordinary Subjects, } Good
Special Subjects, }
Own Mental State, Depressed & melancholy
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed & irritable

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,
ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or 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
Paternal Relatives,
Mother, living — well.
Maternal Relatives,
Brothers and Sisters, 3 brothers 2 Dead: 1 living
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
— No
HABITS, Drinking and Smoking, No
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 fair constipated

Personal and Medical History of Ora Bindleman

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, Prompt: White Coating
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes Yes
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal
HEARING, Good
COORDINATION, Arms, Good Legs, good Grasp, —
TREMORS, Hands, Tongue, Facial Muscles, General, of hands, present.
PATELLAR REFLEX, Exaggerated Other Reflexes, Elbow & wrist
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, Symmetrical 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, Genitals normal: slight prolapse of uterus: retroflexion cervicitis, erosion and cystic degeneration of uterus: 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 fair physical condition. Is irritable & fretful & cannot understand why she cannot go to her home in St Paul. At first, patient was violent & struck at nurses: patient has evidently been a woman of some education.

1900

This patient was brought here by Deputy Hanson, attended by James. J. Bidleman, in poor physical condition, with following history of Case. There is no history of consanguinity: this is 1st attack; first symptoms manifested last September, when she attempted suicide: disease appears increasing; not variable; no rational intervals; Derangement now shown in that patient is depressed and suicidal; is not disposed to injure others; has attempted suicide by taking carbolic acid, and propensity is now active: no filthy or destructive habits: as to any relatives having been insane, dont know: previously, she exhibited a violent temper. There is no history of intemperance: nor of any severe disease, convulsions or head-injury. She has not been restrained or confined. Cause of disease, unknown: has had no treatment. On personal examination, patient is reserved, depressed, mutters to herself, neglects her child, and threatens suicide.

Dec 26 On admission, was put upon T.W. (G.H.N. R'pt. Complexion dark; hair black; eyes brown; condition of skin, normal; no marks: scars noted on right side of face, on left buttock and left wrist; no eruptions ulcers &c: is clean: has an entire upper and lower plate: inclined to be violent; resisted when being bathed; talks very little). N.B. see letter from Covedale, Ky (2/12/1901) from Mrs Lucinda Lang, mother of Mrs Ora Bidleman, giving following points regarding her case: "my daughter Ora was born May 25/68; girlhood happy and free & everywish gratified as far as possible: (she being youngest child): was very healthy & rather fleshy: was married in 1889: previous year, had Typhoid fever, very bad. Soon after marriage, she learned her husband (J.J. Bidleman) had Epileptic fits & would then have "spells" of wandering from home (once to Denver. Col & again to New Orleans. La) & writing to her that "Ere she read this, I shall have committed suicide". Was always more or less uneasy when husband was out of her sight. (Think this trouble in Mr. B. is now cured). She has one living child & 2 Dead: has had several miscarriages (from I know of & perhaps more). Of late years was very cold-natured; complained of headaches for at least 10 years, almost constantly. (Mother asks several questions concerning patient. Vide). Asks advice as to leaving her where she is, but whenever she is able to leave Hospital, she wants her to come and see her.

Dec 26 (Summary 1st da Record by Dr. Heysedale) Admitted on Infirmary: Scars on right side of face: Very resistive: Restless & did not sleep: First week, temp. pulse & resp. about normal Appetite rather poor: hypnotics required for sleep. Bowels regular. Remained in bed - inclined to be stubborn: Very noisy first few nights, latter part of week slept well. Inclined to be melancholy & cried more or less. Often asked why she was not allowed to go to St Paul: Very irritable Does not express any delusions. Second week temp. pulse & resp. normal: appetite fair. Given malt & cod liver oil. Slept well. Up & dressed on Jan 3rd. Jan 5 Menstruated Very quiet in behavior & manner altho irritable: somewhat melancholy & acts in a somewhat hypochondriacal manner.

Jan 4. Patient somewhat obstinate & resistive: Very irritable in manner:

Jan 4 - Feb 10. Given electrical treatments: Quiet: neat: Does nothing to occupy mind: Takes some outdoor exercise under protest. Appetite fair: Vaccinated Feb 7 Wt. 105# Somewhat untidy & very disagreeable. Mar. to June Mar. 13 visited by husband; Mar 14 patient up on ward neat in appearance, but is at times unclean in her

1901

habits; takes out door exercise; bowels regular but needs cathartics occasionally sleeps well, appetite fair; quiet in behavior; not able to converse intelligently: Apr. 21 visited by husband: May 1 had operation of curettament of uteris up on ward May 7: at times quite noisy, disturbed and violent towards nurses put in restraint at times; receives gynaecological treatment, May 31 Wt 99½#.

June to Sept. June 3 patient often refuses to go to bed; hides away in some dark corner: June 6 threw false teeth down the water closet and lower set was broken only a small part of plate being found which was rescued by the nurse; June 22 tran. to C.3.: July 6 visited by husband: is at times extremely noisy and violent; Aug. 31 tran. to C1; Sept. 2 Wt. 109#.

Sept. to Dec. Is very delusional and calls almost constantly for her husband and runs about on the ward in an aimless way: at times quite hysterical; Nov. 22. Wt. 103#. Dec. to Mar. 1902 Dec. 24 visited by husband: very indifferent to surroundings: untidy so that hands were kept in muff: is at times quite noisy: is becoming more quiet of late: sometimes replies when questioned by the nurses, has to be dressed and undressed: sleeps well: menstruates regularly: appetite poor: bowels regular: Feb. 26 Wt. 98#. Mar. to June. Continued to fail during the next quarter Apr. 11 Wt. 90#. Urine examined for Diazo Reaction which was obtained Apr 24th. Tem. 102.8: Pl. 106 Res. 26: appetite very poor transferred to Inf. May 2 visited by friend May 3 by husband: Tem. ran up rapidly May 5 was 105.2; became very weak but did not expectorate though both lungs showed areas of consolidation May 8 died at 1:00 A. M. of Pulmonary Tuberculosis.

Dead

Personal and Medical History of Kate Hendry

Whole No. 5725.
Residence, Claremont, Dodge County, Minn.
Date Admission, 27th December 1900
Admitted by Dr. E. J. Mayou hour, 4th P.M.
How Sent, J. J. Hunt, Jr. P. Dodge County
Sex, Female Age, 28
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Has none: Father, a farmer
Degree Education, Common School
Profession, Religion, Wesleyan M.E.
Habits, no history of intemperance or other habits
Nativity, Minnesota; father's, Scotland; mother's, Canada
Physicians Committing, C.L. Chambers & C.S. Bigelow
Correspondents, (Father's address) Joseph Hendry, Claremont, Minn

No. of Year, 88
Insane Relatives, none
Cause Exciting, unknown
Cause Predisposing, chronic
Form, Chr. Melancholia
Accompanying Bodily Disorder, none Mentioned
Suicidal or not, not: but disposed to injure others
Date of this Attack, 9 years ago
Duration, 9 years, off and on.
No. of Attack, has had several, for years.
No. of Admission, 1st
Age First Attack, about 19.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* Dec 29/1900.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused
MEMORY, Past Events,
Recent Events, Poor Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert; illusive
REASONING POWER, Ordinary Subjects,
Special Subjects, Poor
Own Mental State, quiet
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Seems 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).
Has a sister who is hysterical
Father, Living
Paternal Relatives,
Mother, Living - well
Maternal Relatives,
Brothers and Sisters, 3 well
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
She says - No
HABITS, Drinking and Smoking, At times drank tea & coffee to excess
HEADACHES, VERTIGO, OR CONVULSIONS, had Epilepsy
OCCUPATION, Healthy or not, Housework: Dressmaker
Detail Date, Duration, and Character of Previous Attack, if any,
Poor Good
Sleep, Appetite, and Bowels, Constipated.

Personal and Medical History of Kate Hendry

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6½ PRESENT WEIGHT, 107¾ lbs USUAL WEIGHT, NUTRITION, Fair
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, prompt: slight white coat.
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal good good
SIGHT, fair: She says "eyes frequently blur" —
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal
HEARING, good
COORDINATION, Arms, good Legs, good: Other tests Grasp, also good.
TREMORS, Hands, Tongue, Facial Muscles, General, of hands slight: of others, none.
PATELLAR REFLEX, present Other Reflexes, slight of wrist.
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, none Strength, good Sounds, normal Size, normal
Apex Beat, Regularity, regular
ARTERIES,
Normal
LUNGS, Chest, Symmetry, Good flat 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, Genitals normal: antero-dextro flexion of uterus: cervicitis Endometritus: 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, very fair physical condition. Is quiet & tractable although the has a history of attempting to injure others. She answers very simple questions, but frequently talks very incoherently & confusedly. She has probably never had much education or advantages.

Personal and Medical History of Kate Hendry.

1900

This patient was brought here by Deputy J. Tucker, attended by Mr. & Mrs Root, in fair physical condition & with following history of case. There is no record of Consanguinity or heredity: this is not first attack; they have occured every few days for 8 or 9 years, duration being 6 or 8 hours. First symptoms of this attack manifested 9 years ago, after an attack of La Grip, by hysteria. Disease appears increasing; is variable & with rational intervals, but these, not at regular periods. Derangement now manifested on no particular subject. Is disposed to injure others, but not suicidal. Is of filthy & destructive habits. No previous peculiarities known. There is no history of intemperance or other habits, nor of any severe disease or head-injury. She has not been restrained or confined. Cause of disease is unknown: has had no treatment. On personal examination. She is emotional, easily excited, and has delusions of all kinds.

Dec 29 On admission, was put upon T.W. (G.A.N.R.H. Complexion dark; hair black: eyes brown; condition of skin normal: no marks: small scar on right arm: no eruptions, bruises &c: is clean: has 11 upper and 10 lower teeth, and her teeth are very poor. Behavior quiet: talks intelligently).

Dec 29 (Summary 14 da. record by Dr. Heyerdahl) Admitted on Infirmary, given bath & put to bed slept well with aid of hypnotic. First week temp- pulse & respiration varied slightly: Appetite poor the first three days. Hypnotics given the first four nights: Remained in bed until Jan. 2nd. Usually quiet in manner & behavior. Expressed delusions of persecution: at times somewhat hypochondriacal. Urinalysis showed trace of albumen: Jan 2. Up & dressed. Seemed in rather a depleted physical condition: Depressed & quiet. Second week Temp. from 98°-102. Resp. 14-22. Appetite fair. Occasional cathartics given for bowels. Upon ward. Slept well. Habits untidy. Somewhat resistive in manner.

Jan 7 1901. Visited by mother. Feb 10. Neat in habits but careless in appearance: Bowels somewhat constipated: given cathartics: Very quiet. Talks little: sleeps well: Attends chapel. Takes outdoor exercise

Feb 7 1901. Vaccinated: Wt. 98#. Received gynecological treatments

May to June 1901 May 22. patient very melancholy quite emaciated and run down, takes but little interest in her surroundings, takes out door exercise, has many delusions about her people, takes regular gynecological treatment, massage, and electrical treatment, menstruates regularly. May 30 Wt. 101#. June to Sept. Sept. 1st. is growing more melancholy, sits about in one place on the ward, untidy in her appearance, cries a great deal, sits with her face covered with her hands, appetite poor, Sept. 31 Wt. 101#. June 22 visited by mother. Sept. to Dec. no change, Nov. 30 Wt. 96#.

Dec 1-'01 to May 31-'02 No changes Wt 96#. Dec. 23rd, '01 visited by mother. Patient is very much depressed. Sits with head averted all day long as a rule. Rather pale and thin: has gastric trouble: stomach dilated & prolapsed: appetite is good notwithstanding. She sleeps well, sometimes during the day time. Bowels regular: takes exercise: helps at times in dining room. Nov 25th Wt 97# Dec 24th Visited by mother.

Personal and Medical History of

Personal and Medical History of Mary Connors

Whole No. 5726.
Residence, Janesville, Minn {Resident of State Nov 25/82 " " County Nov 25/82
Date Admission, 27th December 1900.
Admitted by Dr. O. C. Heyerdale hour, 7 45 P.M.
How Sent, Geo. A. Wilson, J of P. Waseca County
Sex, Female Age, 18
Civil Condition, single
Children, none
Age Youngest Child, —
Occupation, no occupation; (no father living) —
Degree Education, Common School
Profession, Religion, Catholic.
Habits, probably good
Nativity, Waseca, Minn: father's unknown; mothers, N. Y. State
Physicians Committing, M. J. Taylor & T. A. Swartwood
Correspondents, Uncle's address, Thos. Foley Jr, Janesville, (lives 3½ miles South-East of town)

No. of Year, 89
Insane Relatives, none
Cause Exciting, unknown
Cause Predisposing, unknown
Form, Acute Melancholia
Accompanying Bodily Disorder, Is nervous & Excitable
Suicidal or not, not
Date of this Attack, Monday Dec 24th
Duration, — 3 days —
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, — 18 —
Time of Leaving, Mch 24, 1901.
Time in Hospital, 2 mo, 25 da,
Result, Died. Pneumonia complicated
Minn with Valvular heart disease & double pleurisy.

* Letter of Enquiry sent Thos. Foley Jr. 1/5/1901. The following answers marked * given by him, with returned letter

EXAMINATION ON ADMISSION BY DR. Heyerdale Date of Dec 31/1900

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick, but Confused
MEMORY, Past Events, Is incoherent in talk
Recent Events, — Special Subjects, —
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert: illusive
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, Exalted: Confused
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted
DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks the nurses about her are people of St. Paul & calls them by names of her friends.
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, one week
ONSET, Gradual or Sudden, Sudden —
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
* none of the ailments in the family on either side that we know of
Father, * Dead Can
Paternal Relatives, not
Mother, * Living get
Maternal Relatives,
Brothers and Sisters, * an only child
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
* no
HABITS, Drinking and Smoking,
* only when she had her "monthly" — no *
HEADACHES, VERTIGO, OR CONVULSIONS, or Dizziness
* OCCUPATION, Healthy or not, School-girl till last June at home after —
Detail Date, Duration, and Character of Previous Attack, if any,
* Sleep, Appetite, and Bowels, They seemed to be all right on all those things —

Personal and Medical History of Mary Connors

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in PRESENT WEIGHT, 85 lbs USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, prompt: white coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, yes yes yes: normal size:
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, none
HEARING, good
COORDINATION, Arms, good Legs, good ~~Grasp~~, other tests good —
TREMORS, Hands, Tongue, Facial Muscles, General, none.
PATELLAR REFLEX, Exaggerated Other Reflexes, absent.
ARTICULATION, Slurred, Hesitating, Slow, good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, none strong normal
Apex Beat, Regularity, normal regular
ARTERIES,
normal
LUNGS, Chest, Symmetry, Expansion, Symm. 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, Genitals normal: hymen intact: Easily dilatable: uterus retro-verted: cervix patulous.
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 & very delirious & restless. Is active & out of bed frequently. Talks readily but does not give correct answers to questions. Imagines those about her are people from her house & calls them by the names of her friends. —

Personal and Medical History of *Mary Connors*

1900

This patient was brought here by Deputy Michael Ryan, attended by Thos. Foley and Mrs Foley, in fair physical condition & with following history of case. There is no history of consanguinity or heredity. This is first attack; first symptoms manifested Monday 24th December; she imagined that "Knock-out Drops" had been given her. Disease seems increasing; not variable; no rational intervals: Derangement now shown in that she imagines that the people about her are planning to destroy her. Is not disposed to injure others: not suicidal: no filthy or destructive habits. No previous peculiarities manifested so far as can be learned. Do not know of any history of intemperance. No severe disease or head-injury mentioned. Has not been restrained or confined except since last Monday. Cause of the Disease, unknown. Sedatives have been given her, as treatment.

On Personal Examination, she is nervous and excitable; and fears that people are plotting against her. It is believed that hospital restraint and treatment are necessary.

Dec 27 On admission, was put upon T.W. (G.H.N. R'pt. Complexion fair; hair light; eyes, bluish gray; no marks, scars or bruises noted; is clean; has 12 upper and 13 lower teeth. Is quiet; resisted a little when bathing; refused to talk). See letter of Tom Foley Jr. Janesville, Minn. Jany 12/1901. "The Monday before she went there it seemed she woke out of sleep, (if it was not caused by a bad dream); she had no trouble or care on her. A couple of nights before she was taken sick, she complained of not sleeping good: she is 18 years old & she never had her "monthly trouble" until last April. Doctored for it but was not regular: about a month since she had it. used to have them twice a month: complained of headaches but not bad ones: had the nose-bleed a good deal, otherwise seemed in perfect health. Guessed the population of State, & the Thursday she was taken sick, she received a letter, telling her that she would win some money; seemed to be delighted over it. &c. If she didn't think of that I don't know of anything: I know as much about her as anyone." &c —

Dec 27 (Summary 14 da. record by Dr Heyerdale) Admitted an Infirmary. Given bath & put to bed. Very resistive & excited: extremely noisy most of night. Temp. 98-99° the first week. Pulse

to 78-112. Resp. 17-20. Appetite poor at first but improved toward end of week.

Jan 10 Bowels somewhat constipated requiring enemata. Restless & noisy & out of bed frequently. Fed by nurses. Second night slept only three hours. Untidy in habits. Third night slept well with aid of hypnotics & hot bath. Slept 4 hrs. the 4th night. Slept well the 5th night also remainder of week. Took medicine & nourishment well. Second week Temp. ranged from 98-100° - Pulse 72-88. Resp. 18-24. Appetite good: Given malt & cod liver oil, also wine. Bowels regular with aid of cathartics. Slept well. Slept well first night, after that noisy & restless for four nights. Given hypnotics regularly. Hot baths given occasionally at bed time.

Jan 14 Up on ward: Attacked Betsy Berge & A. Schneider also nurses: Quite exalted & very active at times. Electrical treatments given from Jan 18 - Feb 13th. Improved in general health: rarely speaks: untidy. Violent at times: appetite good. Sleeps well. Stomach washed daily. Feb 27 81½ H. Vaccinated. Very destructive at times. Requires constant attention. Mch 10. Kept in bay. Usually sleeps well. Usually fairly quiet on ward: occasionally very active 12 In bed. Has severe cold & epistaxis, coughs & expectorates. Mch 15 Up on ward. 19 In bed. In evening complained of being dizzy & nauseated. Had a sudden rise of temperature

Personal and Medical History of

to 103° Pulse 145. Resp. 27. 21 Visited by mother relatives. Complained of severe pain in chest. Very restless. Temperature high. On liquid diet. Very sick. 22 & 23 Temp. very high: given sponge baths. Sleeps fairly well. Complained of pain, coughed & expectorated. Mch. 24 Fairing gradually - Given 1/40 strych. hypodermically every 3 hours since March 23rd. Died at 10:45. Cause of death pneumonia complicated with heart disease and double pleurisy.

Died.

Personal and Medical History of Josephine Kult

Whole No. 5731.
Residence, West St. Paul, Minn.
Date Admission, 3rd January 1901.
Admitted by Dr. O.C. Heyerdale hour, 7.30 P.M.
How Sent, Thos. O'Moran, Jeff. Dakota County
Sex, Female Age, 40 years
Civil Condition, Single.
Children,
Age Youngest Child,
Occupation, Housekeeper: (father, Gardener & tailor)
Degree Education, Common School.
Profession, Religion, not a church member
Habits, (probably good: no history of intemperance.
Nativity, Minnesota: Parents born in Germany.
Physicians Committing, H. VanBeeck & D. Van Cappellen
Correspondents, Frederick Kult (a brother)
c/o Annapolis St. and Oakdale Ave
St. Paul Minn

No. of Year, 9th.
Insane Relatives, None
Cause Exciting, Probably Menstrual Derangement.
Cause Predisposing, Chronic
Form, Delusional Insanity
Chronic Mania occasional discharges from Ear.
Accompanying Bodily Disorder, Menstrual Derangement.
Suicidal or not, Not; but will injure others
Date of this Attack, 7 years ago
Duration, 7 Years
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, about 33.
Time of Leaving, June 13th 1902
Time in Hospital, 1 yr 5 mos 10 Ds
Result, Improved: Dis? Dec 17/02
By Boff C.

EXAMINATION ON ADMISSION BY DR. Heyerdale Date of Jany 5/1901.

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.
Alert: Illusive
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

DELUSIONS, Systematized, Transitory, Special Subjects,
Patient believes that people are constantly Scheming against 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, Gradual.
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Living (well) 80 years.
Paternal Relatives,
Mother, Living (well) 70 years
Maternal Relatives,
Brothers and Sisters, Brother, Sister well.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No
HABITS, Drinking and Smoking, Good
HEADACHES, VERTIGO, OR CONVULSIONS, No No
OCCUPATION, Healthy or not, H
Detail Date, Duration, and Character of Previous Attack, if any,

Sleep, Appetite, and Bowels, Poor Poor

Personal and Medical History of Josephine Kult

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, fair physical
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, Prompt: Coated.
PUPILS, Equality, Size, Response to Light, and Accommodation, Eq fair good – Size Small.
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal
HEARING, Seems poor.
COORDINATION, Arms, Legs, Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, present
PATELLAR REFLEX, present Other Reflexes, Elbow & wrist
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, Yes 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, Genitals normal: hymen intact; somewhat rigid: uterus retro-verted - Cervicitis - 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 fair physical condition: patient has many delusions: believes that people are scheming against her. Is very suspicious of those about her and of what is done for her. At times she is obstinate & even violent.

Personal and Medical History of Josephine Kuelt

1901

This patient was brought here by her brother Frederick Kuelt, in fair physical condition, with the following history &c. There is no history of consanguinity or heredity. This is 1st attack: Symptoms manifested seven years ago, under impression of being hypnotized by certain party: would be taciturn for 3 or 4 days, then very loquacious for a few days, this alternating; of late, became abusive to others: found herself: insists upon going to bed with clothes on: occasionally gorges herself with food. Disease seems increasing: is variable, with rational intervals, but these are not regular. Derangement now manifested in that she imagines some influence is acting upon her, preventing her from doing her duty: decided incoherency of thought and expression. She is disposed to injure others, but not suicidal. No filthy or destructive habits. No previous peculiarities known: no history of intemperance in self or parents: She has occasional discharges from ear, and there is menstrual derangement. She has not been restrained or confined. Cause of the disease is probably menstrual Derangement. Treatment, none; patient refused any medication —

On Personal Examination, the facts brought out are only as above described. —

Jan 3 On admission, was put upon T.W. (G.H.R.Rpt. Complexion dark: hair black: eyes brown; condition of skin normal: no marks, scars or bruises noted: is dirty: has 13 upper and 12 lower teeth. Resisted when being bathed; think she has delusions). See Letter 1/8/1901 from Fred'k Kuelt (Bro) on file. "Mother states illness commenced with running at ears; thick matter followed by blood: several times a year, for several years: menstruation very irregular: for 4 years (92 – 96) hardly noticable; since then scant: for a year or more, would do all she could to prevent it coming on". No insanity, epilepsy, hysteria or inebriety on either mother's or father's side: mothers mother died when mother about 7 years of age; Some lung trouble: can't say if consumption or not. Father & mother still living: 1 brother & sister: She has had some headache lately and, at times, some dizziness; occupation, last 2 years, virtually nothing; assisted in housework. Ripped most of her clothing intending to make them over: never did so. Would play the piano, at times, as well as ever; at other times, like a beginner; also gave instruction on piano: 2 pupils. Sleep restless: sometimes talk and "halloa" until 2 and 3 o'clock, for 3 or 4 nights; then rest better for a time (sometimes 4 nights a week or even 2 weeks): appetite as a rule good; was nearly all the time constipated".

Jan 3 to Jan 17 (Summary of 14 days record by Dr Reynolds) Received as Infirmary, given bath & put to bed. Very resistive, awake & out of bed all night. Temp. pulse & resp. about normal the first week; some slight variation. Refused nourishment the first day. Hypnotics given. bowels constipated. Expressed delusion that some one wanted to hypnotize her. Latter part of week slept well & talked quite intelligently at times. More quiet in manner & behavior: dressed & up on ward on the 8th. Second week temperature, pulse & resp. about normal. Appetite fair. Bowels regular. Slept well at night. At first resisted when temperature was taken but otherwise quiet in manner & behavior: talked intelligently most of time & read a great deal. Continued resistive when bathed & when hair was combed.

Feb 5 1901. Up on ward: quiet: neat. Talks very little: Sleeps well: Bowels regular: Appetite good. 2 runs to A[r]. Expresses few delusions & is more intelligent.

Feb 28 Wt. 116½. Vaccinated. General health good. Is quiet & usually agreeable. Occasionally somewhat bitter because not allowed to go home. Has a great many

Personal and Medical History of

ideas about Spiritualism &c. Mar. to June 1901. May 29 patient is neat in habits and appearance, takes regular out of door exercise, converses very little, has many delusions, constantly asks to be sent home, at times is inclined to be somewhat violent. May 29 Wt. 123#. June to Sept. June 5 attacked nurses, made threats against nurses and physicians, June 29 attempted to run away. Aug. 26 Wt. 127#. Sept. to Dec Oct. 5 patient attempted to get away was very angry when brought back and refused her supper, Oct. 19 attempted to run away again while out walking, Nov. 5 refused nourishment was fed by a tube. patient is wholly unoccupied, Nov. 29 Wt. 130#.

Dec to June, 1902 No change. Wt 126#. June 13th Visited by mother and

Taken home on trial.

Personal and Medical History of Pauline Brodhag

Whole No. 5736.
Residence, St. Paul, Minn. Resident of State 13 yrs. " of County 13 "
Date Admission, 16th January 1901.
Admitted by D. E. J. Wanous. hour, 7.30 P.M.
How Sent, E. W. Bazille, J. of P. Ramsey County.
Sex, Female Age, 45
Civil Condition, married (husband, a brass-polisher)
Children, - 4 -
Age Youngest Child, 9 years.
Occupation, Housewife
Degree Education, Common School
Profession, Religion, German - Lutheran
Habits, patient & both parents used liquor
Nativity, Germany; parents also born there
Physicians Committing, E. C. Estulby & O. Martel
Correspondents, none given in Com.t papers

No. for Year, 99
Insane Relatives, none
Cause Exciting, not known
Cause Predisposing, previous attack & probably habit
Form, Melancholia (mild) delusions - Sub acute melancholia
Accompanying Bodily Disorder, none mentioned
Suicidal or not, not -
Date of this Attack, about September last
Duration, about 4 months -
No. of Attack, 2nd (other occurred June 23/1900)
No. of Admission, 2nd (was here June 23. - Aug 9 - 1900)
Age First Attack, 44+
Time of Leaving, Mch 12' 1901
Time in Hospital, 1 mo. 24 da.
Result, Dischg. Recovered Apr 30' 1901.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* Jan 19/1901

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,
Does not express any

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).
Both parents used liquor -
Father,
Paternal Relatives, negative
Mother,
Maternal Relatives,
Brothers and Sisters, 1 Brother died (accident): 1 sister living 4 children.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
no
HABITS, Drinking and Smoking, Good
HEADACHES, VERTIGO, OR CONVULSIONS, no
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
was committed to hospital once before - came first in June 1900 and remained 6½ weeks -
Sleep, Appetite, and Bowels,
good - good - regular -

Personal and Medical History of Pauline Brodhag

WOMAN BECOMES VIOLENT—Mrs. Pauline Brodhag, 62 Como avenue, was taken to the county jail last night, and it is feared her mind is affected. She was violent when taken in charge by officers from the Rondo street station. She has a married son and two smaller children.
P.D. Oct 24/1901

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 152 lbs USUAL WEIGHT, NUTRITION,
and condition of Skin, healthy
TONGUE, Coatings or Promptness of Movement, prompt; clear.
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal: size normal. good good
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Good
COORDINATION, Arms, good Legs, good Grasp, other tests good.
TREMORS, Hands, fine Tongue, Facial Muscles, General,
PATELLAR REFLEX, present in left knee: absent in rt knee Other Reflexes, absent
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, none Strength, Strong Sounds, Size, normal
Apex Beat, normal Regularity, regular
ARTERIES, normal
LUNGS, Chest, Symmetry, yes 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,

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 good physical condition: talks sensibly & rationally in all subjects: patient's condition was brought on by "domestic troubles", caused by a "Drinking husband" -

Personal and Medical History of *Pauline Brodbag*

Whole No. 5736.

Residence, St. Paul, Minn. Resident of State 13 yrs. of County 13

Date Admission, 16th January 1901.

Admitted by Dr. E. J. Wanous. hour, 7.30 P.M.

How Sent, E.W. Bazille, J. of P. Ramsey County.

Sex, Female Age, 45

Civil Condition, married (husband, a brass-polisher)

Children, - 4 -

Age Youngest Child, 9 years.

Occupation, Housewife

Degree Education, Common School

Profession, Religion, German - Lutheran

Habits, patient & both parents used liquor

Nativity, Germany; parents also born there

Physicians Committing, E. L. Estelly & O. Martel

Correspondents, None given in Com. papers

No. of Year, 99

Insane Relatives, None

Cause Exciting, not known

Cause Predisposing, previous attack & probable habit

Form, Melancholia (mild) delusions - Sub acute Melancholia

Accompanying Bodily Disorder, None mentioned

Suicidal or not, not -

Date of this Attack, about September last

Duration, about 4 months -

No. of Attack, 2nd (other occurred June 23/1900)

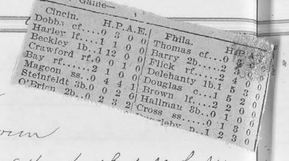
No. of Admission, 2nd (was here June 23. - Aug 9 - 1900)

Age First Attack, 44+

Time of Leaving, Mch 17 1901

Time in Hospital, 1 mo. 24 da.

Result, Discha Recovered Apr 30 1901.



EXAMINATION ON ADMISSION BY DR. O. C. Hesperdale *Date of* Jan 19/1901

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,
Does not express any

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, Both parents used liquor -
Paternal Relatives, Negative
Mother,
Maternal Relatives,
Brothers and Sisters, 1 Brother died (accident): 1 sister living 4 children.

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

HABITS, Drinking and Smoking, Good

HEADACHES, VERTIGO, OR CONVULSIONS, No

OCCUPATION, Healthy or not, Housework

Detail Date, Duration, and Character of Previous Attack, if any,
was committed to hospital once before - came first in June 1900 and remained 6 weeks -

Sleep, Appetite, and Bowels,
Good - good - regular -

Personal and Medical History of *Pauline Brodbag*

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5in PRESENT WEIGHT, 152 lbs USUAL WEIGHT, NUTRITION,

WOUNDS, Abnormalities and condition of Skin, healthy

TONGUE, Coatings or Promptness of Movement, prompt; clean.

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal; size normal; good good

SIGHT, Good

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

HEARING, Good

COORDINATION, Arms, good Legs, good Grasp, Other legs good.

TREMORS, fine Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, present in left knee; absent in right Other Reflexes, Absent

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, None Thing Normal
Apex Beat, Regularity, Normal regular

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Yes 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,

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 good physical condition: talks sensibly & rationally on all subjects: patient's condition was brought on by "domestic troubles", caused by a "Drinking husband" -

Personal and Medical History of *Pauline Brodhag.*

1901

This patient was brought here by Deputy E. Johnson, attended by Leah Sutherland, with following history of case. There is no history of consanguinity or heredity. This is not first attack; one occurred in June 23/1900 duration 6 weeks (?), when she was sent to this (Rochester) Hospital, and duly discharged. First symptoms of this attack were manifested about September last, by delusions. Disease seems increasing; variable and there are rational intervals, but these are not regular. Derangement now shown by delusions as to parentage and pregnancy. Patient is not disposed to injure others, nor suicidal: no filthy or destructive habits. No peculiarities previously manifested. There is history of intemperance as patient and both parents used liquor. No mention of any severe disease &c or head-injury. Has not been restrained or confined during this attack. Don't know cause of the disease. No treatment has been given. On personal Examn. patient shows irritable temper & reckless manner. (N.B. Patient has been here before: see Case No 5602 Vol 42. p 277. from June 23/1900 to Aug 9/1900: was discharged, recovered, on Nov 6th 1900)

Jan 16. On admission, was put on I.W. (G.H.N.R'pt. Complexion, dark; hair black; eyes gray; condition of skin, normal: no marks, scars, bruises &c noted: is rather dirty: has 7 upper and 8 lower teeth. Behavior quiet: talks intelligently.

Jan 16 to Jan 31. Summary 14 da. record by Dr Heyerdale. Received on Infirmary. Bathed & put to bed: Talked intelligently: expressed no delusions: Slept well during night. Up & dressed next day: Quiet & intelligent: began assisting with work. First week. Temp. &c. slightly above normal: Appetite very good: Took tonics after meals. Bowels regular: Slept well: Converses readily: Took outdoor exercise. Second week. Temp. pulse & resp. normal: Appetite good: Tonic given after meals: Bowels regular: Slept well: Willing & agreeable on ward. Took out door exercise. In good condition mentally & physically.

Feb 12 1901. In very good general health: Attends chapel: Takes exercise: Agreeable & pleasant: Appetite good: Quite helpless on ward: Intelligent in speech & actions. Today while bringing flowers from greenhouse slipped & sprained left wrist. Feb 28 Wt. 153½#. Vaccinated. Takes gynaecological treatment three times a week. Mch. 8 In excellent physical condition: neat: very quiet mentally. Mar 12 Sent home this morning.

Discharged.

Personal and Medical History of

Personal and Medical History of Emma Swanson

Whole No. 5738. Resident of State 11 yrs. of County 3.
Residence, St. Paul, Minn.
Date Admission, 19th January 1901.
Admitted by Dr. O. C. Heyerdale hour, 7 30 P.M.
How Sent, E. W. Bazille, J. of P. Ramsey County
Sex, Female Age, 29 years.
Civil Condition, married
Children, Three —
Age Youngest Child, three months
Occupation, Housewife: (husband, laborer).
Degree Education, limited; can read & write.
Profession, Religion, Mission Church
Habits, not history of intemperance
Nativity, Sweden; parents also born there.
Physicians Committing, Charles Wirth & Arthur Sweeney
Correspondents, (Husband's Address)
Mr. Gustaf Swanson #1199 Faquar St. St. Paul

No. of Year, 101.
Insane Relatives, unknown
Cause Exciting, unknown
Cause Predisposing, unknown
Form, Lactational Insanity Melancholia Acute Melancholia
Accompanying Bodily Disorder, none mentioned
Suicidal or not, not —
Date of this Attack, January 11th last
Duration, about a week — (8 days)
No. of Attack, 1st —
No. of Admission, 1st —
Age First Attack, 29
Time of Leaving, August 13 — 1901.
Time in Hospital, 6 mos 25 ds.
Result, Improved —
Discharged by Board of Control
Feby 26 — 1901.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Jany 21/1900

*These particulars from husband's letter of Jany 23/1901 (on file)

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused
MEMORY, Past Events, patient is incoherent
Recent Events, " Special Subjects, "
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Illusive
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted
DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses many delusions: believes she is being teased & annoyed purposely: also says the nurses have been killing 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,
ONSET, Gradual or Sudden, —
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, *Died, about 4 years ago (70-80 yrs) cause of death, old age —
Paternal Relatives,
Mother, *Still living (about 60) — apptly good health
Maternal Relatives,
Brothers and Sisters, *4 brothers & 2 sisters: all well so far as I know.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
*never had any prominent diseases nor gone through any operations
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, *has suffered some from headache — no dizziness or convulsions
OCCUPATION, Healthy or not, *general housework & taking care of children (3).
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, *sleep & appetite have been good until within last few days — bowels have not operated
Albright within past 13 months or since birth of last child born about that time.

Personal and Medical History of Emma Swanson

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, healthy
TONGUE, Coatings or Promptness of Movement, prompt
PUPILS, Equality, Size, Response to Light, and Accommodation, good good
SIGHT, Seems good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Seems good
COORDINATION, Arms, good Legs, good Grasp, Other tests good
TREMORS, Hands, Tongue, Facial Muscles, General, no
PATELLAR REFLEX, present Other Reflexes, wrist jerk
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, no strong normal
Apex Beat, Regularity, normal yes
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, yes 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,

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. She was confined 3 months ago; breasts on full of milk. Mentally, patient is noisy & excited; talks a great deal & incoherently. Says "people are wronging her;" "Killing her & so on". Sleep & out of bed, a great deal. Has hallucinations of hearing: "thinks she hears people under her bed," and frequently will be found looking under her bed for them.

Personal and Medical History of Emma Swanson.

1901

This patient was brought here by Deputy Emanuel Johnson, attended by husband Gustaf Swanson, in poor condition, with following history of case. There is no history of consanguinity; no previous peculiarities; no history of intemperance, nor of any severe disease &c or head injury: as to insane relatives unknown; This is 1st attack; first symptoms manifested January 11th by delusions, incoherence & violence. Disease appears increasing; not variable; no rational intervals. Derangement now shown by religious delusions & general incoherence. Patient is not disposed to injure others, nor suicidal, nor of filthy or destructive habits. She has not been restrained or confined. Cause of the disease is unknown: if under treatment, unknown. On personal examination, patient is forgetful; said "that she had been sawed in two: bad worms are put on her & that she has been dead in

Jan 19 the woods" – On admission was put on I.W. (G.H.N.R'pt. Complexion fair: hair light brown; eyes blue; condition of skin, hot & dry: no marks or scars noted: small eruption on lower part of back: no ulcers; a few small bruises on right knee; and a scratch on right side of back & left knee. Scrather dirty. Has 13 upper and 14 lower teeth; a few are in a very bad condition. Behavior quiet: is incoherent). N.B. see letter from husband, of date of Jany 23/1901, on file: states first notice of illness Jany 11th of this year: began crying without cause; there has never been anything wrong on her father's or mother's side to my knowledge: further particulars in examination blank *=

Jan 19 to Feb. 3 Summary 14 da. Record. (by Dr Heyerdale) Admitted on Infirmary, bathed & put to bed: somewhat disturbed: Talks incoherently: Noisy at times: Slept several hours: First week. Temp. pulse & resp. about normal: On liquid diet: Bowels regular: Hypnotics given: breasts full of milk (had been nursing child) & required daily attention: breath very offensive: mouth washed with listerine. Slept well at night: Fairly quiet in behavior somewhat disturbed & noisy at times: In bed: Had hallucinations of sight & hearing. Right nipple slightly caked & chapped. 25 Given vaginal douches: seems somewhat better: urine examined: found to contain trace of sugar. 2nd week. Temp. pulse & resp. normal. Sleep good with aid of hypnotics bowels regular: Appetite good. Amt. urine in 24 hrs 26 oz. first of week somewhat depressed: Jan 28. Six roots extracted: Teeth in very bad condition. Takes nourishment well: Breasts contain milk still. Feb 16 Visited by husband

Feb 28. Up on ward: Kept in bay greater part of time. Quite disturbed: Not as well as some time ago: dirty: Appetite fair: bowels regular: sleeps poorly: requiring hypnotics. Very foolish & childish: Strikes patients & nurses. Wt 118½#. Receives gynaecological treatment.

Mar. to June 1901 Patient improving somewhat, has been very incoherent, but for the past month has become somewhat rational in her conversation, expressed delusions and hallucinations, assists some with ward work, general health good, May 29 Wt. 144#. June to Sept. Aug. 13. patient went home to attend the funeral of her husband, is very much improved mentally at times seems slightly disturbed, pleasant and agreeable on ward, assists with ward work, takes out door exercise, attends amusements.

Personal and Medical History of

Personal and Medical History of Catherine Elle

Whole No. 5739. Register Stude 15 yrs

Residence, St. Paul, Minn. Ramsey County

Date Admission, 23rd January 1901.

Admitted by D. O. C. Heyerdale hour, 7.30 P.M.

How Sent, E. W. Bazille, J. of P. Ramsey County

Sex, Female Age, 33

Civil Condition, married.

Children, 6.

Age Youngest Child, 1½ years.

Occupation, Housewife; (husband's plasterer)

Degree Education, very poor; neither reads nor writes

Profession, Religion, Catholic

Habits, hard-working woman of good habits: takes glass beer occasionally

Nativity, Hungary: (parents also born there)

Physicians Committing, Arthur B. Ancker & Allen Dunning

Correspondents, (Husband's Address) John Elle 1221 Gaultier St. St. Paul, Minn

No. of Year, 102.

Insane Relatives, no history of insanity

Cause Exciting, not known

Cause Predisposing, not known

Form, Acute mania

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, not

Date of this Attack, beginning of January 1901

Duration, about 3 weeks

No. of Attack, 1st

No. of Admission, 1st { has been at City & County Hospital since Jany 18/1901

Age First Attack, 33

Time of Leaving, September 17 - 1901

Time in Hospital, 7 mos 25 ds.

Result, Improved

Discharged by Board of Control - April 14 - 1902 -

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Jany 30/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quick: somewhat confused

MEMORY, Past Events, not reliable

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,

Exalted

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 3 weeks

ONSET, Gradual or Sudden, sudden

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

Father, Living

Paternal Relatives,

Mother, Living

Maternal Relatives,

Brothers and Sisters, 5 — 3 (?)

Children — 4 sons: 2 Daughters?

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, Did not sleep well.

Personal and Medical History of Catherine Elle

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1½in PRESENT WEIGHT, 100 lbs USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt; slight Coating

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

SIGHT, good

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

HEARING, good

COORDINATION, Arms, good Legs, good Grasp, — when tests good.

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

PATELLAR REFLEX, present Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none strong normal

Apex Beat, Regularity, normal regular

ARTERIES,

Arterio-sclerosis

LUNGS, Chest, Symmetry, Expansion, fair 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, Genitals normal: vulvitis: urethral caruncle: perinaeum slightly lacerated; recto-cele, cervicitis: cervix eroded: herpes vaginalis, leucorrhoea, cervix slightly lacerated. uterus movable: slight anteversion.

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: is very restless & sleepless: takes very little nourishment: talks, laughs & sings a great deal: uses vulgar, profane language. Talks German & very little English. Keeps constantly, a great deal; is maniacal in manner & behavior.

Personal and Medical History of Catherine Elle

1901

This patient was brought here by Deputy Emanuel Johnson, attended by husband John Elle, in fair physical condition, with following history of case. Do not know of any consanguinity: no history of insanity: this is first attack: first symptoms manifested the beginning of January 1901, by incoherent language and wandering from home. Disease seems increasing; not variable; no rational intervals: Derangement now shown by raving; using vile and obscene language; restlessness, insomnia etc. Patient is not disposed to injure others, nor suicidal: no filthy or destructive habits. She has been a hard-working woman, of good habits; takes an occasional glass of beer: has not been subject to any severe disease etc or head-injury: She has been restrained & confined at City & County Hospital since January 18th 1901. Cause of the disease we do not know: treatment pursued has been rest, hypnotics, nourishment. On personal Examination, patient is very restless, and talkative; has to be restrained by her husband & friend. N.B. Patient was accompanied on her admission here by her "Social History Sheet" and her "Clinical history sheet" from the City & County hospital. These are filed with her "Commitment papers." - Diagnosis of "Acute Mania" made while there.

Jan 23 On admission, was put on T.W. (G.H.N.R/t. Complexion dark; hair brown; eyes gray; condition of skin normal; no marks, bruises or eruptions noted: a few scars on right leg from varicose ulcers; and has several varicose veins; has vermin & is very dirty: 14 upper + 13 lower teeth + a few roots. Is quiet. Does not speak English very well).

Jan 23 to Feb 8 Summary 14 da. Record by Dr Heyerdale. Very dirty & noisy: breasts caked & full of milk had haemorrhoids. vomited Brown fluid full of undigested food: very offensive odor. Hot applications to limbs. Salts given: also brandy. First week temp. & pulse above normal: resp. normal. on liquid diet took fair amount of milk & water: cathartics given. & enemata first 3 days. Catheterized on Jan 24. Salts given by tube on 29th. Breasts pumped several times daily. Slept 5 to 8 hrs. per night Noisy restless & disturbed at times: Vomited occasionally: Second week: Temp & c normal: on liquid diet: Bowels moved by cathartics Slept quite well until Feb 5, did not sleep any: noisy & disturbed at times Talks only German

Feb 7-27 Continued much the same: untidy noisy, restless: Took nourishment well: Bowels moved by cathartics: Stomach washed: Very resistive & violent toward other patients: Talked loudly & was profane. Up on ward on Feb 10th. Feb 11 Visited by relatives. Feb 28 Very much disturbed during day: required Hypnotics at night: on liquid diet. expectorates a great deal. Stomach washed at times. Wt. 93# Received electrical treatments. Mar-June. Patient is untidy in habits and appearance. Bowels regular but sometimes requires cathartics: appetite good: sleeps well: takes out of door exercise. Takes gynaecological treatments: menstruates regularly. April-9-11-13-14 given massage. She is kept in bay. Converses freely in German, is often noisy & uses vile and profane language: at times expresses delusions. May 2 Wt. 108#

June General health good; appetite good. menstruates regularly: takes exercise and works on the ward: habits dirty: does not speak English: has delusions and is quite mischievous: sometimes talks in a vulgar manner. June 9 visited by husband. Sept. 1 - Wt 106#. During next quarter marked improvement: patient ceased to be disturbed and slept well at night: attended amusements: habits became clean and appearance much neater: and was more agreeable in every way: became very useful on the ward. Sept. 17 visited by husband and taken home.

Discharged

Personal and Medical History of Catherine Elle

Personal and Medical History of Jennie Suisse

Whole No. 5/442.
Residence, Cannon City, Minn
Date Admission, 26th January 1901.
Admitted by D.O.C. Heyerdale hour, 4.40 PM.
How Sent, James Hunter, J.P. Rice County
Sex, Female Age, 54.
Civil Condition, Married
Children, - 7 -
Age Youngest Child, 10 -
Occupation, *Housewife (husband's farmer)
Degree Education, Slight; Can read, not write.
Profession, Religion, Catholic
Habits, no history of intemperance.
Nativity, Belgium; parents also born there
Physicians Committing, Roscoe N. Jackson & D.M. Cool
Correspondents, Son-in-law J.L. Frick (lives in town) Faribault, Minn

No. of Year, 105
Insane Relatives, None
Cause Exciting, Family trouble: death of a daughter
Cause Predisposing, Previous attack
Form, Melancholia (mild) Acute
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Suicidal & dangerously active
Date of this Attack, Probably recent
Duration, Probably short.
No. of Attack, 2nd (had one, 8 years ago).
No. of Admission, 1st
Age First Attack, 46 Years.
Time of Leaving, 18th March 1901
Time in Hospital, 1 Mo 15 Ds
Result, Recovered: Discharged Mar 30/1901.

EXAMINATION ON ADMISSION BY DR. O.C. Heyerdale Date of Feby 1901

* Items marked thus were answers in reply to letter to J.L. Frick – (on file)

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Seems good

Recent Events, Seems good Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive. Alert

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State, Says "She is not crazy but sick in her head"

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).
Daughter died of Tuberculosis –
Father, Dead — Pneumonia
Paternal Relatives,
Mother, Dead (Dropsical condition)
Maternal Relatives,
Brothers and Sisters, 2 brothers; 1 Sister
7 Children: 3 boys living – 2 girls living

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

HABITS, Drinking and Smoking,
Much of late? Yes. Suffered from Dizziness? Yes
HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework & farm work

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

Sleep, Appetite, and Bowels, Constp?
poor good fair

Personal and Medical History of Jennie Suisse

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3in PRESENT WEIGHT, 128 lbs USUAL WEIGHT, NUTRITION, Fair
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt: White Coating: Coated; prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal Slight
SIGHT, Yes
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Yes
COORDINATION, Arms, good Legs, good Grasp, Rt hand good
TREMORS, Hands, Tongue, Facial Muscles, General, Hands: Coarse tremor: tongue, tremor.
PATELLAR REFLEX, present Other Reflexes, Elbow + wrist
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, None fairly strong
Apex Beat, Regularity, normal regular
ARTERIES, Sclerotic
LUNGS, Chest, Symmetry, Expansion, Yes 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, Genitals normal; urethral Caruncle: vulvitis: haemorrhoids: lacerated & eroded cervix: cervicitis: leucorrhoea: uterus retroflexed.
MENSTRUATION, = Remarks =
OPHTHALMOSCOPIC EXAMINATION, Patient admitted in fair physical condition. Speaks French and very little English, so that a conversation must be carried on through an interpreter. She is mentally depressed & cries a great deal — thinks she is not going to get well & that she must go home that she

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). may die with her children. Complains of pain in her head & stomach, but no cause is discoverable. Her urine shows presence of some kidney trouble. In the morning of Jany 31, patient lapsed into a semi-unconscious condition from which she did not arouse until about 10 PM. At 4 am she again became unconscious, rousing up at about 11 am on Feb 1. While in this condition she is relaxed, breathes regularly, pulse is good; takes no nourishment. Seems like a deep sleep rather than a Coma. Quantity of urine passed since this time was scanty.

Personal and Medical History of *Jennie Suisse*

1901

This patient was brought here by Deputy J. L. Fuik, in fair physical condition, with following history. There is no history of consanguinity or heredity. This is not first attack; one occurred 8 years ago, the duration, one year: was kept at home; got better, not as before. When first symptoms of this attack were manifested, is not stated: they were in the way of overwork & anxiety, caring for sick members of the family. Disease is increasing: is variable & with rational intervals, but these are not regular. Derangement now shown by suicide, wants to die, melancholy. Is not disposed to injure others: She has not attempted suicide, but propensity is now active & she threatens to take her own life. No filthy or destructive habits. No previous peculiarities known; no history of intemperance; no of any severe disease or of head-injury. She has not been restrained or confined. Supposed cause of the disease is Family Trouble, death of a daughter. Has had medicine; no result. On personal Examination, Pulse 100, soft, small, says "her head is killing her". J. L. Fuik deposes and says she has "violent spells"; tries to kill herself by throwing herself on floor, against walls &c.

Jan 26 On admission, was put on T.W. (G.H.N. Rpt. Hair black; eyes hazel: condition of skin, normal; no marks or scars noted: Several small sores on chest, back, arms & legs: nose bruised: No hernias. In jaw: has 2 upper & 6 lower teeth, & several roots. Behavior quiet: talked fairly well):-

Jan 26 to Feb 9 Summary of da record (Dr. Heydrick) Quit an admission: slight eruption on body: coughs considerably: Slept well at night. Talks only French. During first week Temp. pulse & resp. about normal: Appetite fair: bowels regular: Hypnotics given to hypochondriacal & complained of headache & pain in chest. Expressed desire to die & begged nurses to kill her: Disturbed all week: Complained of pain in urinating. Slept fairly well: sometimes noisy: Teeth badly decayed. On morning of Jan 31. Seemed as usual but at 10:15 went into a comatose condition. Remained in this state until 10:50 P.M. when she aroused & looked as if intoxicated. She again relapsed into this condition & aroused again at 8 A.M. on Feb 1st. Condition seemed one of hysteria. No cause known.

Feb 1 to Feb 10. Mch. Temp. pulse & resp. normal: appetite fair: bowels regular without aid of cathartics: Slept well. Complained constantly of being tired & seemed somewhat stupid. Bladder irrigated for several days: Very melancholy thinks she is going to die. At times noisy: usually sleeps well.

Feb 10. Up on ward: Seems quite cheerful & talks freely. Speaks only French. Appetite fair: Bowels regular: requires hypnotics. Feb. 29 Wt. 117#. Vaccinated Receives gynaecological treatment 3 times a week. Mch 6 Up on ward each day. Takes regular outdoor exercise: Complains some of pain in head: Assists with ward work: Is agreeable & pleasant: occasionally melancholy & cries. Asks to be sent home. Trans. to A3. Mch. 9. Coughs & expectorates a good deal. Gives malt & cod liver oil 3x day. Mch 13 Visited by son & taken home.

Discharged.

Personal and Medical History of

Personal and Medical History of Emma Erickson

Whole No. 5744. {Resident of State 1890 " " County 1897.
Residence, St Paul, Minn.
Date Admission, 28th January 1901.
Admitted by Dr. O. C. Heyerdale hour, 7 15 P.M.
How Sent, E. W. Bazille, J. of P. Ramsey County
Sex, Female Age, 33.
Civil Condition, Single.
Children, —
Age Youngest Child, —
Occupation, Domestic; father a farmer.
Degree Education, Common school
Profession, Religion, not a church member.
Habits, no history of intemperance —
Nativity, Sweden; (parents also born there).
Physicians Committing, John B. Brimhall & A. W. Whitney
Correspondents, (Sister) Sophia. M. Frees
*(665 Case St.) 665 K. Street, St Paul. Minn
* See letter Feby 19/1901. from Mrs Axel. T. Frees.

No. of Year, 107.
Insane Relatives, Sister sent to Fergus Falls Asylum 1899
Cause Exciting, overwork
Cause Predisposing, previous attacks; (heredity?)
Form, Recurrent Mania
Acute Mania
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, — not —
Date of this Attack, January 20th 1901.
Duration, — about 8 Days —
No. of Attack, 3rd
No. of Admission, 1st here (California 1892. Fergus Falls 1899)
Age First Attack, about 24.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Jany 30/1901

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,
Exalted
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, Eight Days
ONSET, Gradual or Sudden, sudden
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, a drinker; not well; always ailing
Paternal Relatives,
Mother, healthy
Maternal Relatives,
Brothers and Sisters, 3 sisters; one sister has been insane
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
None
HABITS, Drinking and Smoking, Drinks
HEADACHES, VERTIGO, OR CONVULSIONS, headache; vertigo.
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
I said "had been at St. Peter twice; once at Fergus"
Sleep, Appetite, and Bowels, Slap, appetite poor.

Personal and Medical History of Emma Erickson

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5½ PRESENT WEIGHT, 143 lb 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, good good equal, normal.
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, good Legs, good Grasp, other tests, good
TREMORS, Hands, fine Tongue, none Facial Muscles, none General,
PATELLAR REFLEX, exaggerated Other Reflexes, Elbow; wrist; Jaw.
ARTICULATION, Slurred, Hesitating, Slow, good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, none Strength, Strong Sounds, Size,
Apex Beat, Regularity, normal
ARTERIES,
Slightly Sclerotic
LUNGS, Chest, Symmetry, Sym 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, Genitals normal — hymen intact — uterus adherent — levo-retroverted, cervicitis — 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; is very strong; has been employed as a cook; she is maniacal in manner & behavior; talks a great deal & is very restless also inclined to be violent, at times. answers questions readily & intelligently. is sleepless at night. Brother in law states that her condition is due to overwork.

Personal and Medical History of Emma Erickson

1901

This patient was brought here by Deputy Emanuel Johnson, attended by Dr. L. M. Luther-land and W. A. F. Frees, in fair physical condition, with following history of case. (Patient was brought here in Restraint by "muff"). There is no history of consanguinity: her sister was sent to Fergus Falls Asylum in 1899. This is not 1st attack; seemingly the 3rd as she had them in 1892 + 1895: duration 3 months: was in California in 1892 & in Fergus Falls, Minn, 1895. was discharged, cured. First symptoms of this attack were manifested Jany 20th 1901, by incoherent talk. Disease seems increasing; not variable; no rational intervals. Derangement now shown in no particular subject; appears to be generally demented. Is disposed to injure others, but is not suicidal: Is destructive; tears clothing and destroys property. Melancholia noticed a few days before this attack. There is no history of intemperance in self or parents, nor of any severe disease or head-injury. Patient has been in Ramsey County Jail since January 26th 1901. Supposed cause of the disease is Overwork. No treatment. On personal Examination, She is very violent, and is under closest confinement.

Jan 28 On admission, was put on T.W. (G.H.N.Rpt. Complexion fair; hair light; eyes gray; condition of skin normal; no marks, scars or bruises noted; Is dirty; has 12 lower and 9 upper teeth and several roots. Behavir maniacal: talks intelligently, at times).

NB. See Letter from Mrs Aveh. J. Frees. 665 Case St. St Paul. In 1893. She accompanied her father to California for her health; two months after arrival, took sick mentally; was committed to Hospital in San Jose; was confined for 3 months: when released, father took her to Minnesota: was very well till the "Hinckley Fire" broke out: she was saved from a burned Corpse: Excitement preyed on her mind + she was sent to Fergus Falls, hospital: was there 3 or 4 months: afterward, did well, working as domestic in families + all through winter of '98-'99. Worked for Dr. Price; he died + a daughter took sick: excitement about funeral &c + waiting on people caused her to lose sleep + she would halloa, scream, talk + sing. She was then sent home to her family, who sent her to County Jail. She did not sleep for a whole week almost. In regard to her parents + grand-parents, they were all good moral citizens, dying of old age. Father mother + 2 sisters living + enjoying good health. Her appetite was poor; she suffered from diarrhoea.

Jan 28 to Feb 14 Summary 14 da. record (Dr Weygandt) Received on ward. Resistive + disturbed Talk incoherent. Slept 5 hrs. noisy. given hypnotic. First week Temp. pulse + resp. normal. Slept with aid of hypnotics. Bowels regular with cathartics. Somewhat dirty; violent + destructive. Talked quite intelligently. During record week. Appetite good. Bowels regular. Slept well. Somewhat noisy + restless during day. Expressed some delusions. Up on ward Feb 4. Assisted with ward work. Quite agreeable. Night of Feb 23 noisy + disturbed Feb 4. Trans. to C2. up on ward: assisted with work: fairly agreeable: At times resistive talks a great deal: quite maniacal: Rather inclined to be noisy at night

Feb 15. Improved mentally: habits neat: Sleeps better at the still noisy at night Takes outdoor exercise. Bowels regular. Assists with ward work.

Feb 18 Wt. 147½#. Vaccinated. Mar. to June 1901 Mar. 2 had two teeth pulled. Mar. 31. Patient in good physical health, talks a great deal,

Personal and Medical History of

expresses many delusions, quite exalted, noisy most of the time, sings a great deal, appetite good, sleeps poorly, assists with the ward work. May 6 trans. to A-3. patient is very much quieter and improving May 31 Wt. 144#.

June to Sept July 2 patient went home July 10 returned after having been out on trial only eight days, bathed and put to bed, is despondent and expresses a desire to commit suicide. Aug 10. attempted to commit suicide by choking herself with a roller towel in washroom of B 4 West. Aug. 31 very much improved, assists with ward work, takes medicine regularly, recieves massage and regular electrical treatment. Wt. 128 3/4 #. Sept. to Dec. Nov. 29 general health good., patient interests herself by making torchon lace, takes regular out of door exercise, assists with the ward work, is very well mentally, expresses no delusions and is cheerful and agreeable, Wt. 153#.

Dec. to May-1902 Patient very much improved in health: quiet and agreeable: very rational: assists with the work. May 19th Taken out on trial. June 15th Patient returned to Infirmary. Conversat: very much disturbed mentally: melancholy and agitated: very noisy and quarrelsome: disagreeable fault finding destructive: untidy in appearance. Sept. 16th Patient beginning to improve: takes more interest in surroundings: quiet in behavior. Nov. 12th transferred to A 3 Nov. 13th transferred to B 2. again disturbed.

Personal and Medical History of Elizabeth Morisette

Whole No. 5745.
Residence, St Paul: Resident of State, Minn. of County, Ramsey
Date Admission, 28th January 1901.
Admitted by Dr. O. C. Heyerdale hour, 7 15 P.M.
How Sent, E. W. Bazille, Jo. P. Ramsey County
Sex, Female Age, 43 (?)
Civil Condition, single
Children, —
Age Youngest Child, —
Occupation, Seamstress; father, a farmer
Degree Education, Common School
Profession, Religion, Roman Catholic
Habits, not known
Nativity, White Bear, Minn; (parents born in Canada).
Physicians Committing, Chas. E. Lee & R. S. Bole
Correspondents, (Sister's address) Mrs. Alphons Farrelle
365 Constant St. St Paul. Minn.
* See letter from sister Mrs Mary Farrell (address 332. St. Laurence Str. St Paul. Minn).

No. for Year, 108.
Insane Relatives, no testimony.
Cause Exciting, unknown
Cause Predisposing, previous attacks
Form, Mania Acute
Accompanying Bodily Disorder, none known
Suicidal or not, not stated; but threatens others.
Date of this Attack, dont know; no one to testify
Duration, probably short
No. of Attack, one in 1884 & several others of short duration
No. of Admission, 1st here: (was at St. Peter)
Age First Attack, about 26 (?)
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Febry 1/1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear: quick
MEMORY, Past Events, fair
Recent Events, good Special Subjects, good
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert: Correct
REASONING POWER, Ordinary Subjects, good
Special Subjects, good
Own Mental State, says: thinks she was somewhat insane, when committed —
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
normal generally becomes excited when she talks of the Insurance Agent
DELUSIONS, Systematized, Transitory, Special Subjects,
she has some 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).
says: the thinks one sister was insane —
Father, Dead
Paternal Relatives, no history
Mother, Dead. probably tuberculosis.
Maternal Relatives, no history
Brothers and Sisters, one brother — 10 sisters her brother is deaf & dumb
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), no hurt head by falling on R.R. track; lost consciousness for a few moments —
HABITS, Drinking and Smoking, Takes wine daily.
HEADACHES, VERTIGO, OR CONVULSIONS, headache — 2
OCCUPATION, Healthy or not, housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, poor Appetite, good and Bowels, do not move every day.

Personal and Medical History of Elizabeth Morisette

5745
44/101
M Elizabeth Morisette
Copy of Order for Hearing Petition of Alphonse Farrell for appointment of as guardian for Elizabeth Morisette insane; served and service admitted March 4/1901 —
(Papers filed with commitment papers.)

...ACTERISTICS.

...USUAL WEIGHT, NUTRITION, fair
...ted: prompt
...l: small
...nal

COORDINATION, Arms, good Legs, good Grasp, other tests good
TREMORS, Hands, none Tongue, fine Facial Muscles, none General,
PATELLAR REFLEX, present Other Reflexes, wrist — elbow
ARTICULATION, Slurred, Hesitating, Slow, good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, no Strength, strong Sounds, normal Size, normal
Apex Beat, Regularity, regular

ARTERIES, normal
LUNGS, Chest, Symmetry, yes 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, genitals normal: hymen intact — uterus hypertrophied — cervicante-flexion — freely movable — leucorrhoea — cervicitis.
MENSTRUATION,
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 fair physical condition. Is somewhat anaemic. Is very quiet in manner except when she speaks of a certain man, who, she says, persecuted her, & then she becomes excited — speaks loudly & her eyes flash. She also tells of others whom she claims to have persecuted her. These alleged persecutions are, no doubt, largely delusional — she says she has lived alone for a number of years.

Personal and Medical History of Elizabeth Morisette

Whole No. 5745.
Residence, St Paul: Resident of State, Minn. " of County, Ramsey
Date Admission, 28th January 1901.
Admitted by Dr. O.C. Heyerdale hour, 7 15 P.M.
How Sent, E.W. Bazille. Jo P. Ramsey County
Sex, Female Age, 43 (?)
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Seamstress; father, a farmer
Degree Education, Common School
Profession, Religion, Roman Catholic
Habits, not known
Nativity, White Bear, Minn; (parents born in Canada).
Physicians Committing, Chas. E. Lee & R. S. Bole
Correspondents, (Sister's address) Mrs. Alphons Farrelle
365 Constant St. St Paul. Minn.
* See letter from sister Mrs Mary Farrell (address 332. St. Laurence Str. St Paul. Minn).

No. fo
Insane
Cause
Cause
Form,
Accom
Suicida
Date o
Duration, probably short
No. of Attack, one in 1884 & several others of short duration
No. of Admission, 1st here: (was at St Peter)
Age First Attack, about 26 (?)
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O.C. Heyerdale Date of Feby 1/1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear: quick
MEMORY, Past Events, fair
Recent Events, good Special Subjects, good
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert: Correct
REASONING POWER, Ordinary Subjects, good
Special Subjects, good
Own Mental State, says: thinks she was somewhat insane, when committed
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
normal generally becomes excited when she talks of the Insurance Agent
DELUSIONS, Systematized, Transitory, Special Subjects,
she has some 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).
says: she thinks one sister was insane —
Father, Dead
Paternal Relatives, no history
Mother, Dead. probably tuberculosis.
Maternal Relatives, no history
Brothers and Sisters, one brother — 10 sisters
her brother is deaf & dumb
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), no hurt head by falling on R.R. track; lost consciousness for a few moments —
HABITS, Drinking and Smoking, Takes wine daily.
HEADACHES, VERTIGO, OR CONVULSIONS, headache — 2
OCCUPATION, Healthy or not, housework
Detail Date, Duration, and Character of Previous Attack, if any,
poor good
Sleep, Appetite, and Bowels, do not move every day.

Personal and Medical History of Elizabeth Morisette

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1 in PRESENT WEIGHT, 110 lbs USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, white coated: prompt
PUPILS, Equality, Size, Response to Light, and Accommodation, poor yes Equal: small
SIGHT, poor: wears glasses
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, good Legs, good Grasp, other tests good
TREMORS, Hands, Tongue, Facial Muscles, General, none fine none
PATELLAR REFLEX, present Other Reflexes, wrist — elbow
ARTICULATION, Slurred, Hesitating, Slow, good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, no strong normal
Apex Beat, Regularity, normal regular
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, yes 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, genitals normal: hymen intact — uterus hypertrophied — leso ante-flexion — freely movable — leucorrhoea — cervicitis.
MENSTRUATION,
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 fair physical condition. Is somewhat anaemic. Is very quiet in manner except when she speaks of a certain man, who, she says, persecuted her, & then she becomes excited — speaks loudly & her eyes flash. She also tells of others whom she claims to have persecuted her. These alleged persecutions are, no doubt, largely delusional — she says she has lived alone for a number of years.

Personal and Medical History of Elizabeth Morisette

1901

This patient was brought here by Deputy D. L. Courteau attended by Mrs Jos. Salmon, in fair physical condition, & with following history of case. No history of consanguinity. This is not 1st attack; had one in 1884 and several others of short duration; was sent to St. Peter; dont know result of treatment. Dont know when 1st symptoms of this attack were manifested; no one to testify; whether increasing, decreasing or stationary, dont know; if variable &c, no testimony; Derangement now shown by delusions of persecution: has made violent threats to injure others. Dont know as to habits; no testimony as to relatives having been insane. Dont know as to any previous peculiarities, as to any intemperance or any severe disease &c. Has not been confined since at St. Peter in 1884. Cause of disease unknown: no treatment that is known of: On personal Examination, patient is extremely violent.

Jan 28 On admission, was put on T.W. (G.H.N. R'pt. Complexion dark; hair brown; eyes brown; Condition of skin normal; no marks or scars noted: both knees bruised; no hernia: is clean: 11 upper, 13 lower teeth

* See letter from Sister Mrs Mary Farrell, dated Feb 18/1901. "was in Rochester about 17 years ago, but she returned well & remained well until 6 years ago, when she had another spell: was sent to St. Joseph's Hospital, but she never was very well since 1894. Father & mother both dead: were in good health & lived to an old age: never was any sickness in family, on either side: she has 9 sisters & 3 brothers: she never had any prominent diseases or operations: often complained of headaches. Last occupation was working in Shirt factory: has always been doing dressmaking or factory work, since she was able. Dont know anything about character of her health during past few months, because she never came to my house, but I heard from neighbors that she was very insane, "by spells"."

Jan 28 to Feb 12 Summary by Dr Heyerdale - 14 da. record. Received an Infirmary: Quiet: Talks freely: bathed & put to bed: Slept but little the sleeping dose was given: First week. Temp. pulse & resp. normal. Appetite good: Occasional hypnotics given: Slept fairly well: Bowels regular: Complained some of throat being sore: Talked intelligently except when conversing about a certain insurance man in St Paul whom she says persecuted her then becomes excited. Second week Temp. pulse & resp. normal: appetite good: bowels regular with laxatives. Quiet: talks freely & quite well. Feb 8 up on ward: 1 vaginal douche given

Feb 18 Trans. to A3. Feb. 26 Vaccinated. General health good: quiet pleasant on ward: occasionally slightly disturbed & says she should have pay for her work. Mar. to June 1901 May 29. patient is up on ward, neat in habits and appearance, takes out door exercise, has delusions of persecution, at times when disturbed uses vile and vulgar language, at times becomes somewhat violent x May 30 Wt. 109#. June to Sept. July 15 menstruated: Aug 15 left eye swollen: patient is at times very noisy and disturbed: very delusional and incoherent but usually quiet: habits clean: appearance neat: attends chapel and amusements: Sept. 1 Wt 110½. Sept. to Dec. Sept. 16: Oct 14: Nov. 15 menstruated: no change Nov. 30 Wt. 116½#.

Dec to Feb 1903 Gen'l health good: appetite good: bowels regular: sleeps well: menstruates regularly: Takes exercise: does no work: converses readily, at times intelligently but is quite delusional. Dec 1st Wt 117½#.

Personal and Medical History of

Personal and Medical History of Mrs Michael Wallace (Bridget)

Whole No. 5744.
Residence, St Paul; Resident of State 17 yrs. of Co. 17 yrs.
Date Admission, 29th January 1901.
Admitted by Dr. L. A. Linton hour, 7.15 P.M.
How Sent, E. W. Bazille, Jail. Ramsey County
Sex, Female Age, 80.
Civil Condition, married
Children, 4 Dead
Age Youngest Child, 20 years, when died
Occupation, Housewife; husband, laborer
Degree Education, Not educated
Profession, Religion, Catholic
Habits, No history of intemperance
Nativity, Ireland; parents also born there
Physicians Committing, J. S. Gibillan & H. J. O'Brien
Correspondents, Michael Wallace
23rd Alabama St. St Paul Minn.

No. for Year, 110.
Insane Relatives, no knowledge
Cause Exciting, Grief?
Cause Predisposing, probably old age
Form, Senile Dementia
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, not
Date of this Attack, 6 months ago
Duration, 6 months
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 79th
Time of Leaving, December 3d 1901.
Time in Hospital, 10 mos: 4 Ds.
Result, Died of Senility: valvular heart disease & nephritis were contributing causes.

EXAMINATION ON ADMISSION BY DR. Dr. O. C. Heydale Date of Jany 31/1901

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 Mrs Michael Wallace

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3½ PRESENT WEIGHT, 120 lbs USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement,

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

SIGHT, She seems to see well

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

HEARING, She seems to hear well

COORDINATION, Arms, Could not Legs Get — Grasp, —

TREMOKS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

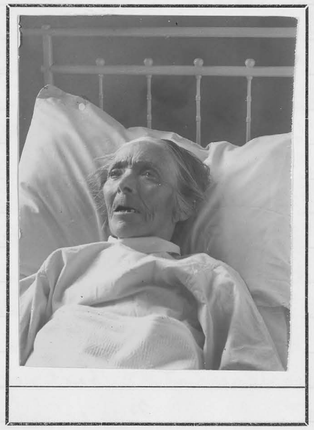
HEART, Murmurs, Strength, Sounds, Size,

Apex Beat, Regularity,

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, Genitals normal: Haemorrhoids; urethral Caruncle; rectocele; Cervix Cystic & carcinomatous; Cervicitis; Senile papillary vaginitis; retroflexion of Uterus — cervix erosed — 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 fair physical condition. She is old & demented, and, as she does not speak English, it is impossible to estimate the degree of dementia. Patient is careless & filthy in habits & extremely restless & wanders aimlessly about.

1901

This patient was brought here by Dep. Sher. Johnson, attended by Louisa Bouchart, in good physical condition, with following history. There is no knowledge of any consanguinity or heredity; This is first attack: has not been in hospital; first symptoms manifested 6 months ago. Disease appears increasing: not variable; no rational intervals: Derangement now shown in that she keeps calling for her children. Patient is not disposed to injure others, nor suicidal: is disposed to filthy & destructive habits. No previous peculiarities shown, unless grief. No history of intemperance nor of any severe disease &c or head-injury. Has been in confinement with "Little Sisters of Poor". Supposed cause of disease is Grief (?). Has had no treatment. On personal Examination, no facts learned, save as above; (it is impossible to understand her). —

Jan 29 On admission, was put on T.W. (G.H.N. Rpt; Complexion dark; hair black, part gray; eyes gray; condition of skin normal; no marks: some scars on lower part of back; small eruption on back; no ulcers, bruises &c noted: Is very dirty: has 1 upper & 10 lower teeth & several roots: Behavior quiet; does not speak or understand English very well).

Jan 29 to Feb 1 Summary 14 da. record by Dr Heyerdale Admitted on Infirmary, bathed & put to bed: resistive & rather violent: slept well: First week. Temp. pulse & resp. normal: Appetite good: hypnotics given for sleep. Patient old & demented: restless: Bowels regular with enema. Very dirty in habits & appearance: destructive. Feb 1 Found in room in morning with head bruised & laceration over right eye. As she is unable to give an account of it & there were no witnesses - it is probably due to falling out of bed. Second week Temp. pulse & resp. normal: appetite good. Bowels moved regularly: Feb 5 Very dirty in habits: Trans. to B'. Feb 6-11 Very resistive on ward: Talks no English. Irish & does not understand what is said to her: Noisy at night Feb 9. Very feeble. fell down & lacerated back of scalp. Feb 10 Troubled some with diarrhea Mch 1 - Wt. 110#. Mar 1 - June 1 - 1901 May 16. patient struck by another patient with a spoon receiving small cut in the forehead, no stitches taken. May 18 fell on floor spraining left hip, has been confined to bed since that time received massage and liniment applied. Patient seems to be in quite a debilitated condition. Weight not taken.

June to Sept. Patient in bed from May 18 to July 24 on account of a sprained hip: July 24 up on ward; restless, destructive of clothing, always doing something, wanders about the ward taking off her clothes or tearing and chewing them; keeps her teeth constantly going chewing on something. Sept. 2 Wt. 106#. Sept to Dec. Sept 6 small toe on right foot badly inflammed: deep fissure beneath the toe joining the foot: bichloride compresses applied: put to bed: Sept. 20 trans. to Inf. West: stimulants given foot dressed twice daily: latter part of Nov. patient sat up in chair part of the day on account of a bed sore that developed on lower part of back; became stuporous and gradually failed: Father Riordon called in Dec. 3: Patient died at 5:40 A.M. Dec. 3d, 1901. — Died —

Personal and Medical History of Margaret (Margrate) Farrell

Whole No. 5748. Resident of State 36 yrs ago May 1865 " of County about 1875 or 76

Residence, Winona, Minn.

Date Admission, 31st January 1901.

Admitted by Dr. O. C. Heyerdale hour, 4.15 PM

How Sent, D. E. Vance. Jof P. Winona County

Sex, Female Age, 60.

Civil Condition, Widow

Children, - 2 -

Age Youngest Child, about 27 years

Occupation, Housewife (husband, Car repairer)

Degree Education, Not educated

Profession, Religion, Catholic

Habits, no history of intemperance.

Nativity, Ireland; parents also born there

Physicians Committing, L. A. Kelly & Thos. A. Pierce

Correspondents, (Daughter) Miss Kate Farrell

* See letter from Kate Farrell - Chatfield Minn Feby 17/1901

No. of Year, 111.

Insane Relatives, None

Cause Exciting, Mental Decay

Cause Predisposing, probably age

Form, Senile Dementia

Accompanying Bodily Disorder, Feebleness

Suicidal or not, Not

Date of this Attack, 3 Years ago.

Duration, probably Since then

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 57.

Time of Leaving, 9th July 1901.

Time in Hospital, 5 mos 9 Ds.

Result, Recovered: Discharged Nov 30/1901.

EXAMINATION ON ADMISSION BY DR. Dr. O. C. Heyerdale Date of Feby 2/1901

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.
Alert

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

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Does not express any

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).
* Then has never been any in either side -
Father, * Dead.

Paternal Relatives,

Mother, * Dead.

Maternal Relatives,

* 3
Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
* never had a severe disease or Surgical Operation

HABITS, Drinking and Smoking, Occasionally takes a glass of Stimulant -

HEADACHES, VERTIGO, OR CONVULSIONS,
* Severe during past 4 months * and from dyspepsia frequently

OCCUPATION, Healthy or not, Housework -
* care of the household

Detail Date, Duration, and Character of Previous Attack, if any,
* for a month before going to Rochester took no nourishment to speak of * very poor

Sleep, Appetite, and Bowels, * much constipated
* Slept very soundly at night. but took no rest during day.

Personal and Medical History of Margaret Farrell

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2 PRESENT WEIGHT, 104½ lbs USUAL WEIGHT, NUTRITION, Poor

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt: white Coating -

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

SIGHT, good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, right eye normal; left eye Squint - cataract -

HEARING, Good

COORDINATION, Arms, fair Legs, poor { Finger to nose, eyes shut, good - Standing on one foot poor Grasp, Standing, eyes shut, good -

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

PATELLAR REFLEX, present Other Reflexes, Elbow - wrist

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, None fairly strong Normal
Apex Beat, Regularity, Normal regular

ARTERIES,
Slight Sclerosis

LUNGS, Chest, Symmetry, Expansion, Lyn 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, Haemorrhoids: urethral caruncle: genitals normal - Cervix atrophied - uterus absent: retroverted & carcinomatous. -

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 & is quite emaciated. She is old & feeble and quite demented - Memory is poor. Patient talks freely & answers questions well on ordinary subjects that do not tax her memory. -

Personal and Medical History of Margaret Farrell

1901

This patient was brought here Martin J. Luis (Sheriff M. J. Luis) attended by Mrs Ora Luis, in fair physical condition, with following history of case. There is no history of consanguinity or heredity; This is first attack; first symptoms manifested 3 years ago, by feeble-mindedness and dementia: The disease appears increasing; variable with rational intervals, but these not regular: she wants to be constantly going away; wants to go home. Derangement now shown in no special subjects; uncertain in all subjects; seems to be lost. Is not disposed to injure others; has not attempted suicide; propensity not active: no filthy or destructive habits. No previous peculiarities; no history of intemperance so far as known, nor of any severe disease. They have had to lock doors & keep her from wandering away. Supposed cause of the disease is mental decay. Nothing given in way of treatment. On personal Examination, Sometimes she is pale(?), at other times flushed(?). She is thin & feeble; silent but easily excited. ——————

Jan 31 On admission, was put on T.W. (G.H.N. Rpt: Complexion dark; hair brown, part gray; eyes gray; — conditions of skin normal: small scar on lower part of back: no eruptions, ulcers, or bruises noted: is clean: in of the lower ribs in left side appears to have been injured - Resisted being bathed. — has delusions. She has 14 upper teeth & ten lower, with a few roots). ——————

* See letter from Daughter, Kate Farrell, Feby 17/1901. "Mental trouble commenced about 2 yrs ago, by gradual loss of
E memory, forgetting friends, relatives, streets & familiar places: Health poor for many years: suffered from Weak Stomach.
C Some headache & general weakness: was just recovering from one of periodical "sick spells", when my father
met with accident from effects of which he died 9 months later. She never recovered from shock. Since his
death "she always wants to go home" - Does not realize how ill is - Jany 16. Had attack of "Grippe", which
went to her head: was very forgetful. Up to 2 years ago she was mentally sound. Stomach seemed too weak
to retain nourishment: at the very best, appetite poor: mystery to Doctors what she lived on. She has been in feeble health
a long time."

Jan 31 to Feb 13 Summary 14 da. record by Dr Heyerdale. Admitted on Dispensary, bathed & put to bed: Noisy & resistive & somewhat violent. Slept well. First week. Temp. pulse & respiration about normal: appetite good: bowels constipated. Condition one of senile dementia & she is very nervous & restless; Talks a great deal. Thinks she must go home at once. Does not realize where she is. Has hallucinations, & thinks she hears people talking. Given hypnotics & with their aid slept well. Appetite fair. Second week. Temp. pulse & resp. normal: appetite fair: occasional cathartics given. Somewhat more quiet altho very restless & somewhat noisy. Coughs some.

Feb 28 Up on ward each day: tidy: appetite fair: expresses many delusions so old, feble & demented. Does no work. Frequently asks to go home. Given cathartics: Sleeps well. Mar-June. No change in mental or physical condition. Mar. 28 visited by daughter & friend. May 28 Wt 126#
Her general health is quite good, eats and sleeps well; bowels inclined to be constipated requiring cathartics; goes out riding; habits clean: is inclined to be disturbed at times and sometimes does not keep herself properly clothed; cries a great deal otherwise behavior quiet.

Personal and Medical History of Margaret Farrell.

July 1st Does not answer questions intelligently. July 2 visited by daughter
July 9 visited by daughter and taken home.
Discharged.

Personal and Medical History of Annie A. Griffith

Whole No. 5749.

Residence, St Paul, Ramsey Co. Minn. Resident of State 1866 " County 1866.

Date Admission, 1st February 1901.

Admitted by Dr. L.A. Linton hour, 7.30 P.M.

How Sent, Edmund W. Bazille, Jof P. Ramsey County

Sex, Female Age, 35

Civil Condition, Married

Children, one

Age Youngest Child, 16 –

Occupation, Housewife (father a plaxtiner husband, el. oper.

Degree Education, parochial schools

Profession, Religion, Catholic –

Habits, Probably good: no history of intemperance

Nativity, St Paul, Minn: parents born in Ireland –

Physicians Committing, E.J. Abbott and C.A. Wheaton

Correspondents, Mr. Matlock (Philip J. Matlocks) 108 Leech N. St Paul

No. of Year, 112

Insane Relatives, None

Cause Exciting, unknown

Cause Predisposing, previous attack, possibly.

Form, Acute Melancholia agitans, delusions.

Accompanying Bodily Disorder, None mentioned –

Suicidal or not, – not –

Date of this Attack, 5 months ago

Duration, 5 months

No. of Attack, 2nd (1st, 16 years ago, after childbirth) duration 1 week.

No. of Admission, 1st –

Age First Attack, about 19.

Time of Leaving, January 18–1902

Time in Hospital, 11 mos 18 ds.

Result, Improved: Discd July 15–1902 By Bofc

EXAMINATION ON ADMISSION BY DR. Dr. O.C. Heyerdale Date of Feby 3/1901

MENTAL CHARACTERISTICS.

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

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

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

REASONING POWER, Ordinary Subjects,
Special Subjects, good
Own Mental State, Does not think she is insane; Says "she has a very bad temper" –

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed & cries a great deal

2/23/1901 DELUSIONS, Systematized, Transitory, Special Subjects,
Is very melancholy. Believes she is the cause of all that is wrong. Thinks she caused her mother's death

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 – Pneumonia at 53 – & grandfather –

Paternal Relatives, Don't Know

Mother, Dead. Diabetes or "Bright's" at 62 years

Maternal Relatives, Don't Know

Brothers and Sisters, 4 sisters, 2 brothers living & well

Children – one child – boy –

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
had Pneumonia, 20 years ago.

HABITS, Drinking and Smoking, No – takes an occasional glass beer –

HEADACHES, VERTIGO, OR CONVULSIONS, Has had attack of vertigo, but not for a year.

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 Annie A. Griffith

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1½ PRESENT WEIGHT, 146 lbs USUAL WEIGHT, NUTRITION, good

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt & white coated.

PUPILS, Equality, Size, Response to Light, and Accommodation, Eq normal good good

SIGHT, good

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

HEARING, good in left; slightly impaired in right.

COORDINATION, Arms, good Legs, good Grasp, Other tests good

TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor fine tremor

PATELLAR REFLEX, present Other Reflexes, right elbow & wrist: left, wrist.

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none Strong normal
Apex Beat, Regularity, normal regular

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Yes, well developed – 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, Hyperaemia of vulva, vagina & cervix: uterus enlarged – cervicitis – endometritis – leucorrhoea.

MENSTRUATION, Remarks. Patient admitted in good physical condition: appetite is good:

OPHTHALMOSCOPIC EXAMINATION, and she is strong & well developed. Mentally she is depressed & cries a great

BLOOD, Corpuscles, Hæmoglobin, deal. Says "she is not insane", but says it was due to her temper that she

SLEEP, Present Amount and Character, was sent here" – She is very quiet & answers questions readily. Says "that

BOWELS, Present Condition, her brothers & sister were partial to her & did not treat her well – that they would pick on her.

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). She talks as if she thought she was persecuted by them. She seems to be quite an intelligent woman. Patient states that she worries constantly about her mother's death & thinks that she hastened or caused it, because of her having to marry & giving birth to a child only a short time after marrying. –

Personal and Medical History of Annie A. Griffith

1901

This patient was brought here by Dep. Sher. Johnson, attended by Wm O. Francoeur, in good physical condition, with following history. There is no history of consanguinity, or heredity, previous peculiarities, intemperance, severe disease &c, or head-injury. This is not first attack: sixteen years ago she had one, after child-birth; duration, one week: was not sent to hospital. First symptoms of this attack manifested by her having been growing nervous since the death of her mother, 5 months. Disease seems stationary; variable with rational intervals, but these not regular. Derangement now shown by melancholy: "Believes she killed her mother". Patient not disposed to injure others, nor suicidal; no filthy or destructive habits. She has not been restrained or confined. Dont know cause of the disease: Treatment, none but sedatives. On personal examination, it is found that Catamenia have been scanty and infrequent for years.

Feb 1 On admission, was put on T.W. (G.H.N. Rpt: Complexion dark; hair brown, part gray; eyes gray; condition of skin, normal: no marks, scars, bruises &c noted: Is clean: has 15 lower & 11 upper teeth: Behavior quiet: answers questions intelligently & says it is her temper caused her to be sent to this hospital). See letter of Philip J. Matlocks of Feby 1st "her mother & some sisters are quite nervous. But father was not more nervous than the average person: no recollection of her being hurt in head: has been very nervous for 6 mos, starting at time of my mother's death: not serious until about 2 months ago: then she kept getting worse every day. The last few days, got notion in head that she had killed her mother, can't say how she got that foolish thought: was very kind & good to mother, an invalid with Bright's Disease for 1½ years: the last 5 mos in bed, required constant care, which my sister did most of. Think watching mother suffering & then loss of her affected her mind. She has also been troubled with "rushes of blood" to head, causing big red blotches on face: at times, she coned be as if paralyzed, numb all over."

Feb 1 to Feb 15. Summary 14 da. record. (Dr Reynolds) Received an Infirmary, bathed & put to bed. Talks but is depressed: Slept well. First week temp. pulse & resp. normal. Appetite fair: Cathartics given: Slept well: Up & dressed on 21st. Says she had a very bad hemorrhage & seems to think that is reason for being sent here. Expresses delusions of persecution & says people talk about her. At times restless & disagreeable. Second week. Temp. pulse & resp. normal: appetite fair: bowels regular: Sleeps well. Very melancholy: Talks but little. Feb 27 Wt. 137¾#. Vaccinated: Refuses to take medicine: expresses many delusions: Thinks she is responsible for mother's death. Worries constantly. Is quiet & melancholy. Sits in chair all day long: does nothing to interest herself. Given gynecological treatments: Takes nourishment well.

Mar. to June 1901. General health good, eats and sleeps well, takes out of door exercise, is very melancholy takes little or no interest in her surroundings, does no work, May 30. Wt. 127#. June to Sept. Aug. 30 patient becoming brighter mentally talks more freely with those about her, is learning to make lace, Wt. 129#.

Sept. to Dec. Is very pleasant and agreeable, converses intelligently is much improved mentally, assists with ward work. Nov. 29 Wt. 134¼#. Dec. 19. patient has been sick in bed with cold, Visited by sister and son Jan 18. went home this A.M. very much improved.

Personal and Medical History of

Personal and Medical History of Hannah Hallond

Whole No. 5751.

Residence, Osco, Mizzi: — " " " County, Mays 1868 — Became resident of State May 5-1868

Date Admission, 4th February 1901.

Admitted by Dr. L A Lundin hour, 5 PM

How Sent, Geo. N. Wilson. Jo P. Waseca County

Sex, Female Age, 33

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Housekeeper: Father, a farmer

Degree Education, Country Schools

Profession, Religion, Lutheran

Habits, probably good. no intemperance.

Nativity, Minnesota; Parents born in Norway

Physicians Committing, W. A. Chamberlin & E. J. Batchelder

Correspondents, Tenas Hallond — New Richland

No. of Year, 114.

Insane Relatives, probability that her mother was insane

Cause Exciting, no apparent cause

Cause Predisposing, probably hereditary

Form, Delirium due to Uraemia Acute Mania

Accompanying Bodily Disorder, none mentioned.

Suicidal or not, not

Date of this Attack, probably recent

Duration, probably short.

No. of Attack, not 1st (one, 6 weeks ago).

No. of Admission, 1st

Age First Attack, — 33 —

Time of Leaving, Feb. 18, 1901.

Time in Hospital, 14 days.

Result, Died - Pneumonia complicated with nephritis.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* Feb 5/1901

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, Dead — very old — 86 years

Paternal Relatives,

Mother, Died — 60 about — Dropsy.

Maternal Relatives,

Brothers and Sisters, 6 7 {one brother mongrel - due to injury - was cripples at Kalamazoo - Dutch -

Children - 5 boys - living - well. 2 girls - one dead - one living with

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke,

Head Injuries, and Surgical Operations),

Has had several attacks of rheumatism

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Has occasional attacks of dizziness

OCCUPATION, Healthy or not, Housewife

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

Poor

Sleep, Appetite, and Bowels,

Personal and Medical History of Hannah Hallond

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6in PRESENT WEIGHT, 158 lbs. USUAL WEIGHT, NUTRITION, poor

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt: dark brown coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal Yes yes

SIGHT, fair — wears glasses.

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

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, none Murmurs, Strength, Sounds, Size, strong normal

Apex Beat, Regularity, somewhat normal irregular —

ARTERIES, some atheroma

Yes - well developed good

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, Genitals normal. mucous membrane of vagina & vulva much congested. Cervix enlarged & congested — cystic degeneration - Leucorrhoea - Uterus antero-Rectus flexed - invalid mammilitis - vagina has been packed with filth by patient - self abusive -

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 good physical condition - Is stupid & does not talk. Lies in bed, staring at the ceiling, most of the time. She is very filthy in her habits and masturbates a great deal. At times she becomes very violent -

Personal and Medical History of Hannah Hallond

1901

Patient was brought here by Sher. Frank Collins, attended by Teman Hallond, in good physical condition, with following history. There is no history of consanguinity, previous peculiarities, intemperance, severe disease &c or head-injury, restraint or confinement; but there is probability that her mother was insane. This is not 1st attack; six weeks since, talked in an irrational manner. When first symptoms of this attack were manifested or in what way, is not stated. Disease seems to be increasing; not variable: no rational intervals. Derangement now shown in that she imagines herself persecuted by those about her. Patient is not disposed to injure others, nor suicidal: no filthy or destructive habits. There is no apparent cause of the disease. Has had no treatment. On Personal Examination, nothing abnormal in physical condition, so far as learned — Commitment recommended because of her liability to do herself or others injury. —

Feby 4 On admission, was put on T.W. (G.H.N. R'pt. Complexion dark: hair brown: eyes brown: condition of skin normal: small ulcers on both hands: bruises on upper & lower limbs: no herniae: Is dirty: has an upper plate, and 10 lower teeth of her own. Behavior quiet; answers questions intelligently, but will not carry conversation —

Feb. 4 to Feb 18 Summary 14 da. record (Dr Heyerdale) Received. bathed & put to bed: Very dirty: Quiet: stupid & resistive & out of bed often. Slept about 4 hrs. On liquid diet: eggnogs also given: First week. Temp. & pulse slightly above normal. After four days refused nourishment & fed by tube: hypnotics & occasional cathartics given: seemed stupid: Says bruises on body were caused by father's striking her with a strap. Throws herself against floor & wall: 5th violent when put to bed: Did not sleep. Feb 6. In restraint to keep her from injuring herself. Given vaginal douche: extremely dirty in habits. Coughs some & expectorates Given baths & alcohol rubs. Examination of urine showed nephritis & condition of lungs indicated pneumonia. Second week — Temp. Gradually became higher — ranging from 101 - 105°. Pulse from 116 to 150. Resp. from 30 - 65. Fed by tube & stimulants of brandy & strychnia given also digitalis. Cathartics required. baths & alcohol rubs. Continued. Expectorations streaked with blood: Continued to grow weaker & brother notified by telegraph: arrived next day. Seemed to be in semicomatose condition. Occasionally had attacks when she seemed suffocating. Complained of pain in head. Feb 18. Died at 6 PM. Remains taken home by brother

Died.

Personal and Medical History of

Personal and Medical History of Eliza Jane Carpenter

Whole No. 5752.
Residence, Kellogg, Minn: Resident of State - 1866 (about) County - 1866
Date Admission, 5th February 1901.
Admitted by Dr L. A. Lipton hour, 9.30 P.M.
How Sent, Malcolm Kennedy, Sheriff Wabasha Co
Sex, Female Age, 76.
Civil Condition, Married
Children, Seven —
Age Youngest Child, 39 —
Occupation, Housewife — husband, laborer
Degree Education, Common School —
Profession, Religion, Methodist —
Habits, No history of intemperance.
Nativity, New York: Parents also born there
Physicians Committing, W. H. Lincoln & J. T. Tenney
Correspondents, Mary La Rue
Kellogg, Minn

No. for Year, 115.
Insane Relatives, None, except brother: thought she died trying to kill herself.
Cause Exciting, unknown
Cause Predisposing, probably age & heredity?
Form, Senile Dementia
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Not
Date of this Attack, January 13th 1901
Duration, about 3 weeks
No. of Attack, Not 1st (Has had them for years past)
No. of Admission, 1st —
Age First Attack, not given
Time of Leaving, 4th April 1901
Time in Hospital, 1 Mo 30 ds
Result, Improved Recovered: Discharged Mar 30/1901.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Feb 6/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear: quick
MEMORY, Past Events,
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,
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, Gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption). No
Father, Dead
Paternal Relatives,
Mother, Dead
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
She says "No"
HABITS, Drinking and Smoking, Good
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Poor fair

Personal and Medical History of Eliza Jane Carpenter

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 8½ PRESENT WEIGHT, 165 lbs. USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt: slight white coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, (Eyes) equal, normal, good, good
SIGHT, fair: wears spectacles
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal: wears spectacles
HEARING, Good
COORDINATION, Arms, good Legs, good Grasp, when tested good
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, no, fairly strong, normal
Apex Beat, Regularity, normal
ARTERIES,
somewhat sclerotic
LUNGS, Chest, Symmetry, Expansion, Yes, 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, Lacerated perinaeum — otherwise normal. — rectocele. cystocele. uterus retroflexed — adherent — cervicitis — 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 good physical condition. Is somewhat depressed & frequently cries softly to herself. When asked why, she says that she grieves for her family & husband. Her mental condition is probably one of Dementia of Senile type. She is frequently restless and sleepless at night. During day, patient is usually very quiet and agreeable onward.

Personal and Medical History of Eliza Jane Carpenter.

1901

This patient was brought here by Deputy Geo. D. Dickman, attended by Mary LaRue, in fair physical condition, with following history of case. There is no history of consanguinity; no insane relatives, except brother; thought to be due to injury to head. This is not 1st attack: they have been occurring for years past; duration of various lengths. Last symptoms of this attack were manifested January 13th 1901. Disease seems increasing; variable with rational intervals; these occur regularly. Derangement now known by her being garrulous; not manifested as any one subject. Patient is not disposed to injure others, nor suicidal: no filthy or destructive habits — Previously, she showed melancholy. There is no history of intemperance, nor of any severe disease &c, or head-injury: no restraint or confinement employed. Cause of the disease unknown. No treatment. On personal Examination, her appearance and talk indicate that she is deranged.

Feb 5 On admission, was put on T.W. (G.H.N. Rpt. Complexion dark: hair brown & part gray: eyes brown; Condition of skin normal: small scar on back of second finger of left hand: no bruises, Eruptions &c: is clean: has 6 lower teeth, most of them roots & a few roots above. Is quiet; and talks freely: think she has delusions). —

Feb 5 to Feb 19 Summary 14 da. record (Dr Heyerdahl) Admitted on Infirmary. Slept well. Diet Mark temp- pulse & resp. normal: Appetite fair: bowels regular with cathartics. Feb 6. Up on ward. Quite restless, talkative & inclined to be melancholy. Says she is very homesick & occasionally cries: talks very in- telligently & rationally: somewhat demented. Second week. Temp. pulse & resp. normal: Appetite fair: cathartics occasion- ally required for bowels: Continues quite talkative & somewhat disagreeable: Somewhat restless at night. Neat in habits & ap- pearance. Feb 16 Trans to A3. Very agreeable on ward. More quiet & contented Apr 4. In good physical condition Occasionally complains of pain in lung which is largely imaginary: Given medicine for same.

Apr 4 Taken home by husband.

Discharged

Personal and Medical History of

Personal and Medical History of Anna M. Meyers

Whole No. 5753. Became Resident of State 1890 " " of County 1890.
Residence, St. Paul, Ramsey Co. Minn.
Date Admission, 8th February 1901.
Admitted by Dr. E. Z. Wanous hour, 7.30 P.M.
How Sent, E. W. Bazille, J. of P. Ramsey County
Sex, Female Age, 32.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Photographer: father is dead.
Degree Education, Common School —
Profession, Religion, Baptist Church
Habits, no history of intemperance known.
Nativity, Waterloo, Iowa: father's, Penna.; mother's Ills.
Physicians Committing, Charles L. Ball & J. M. A. Gravelle
Correspondents, Mrs. Susan Preston (Mother) 229 Spruce St. St. Paul

No. of Year, 116.
Insane Relatives, * previous history states an uncle died insane. also an uncle & mother both recovered.
Cause Exciting, — not known —
Cause Predisposing, previous attack; heredity?
Form, Mania (hysterical form) Paranoia
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, — not —
Date of this Attack, several weeks ago
Duration, several weeks
No. of Attack, 2nd (one in May 1895)
No. of Admission, 2nd —
Age First Attack, about 26. (* previous history states 24)
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Feby 9/1901

* Taken from previous Commitment papers

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick & clear
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, Says: "She is insane"
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted
DELUSIONS, Systematized, Transitory, Special Subjects, Expresses delusions in regard to magnetic healing; says: "She healed a man who was killed accidentally". Talks a great deal & loudly. Says: "her mind was crushed by hypnotic influence & that she has never been well since"
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 was insane: an aunt has epilepsy.
Father, Dead: Typhoid fever
Paternal Relatives,
Mother, Living, well.
Maternal Relatives,
Brothers and Sisters, well
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
has had an "Alexander" operation
HABITS, Drinking and Smoking,
HEADACHES, very severe headaches during last 8 months
VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Lived with mother: has no regular occupation
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, poor good Regular

Personal and Medical History of Anna M. Meyers

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 7 in PRESENT WEIGHT, 126 lbs USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt; fine tremor
PUPILS, Equality, Size, Response to Light, and Accommodation, good (Yes, normal, good)
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, Good Legs, good Grasp, other tests good
TREMORS, Hands, Tongue, Facial Muscles, General, (none)
PATELLAR REFLEX, present: Other Reflexes, Elbow, wrist, present
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, (normal, strong, normal)
Apex Beat, Regularity, regular (normal)
ARTERIES,
LUNGS, Chest, Symmetry, Expansion, (Yes, 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, Genitals normal; hymen intact; uterus retroflexed & movable
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 rather poor physical condition: very restless & excited in manner. Talked a great deal, in a loud voice & in a very "stagey" affected manner. Talked about "kings & queens"; magnetic healing: says "her mind was crushed by hypnotic influence" - says "he has been controlled in that way"

Personal and Medical History of Anna M. Meyers

1901

This patient was brought here by Deputy Johnson, attended by Mrs L. Rosen, in fair physical condition, with following history of case. There is no history of consanguinity, but she has insane relatives; (* Previous commitment papers state an uncle died insane; also uncle & mother, both recovered). This is not 1st attack; one occurred in May 1895, duration to November 1895, when she was at this (Rochester) Hospital; result improvement. First symptoms of this attack manifested several weeks ago; the victim of malign influences; disease seems increasing; not variable; no rational intervals. Derangement now shown in that she thinks that she is being persecuted by the clergy and that invisible persons are around her, who will do her harm. Patient is not disposed to injure others, nor suicidal. Is destructive of furniture. No previous peculiarities shown. No history of intemperance to my knowledge. No severe disease &c or head injury. Was confined or restrained this am. Do not know cause of disease: has had no treatment recently. On personal Examination, patient is excited, and talks in rambling manner, about the Evil influences which surround her. N.B. Patient was here before, (see Vol 28 page 201 No 4084) from May 1/95 to Sept 25/95 & discharged Nov 6/95 – recovered: had previously been under care of Dr C. E. Riggs for 2 years.

Feb 8 On admission, was put on T.W. (G.H.N. R'pt. Complexion dark: hair black; eyes brown; condition of skin normal; no bruises, scars or marks noted. Is clean. Has 11 upper & 13 lower teeth; some are very bad. Behavior quiet. She has delusions. —

Feb 8 to Feb 22 Summary 14 da. record by Dr Heyerdale. Given bath & put to bed: Quiet; slept well until 2 AM. Restless & awake rest of night. First week temp. pulse & resp. normal: appetite good: occasional cathartics given Feb 9. Exalted in behavior: Talked a good deal: Incoherent & very much disturbed. Talked about kings, queens &c. During day very violent Trans to C; Feb 10. Very much disturbed; expresses delusions freely: Thinks food is poisoned & that she has great powers of healing &c. Put in restraint: Quiet rest of day: & slept well at night. 11 Taken out of restraint, dressed & up on ward. Talked intelligently 13 Quite disturbed.
Second week. Temp. pulse & resp. normal: Bowels regular: Became much more quiet and agreeable on ward. 16 Trans. to B3. Agreeable & intelligent Feb 26 Vaccinated Wt. 122#. Quiet & agreeable. Appetite good: Sleeps well. Takes some exercise: At times talks along lines of hypnotism & telepathy. Takes some outdoor exercise & interests herself in reading &c.

Mar to June 1901 General health good, takes regular out door exercise, occupies herself by reading and sewing, has a great many delusions of hypnotism and mesmerism, thinks she is controlled by an unseen power, has considerable pain during menstrual period, May 30 Wt 120#. June to Sept. June 17 and 18 visited by mother from June 19 to Aug 8 visited daily by mother Aug. 31 Wt. 117#. Sept. to Dec Nov. 29 & 30 visited by mother and friend, no change Wt. 128 1/4#.

Personal and Medical History of

Sept – Dec. to Feb. 1903 No change. Wt. about 113#. Apr. 3rd, 4th 5th
Visited by mother

Personal and Medical History of Hannah Hammer

Whole No. 5754. Resident of Minn. 13 yrs. " County 13 "

Residence, Winona, Minn.

Date Admission, 9th February 1901.

Admitted by Dr. O. C. Heyerdale hour, 4.15 P.M.

How Sent, D. E. Vance, J. of P. Winona County, Minn.

Sex, Female Age, 33.

Civil Condition, Married

Children, – 6 –

Age Youngest Child, 1 year (dead).

Occupation, Housewife (husband, fireman in saw-mill)

Degree Education, Common School

Profession, Religion, Scandinavian Lutheran

Habits, no history of intemperance

Nativity, Norway: parents also born there.

Physicians Committing, Hans Lichtenstein & H. F. McGaughey

Correspondents, (Husband's address,) Jerry Hammer 607 East Broadway. Winona

* see letter from [illegible] 2/25/1901 from which are taken items marked *

No. for Year, 117.

Insane Relatives, none so far as known

Cause Exciting, grief at death of father may be contributing cause

Cause Predisposing, not stated

Form, acute Melancholia (~~Stuporous~~)

Accompanying Bodily Disorder, poor physical condition

Suicidal or not, not

Date of this Attack, Four weeks ago

Duration, Four weeks

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, – 33 –

Time of Leaving, November 23 – 1901.

Time in Hospital, 9 Mos 14 Ds

Result, Improved: Disgd. May 10 – 1902 By B of C

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Feby 11/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Sluggish: does not talk: seems dazed: mutters to herself attimes.

MEMORY, Past Events,

Recent Events, does not talk Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Will not talk

REASONING POWER, Ordinary Subjects,

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,

ONSET, Gradual or Sudden, Gradual

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

* never had consumption in the family

* Father, Dead

Paternal Relatives,

* Mother, Living

Maternal Relatives,

Brothers and Sisters,

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

* never had surgical operation of any kind

HABITS, Drinking and Smoking, good

HEADACHES, VERTIGO, OR CONVULSIONS,

* Did her own housework

OCCUPATION, Healthy or not, Housework

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

* Sleep very peculiar: could not sleep in bed; would wander around house & most of her sleep would be sitting in chair

Sleep, Appetite, and Bowels, * constipated for last year.

* poor

Personal and Medical History of Hannah Hammer

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in PRESENT WEIGHT, 122 lbs USUAL WEIGHT, NUTRITION, good

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement,

PUPILS, Equality, Size, Response to Light, and Accommodation, good (yes normal good)

SIGHT, seems fair

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Ptosis of right eye-lid: slight strabismus of right eye.

HEARING, seems fair

COORDINATION, ~~Arms~~, Could ~~Legs~~, not test ~~Grasp~~,

TREMORS, Hands, Tongue, Facial Muscles, General,

PATELLAR REFLEX, absent Other Reflexes, absent

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, Genitals normal: lacerated perinaeum; rectocele – cystocele – uterus antero-dextro flexed – movable – cervix eroded – endometritis – cervicitis – 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 poor physical condition. Is quite emaciated: is extremely resistive in manner, opposing all that is done for her. She is very restless & out of bed, a great deal; wanders about in a dazed condition; does not speak or answer questions; attimes, will mutter to herself. Takes her nourishment very well. Husband says this condition has been gradually developing since death of her father about 2 years ago, but in this aggravated form for only a few weeks –

Personal and Medical History of Hannah Hammer

1901

This patient was brought here by M. J. Lins, Sheriff, attended by husband, Jerry Hammer, in poor physical condition, with following history. There is no history of heredity, as far as known, nor of consanguinity. Previous peculiarities, intemperance, severe disease or of head-injury; this is the first attack: first symptoms manifested four weeks ago; became delirious & excited; would not eat; was in fear. Disease appears to be stationary; not variable; no rational intervals. Derangement is now shown in that she is apathetic & will not converse or answer questions. Patient is not disposed to injure others, nor suicidal; no filthy or destructive habits. She has had watchers during attack. Grief at death of father may be contributing cause of the disease. She has been under physicians care, in bed 2½ weeks; delirium subsided. On personal Examination, patient is pale, depressed; pays absolutely no attention to surroundings or questions. Ptosis and strabismus existed since 4 years old.

Feb 9 On admission, was put on T.W. (G.H.N.R'Pt. Complexion fair; hair light brown; eyes gray; condition of skin, hot and dry: small brown mark on left side of abdomen; scars on both legs, caused by varicose ulcers: is clean: some peculiarity of the occipital bone: has 7 upper & 11 lower teeth. - and some roots. Behavior quiet: refused to walk or talk).

= N.B. See letter from Jerry Hammer (2/25/1901). "First Symptoms noticed about 3 months ago: would become absent-
= minded; could'nt think anything: then dizziness would follow: did not want to stay at home: wanted to be on
= the "Go" all the time: (see other particulars in examination heard. Pealed in from this particular letter).

Feb 9 to Feb 24 Summary of data record by Dr Heyndale. Admitted Feb 9. bathed & put to bed. Has varicose ulcers on lower limbs & ptosis of left eye. Slept well at night. First week. Temp. pulse & resp. normal: appetite fair: occasional Cathartics & enema given: Very stupid & would not talk but very restless & out of bed often. Put in restraint Feb 15. Taken out of restraint & dressed. Very disagreeable in manner removed clothing. Second week Temp. pulse & resp. normal. Cathartics & hypnotics given. Slept fairly well. Did not talk. Very resistive: mutters to herself. Tries to get out of windows & doors Given lavage & quart of water twice daily by tube.

Feb 26. Wt. 121½#. Up on ward daily: kept in bed: Very untidy: wanders about in an aimless manner: Takes nourishment quite well. Never speaks but mutters to herself: bowels constipated: Lavage of stomach given twice daily: March to June 1901 Mar. 25 up on ward, untidy in habits and appearance, very resistive at times and at other times seems dull, dazed and stupid, Apr. 19 Patient operated on by Dr. O.S. Heyerdale for varicose veins, patient recovered completely from the operation. May 30 Wt. 114#. June to Sept. July 4 visited by relatives: began to grow very much better mentally: answering questions intelligently and when addressed sometimes volunteering conversation: does not seem so be-wildered as at first: takes out door exercise: began to ask about home and children is more cleanly in habits and tidy in appearance: assists with ward work:

Personal and Medical History of

1901

sometimes sings: Sept. 20 Wt. 121½#.

Sept to Dec. Sept. 3 visited by husband: for a short time after seemed somewhat depressed: refusing to eat for a time: but soon rallied: varicose ulcers on leg entirely healed over: Nov. 23 visited by husband and taken home.

Personal and Medical History of Johannah O'Brien
al. Josephine

Whole No. 5760. Lived here all her life
Residence, Olmsted County, Minn. Born in Olmsted County
Date Admission, February 16th 1901
Admitted by Dr. E. Z. Vanour hour, 3 P.M.
How Sent, J. A. Leonard. J. & P. Olmsted County
Sex, Female Age, 34.
Civil Condition, Single
Children, none
Age Youngest Child, —
Occupation, Housework; father a laborer
Degree Education, Common School
Profession, Religion, Roman Catholic
Habits, not stated: father was intemperate
Nativity, Olmsted County: parents born in Ireland
Physicians Committing, J. G. Cross & H. H. Witherstine
Correspondents, Mr. Wm. O'Brien
(north Broadway) Rochester, Minn

No. of Year, 123.
Insane Relatives, none
Cause Exciting, Do not know
Cause Predisposing, previous attacks
Form, acute Mania (Recurrent)
Accompanying Bodily Disorder, Treated for Tuberculosis
Suicidal or not, not; but will injure others
Date of this Attack, Febry 11th 1901
Duration, 5 days
No. of Attack, 3rd —
No. of Admission, 3rd
Age First Attack, 23.
Time of Leaving, January 18 - 1902
Time in Hospital, 11 mos 2 ds
Result, Improved: Disgd. July 15 - 1902 (By B of C)

EXAMINATION ON ADMISSION BY DRS. Heyerdale & Linton Date of Feb 20/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Quick
MEMORY, Past Events, will not converse
Recent Events, " Special Subjects, "
PERCEPTIVITY, Alert or Dull, Correct or Illusive. Alert
REASONING POWER, Ordinary Subjects, will not converse
Special Subjects, " " "
Own Mental State, Thinks she is insane
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Exalted: noisy: talks a great deal
DELUSIONS, Systematized, Transitory, Special Subjects, Says people slur on her & talk 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, one week
ONSET, Gradual or Sudden, —
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, one brother died with consumption Dead: old age: father was a drinking man
Paternal Relatives,
Mother, Living — well
Maternal Relatives,
4 Brothers and 4 Sisters, —
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Had Typhoid, when young
HABITS, Drinking and Smoking, Drank beer & whisky occasionally
HEADACHES, VERTIGO, OR CONVULSIONS, had occasional headaches.
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 Johannah O'Brien
al. Josephine

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in PRESENT WEIGHT, 125 lbs USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt, white coating
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal Good good
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, good Legs, good Grasp, other tests good,
TREMORS, Hands, Tongue, Facial Muscles, General, fine Tremor of tongue
PATELLAR REFLEX, Knee jerk exaggerated Other Reflexes, Elbow present; wrist present
ARTICULATION, Slurred, Hesitating, Slow, good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, none Strong normal
Apex Beat, Regularity, normal regular
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, Yes 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,
Color and Appearance,

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

GYNECOLOGICAL EXAMINATION, Genitals normal: hymen intact: uterus retroflexed: movable: Enlarged: Cervix patulous: os gaping: Cervicitis: 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 poor physical condition. Is extremely noisy: talks a great deal & in a loud voice. Is restless during day-time & noisy at night. Talks about horrible things she has seen & says people talk about her & cast slurs about her. March 1-01. Patient has quieted down very much & talks in an intelligent rational manner. A goodly portion of her previous maniacal behavior was "put on as it were" for the Knewbetter, realizing very well her actions. She says: she thinks she is insane & that she is run down physically, which, with over-work - brought this attack on. H.

Personal and Medical History of Johannah O'Brien al. Josephine

1901

This patient was brought here by Sheriff Vine, attended by Wm O'Brien, in poor physical condition, with following history of case. No history of consanguinity. This is not 1st attack; one occurred 9 years ago, and one, 3½ years ago; duration of 1st attack, 3 months; of second attack one week: when she was at this 2nd Minn. State Hospital. result of treatment good. First symptoms of this attack manifested July 11-1901 by unreasonable anger & violent actions. Disease appears increasing; is variable-has with irregular intervals. Derangement now shown in no particular subject, but has fits of unreasonable anger, when she is destructive. Is disposed to injure others, but not suicidal: has destructive habits. No history of insanity in parents or relatives. No previous peculiarities shown: Father was intemperate. No record of any severe disease &c or head injury. Has been confined in 2nd Minn. Hosp. for Insane 3 mos & 1 week: confined to house, in this case, several days. Do not know cause of the disease: has been under treatment for tuberculosis. Is quiet now, on personal examination. N.B. As stated, patient here before: 1st time committed as "Josephine O'Brien"; Case No. 2573 Vol 15 page 137: 2nd time, Case No 4764 Vol 34 page 193: She was duly discharged as "Recovered"

Feb 16 On admission, was put on IW. (G.H.N. Ward. Complexion dark: hair dark-brown; eyes hazel: condition of skin normal; no marks scars or bruises noted: is clean: has an upper plate and 9 lower teeth of her own. Behavior quiet: uses profane & obscene language.

Feb 16 to Mch 1 Summary of do record by Dr Reynolds. Received on ward, bathed & put to bed. Conversed freely & agreeably. Emot. weak. Temp. pulse & resp. about normal. Appetite fair: required occasional hypnotics & cathartics. Latter part of week refused medicine & extremely noisy days & part of night. Very filthy in habits: vulgar & profane when anyone entered her room: seemed to realize partially what she was doing & language & actions seemed due to lack of self control. 20 Trans. to 6th. During second week. Temp. pulse & resp. not taken: In fairly good condition: Appetite rather poor: Took medicine regularly: Bowels regular. Feb 22-23. Somewhat disturbed & noisy - remainder of week more quiet. Slept well at night: Bowels somewhat constipated: altho quiet still very obstinate & disagreeable. When visited by sister refused to have anything to do with her. Expresses delusions of persecution. Feb 28 Wt 116½ #.

Mar. to June 1901 Mar. 11 patient went home to spend the day, Mar. 14 visited by sister Mar. 16 taken to Rochester to entertainment, Mar. 26 visited by friends, 27 by sister. Apr. 6 taken home by sister returned Apr. 7. Taken home Apr. 10 returned Apr 11. Apr. 14 taken home by people for a visit, 19 visited by friends, 20 by sisters. May 8 visited by sister, 13 by sister, 15 taken home by sister for a visit.

June to Sept. Oct. 26 patient returned, put on Inf. West, bathed and put to bed, answers questions intelligently, Oct. 26 and 29 visited by sister.

Sept. to Dec. Nov. 4 & 6 visited by sister, patient inclined to be very disagreeable and fault finding, complains a great deal, from Nov. 8 to 26 visited frequently by friends & relatives, Nov. 30 Wt. 138 #.

Personal and Medical History of

Dec. to Mar 1902. Dec. 2 visited by sister. Dec. 3 Patient sick in bed, also Dec 8 & 9 and visited by sister and lady friends Dec. 10 still in bed, trans. to Inf. West. Extremely disagreeable and faultfinding Dec. 17 visited by sister, 30 by friends Jan. 2-6-13 visited by sister & friends. Patient has for weeks been extremely faultfinding, and complaining about everything, says that she is badly treated in every way, while on Inf. had special nurse. Jan 18 went home.

Personal and Medical History of Hellena Almquist
nl. Corline

Whole No. 3762. Became resident of Minn: 1879

Residence, Town of Stanton Goodhue Co. " County of Goodhue 1897

Date Admission, 18th February 1901.

Admitted by Dr A J Kilbourne hour, 7.30 Pm.

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

Sex, Female Age, 43

Civil Condition, Married

Children, Two -

Age Youngest Child, six years

Occupation, House-Keeper; husband, Miller.

Degree Education, High School

Profession, Religion, Lutheran

Habits, no history of intemperance -

Nativity, Denmark: parents also born there

Physicians Committing, A.W Jones & J Anderson

Correspondents, (as per previous Commitment Papers)
J A Almquist, husband, Cannon Falls, Minn.
Mrs P P Hansen, Sister, Corline Ills (wrote her Feb 11/99)

* J A Almquist, who made oath as to facts of insanity as follows, states residence as Village of Cannon Falls.

No. of Year, 125.

Insane Relatives, not as far as known

Cause Exciting, not known

Cause Predisposing, previous attacks

Form, Mania (Recurrent) (Acute)

Accompanying Bodily Disorder, none mentioned

Suicidal or not, yes: Drowning; cutting arteries of wrist.

Date of this Attack, worse 3 weeks ago

Duration, probably quite long.

No. of Attack, 4th. Seemingly

No. of Admission, 2nd here: has been in Hospitals at Jacksonville Ills: Mendota Wis: & Rochester Minn - 35 - (?)

Age First Attack,

Time of Leaving, September 3rd 1902 —

Time in Hospital, 1 yr 6 mo 16 dys

Result, Recovered: Dis. 5th Sept 5 - 1902
By Supt

EXAMINATION ON ADMISSION BY DR. Heyerdale Date of Feb 20/1901

MENTAL CHARACTERISTICS.

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

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

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

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

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

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, Had Rheumatism.
Paternal Relatives,
Mother, died of consumption
Maternal Relatives,
Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Had Inflammatory Rheumatism in 1879 - 1882
States at Jacksonville - June 4 — 1892 (for 2 mos)
" Mendota — March 1894 (for 2 wks)
" R S H — May 3 — 1897 to Aug 24/99

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,
poor fair

Personal and Medical History of Hellena Almquist
nl. Corline

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5 PRESENT WEIGHT, 118 lbs USUAL WEIGHT, NUTRITION, good

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt; white coating

PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal good good.

SIGHT, Seems good

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

HEARING, Seems good

COORDINATION, Arms, could not get Logs, Grasp,

TREMORS, Hands, Tongue, Facial Muscles, General, Yes

PATELLAR REFLEX, Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Strong normal
Apex Beat, Regularity, regular normal

ARTERIES,

LUNGS, Chest, Symmetry, Expansion, Yes Seems 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,

Passed. Dec 6/1901. Sp. dec 6th 1901

EXAMINATION URINE, Quantity, Sp. g. 1010 Reaction, acid Color and Appearance, Yellow: Cloudy

Albumen, Heat: a trace: Nitric acid 0 — Tanret, trace Sugar, Fehling's Sol. 0. Bismuth 0 -

Casts and Crystals, Several uric acid crystals. — amo. urate: Pus: Several Esp. Epithelium a few cells

GYNECOLOGICAL EXAMINATION, Genitals Normal; uterus retroflexed, movable; cervicitis, leucorrhoea: Bartholmian cysts.

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 good physical condition Mentally, patient is very much excited & noisy at times. Talks a great deal & very much on religious subjects. Talk is rambling & Disconnected: Physically, patient is well & strong & well nourished. —

Personal and Medical History of Hellena Almquist
al. Corline

1901

This patient was brought here by Deputy S. S. Lundquist, attended by Josephine Quamme, in fair physical condition, with following history of case. No consanguinity, as far as known. This is not 1st attack: these occurred in 1889. 1890. & 1896; duration of first 9 mos: has been in hospitals at Jacksonville, Ills; Mendota, Wis: and Rochester, Minn: result of treatment not known: symptoms of this attack worse, 3 weeks ago; she showed melancholy, with religious excitement. The disease appears increasing; variable; rational periods but not at regular intervals. Derangement now shown on religion; praying & singing continuously. Patient is not disposed to injure others: has attempted suicide by drowning, & cutting arteries of wrist; propensity probably not now active: no filthy or destructive habits: no insane relatives, as far as known, nor any previous peculiarities; no history of intemperance, severe disease &c or head-injury. She has been in Asylums about 6 years. Cause of the disease not known: has had none except Asylum treatment. On personal Examination, manner is excited, mind wandering, talk incoherent, prays and sings continuously unless spoken to & then fails to converse intelligently.—
N.B. Was here before as "Corline Almquist" from May 3/97 to Aug 24/99 & discharged as improved Apl 17/1900. See Vol 34: p 177: No 4760 for further particulars.

Feb 18 On admission, was put on I.W. (G.H.N. R.pt. Complexion fair: hair light-brown; eyes blue; condition of skin normal: no marks or scars noted: bruise on right arm: no hernia: So clean: has 4 upper & 5 lower teeth: Behavior maniacal: is very incoherent.)

Feb 18 to Mch 4 Summary 14 da. record (Dr Heyndale) Bathed & put to bed: noisy & incoherent given hypnotics: very restless during night: First week. Temp. pulse & resp. normal: Appetite fair: bowels regular: hypnotics given: maniacal & disturbed & at times violent: untidy: pulls hair down: noisy at night: Talks a great deal on religious subjects. Second week temp. pulse & resp. normal: appetite fair: cathartics & hypnotics given Feb 28 Vaccinated. Wt. 145½#. Very much disturbed

Mar to June 1901 Apr. 2 patient very noisy and violent, interfers with other patients frequently has to be secluded part of the day, Apr. 2 fought with Pauline Frazee received a black eye, dirty in habits and destructive, May 12 patient improving somewhat, talks more sensibly, assists some with ward work, is quiet and agreeable and learning to make lace, very intelligent, tran. to A.3. Wt. 143#.

June to Sept. June 14 went home with husband.

Sept. to Dec Oct. 26 returned to hospital, put on Inf. West, extremely noisy and incoherent in speech, active and somewhat violent, has several bruises on her lower limbs, requires hypnotics, has to be secluded part of the time. Nov. 30 Wt. 134½#. Dec. to Feb. 1903. No change. Dec. 26-'01 Visited by husband. Much disturbed mentally. Violent, noisy, destructive. Wt. 110#.
July 24th Patient has shown marked improvement,
Mar. 26th Visited by husband & child. Sept. 3, 1902 Visited by husband and taken home on trial.

Personal and Medical History of

Personal and Medical History of Bell Cole

Whole No. 5765. (When became president of state or of County - Dont know)
Residence, None
Date Admission, 19th February 1901.
Admitted by Dr L. A. Linton hour, 7.30 pm
How Sent, E. W. Bazille. Jof P. Ramsey County
Sex, Female Age, 38.
Civil Condition, Married
Children, Two
Age Youngest Child, — 17 —
Occupation, Housework; husband, laborer
Degree Education, Not educated
Profession, Religion, Methodist —
Habits, not known
Nativity, U.S. (Father & mother also born U.S.)
Physicians Committing, J.S. Gifillan & Haldor Sneve
Correspondents, None given in papers
(?) Poorhouse in Nelsville this.

No. of Year, 128.
Insane Relatives, None
Cause Exciting, not stated
Cause Predisposing, not stated
Form, Delusional Insanity (due to excesses) Mania-a-potu.
Accompanying Bodily Disorder, Hemiplegia (?)
Suicidal or not, Not
Date of this Attack, Dont know
Duration, Dont know
No. of Attack, not known
No. of Admission, 1st
Age First Attack, not known
Time of Leaving, Apr. 19 1901
Time in Hospital, 2 mos.
Result, Discha Recovered April 30 1901

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Febry 21 1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick, but at times, Confused.
MEMORY, Past Events, rather poor
Recent Events, " Special Subjects,
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,
slightly depressed

DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses religious delusions: says "She heard the voice of God commanding her to do certain things" such as "healing the lame & blind" —
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: paralysis: was paralyzed 14 days before death
Paternal Relatives,
Mother, Living
Maternal Relatives,
Brothers and Sisters, 4 well
2 children — 1 boy (well); 1 girl (well).
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), was paralyzed on left side 8 years ago: "Inflammation of bowels" 14 years ago she has Gonorrhoea - denies having had Syphilis.
HABITS, Drinking and Smoking has been in habit of drinking wine or beer: has led a very fast life
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, has been a "fast-woman"
Detail Date, Duration, and Character of Previous Attack, if any,
good good
Sleep, Appetite, and Bowels,

Personal and Medical History of Bell Cole

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5in PRESENT WEIGHT, 193 lbs USUAL WEIGHT, NUTRITION, good
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt: coated white & thick
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes Normal Yes
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal
HEARING, Good
COORDINATION, Arms, Fair Legs, Poor - staggering on Grasp, no foot, misstep; has Romberg's Sign; is unable to retain equilibrium, with eyes closed -
TREMORS, Hands, Tongue, Facial Muscles, General, Fine at times
PATELLAR REFLEX, present Other Reflexes, elbow, wrist
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, none strong normal
Apex Beat, Regularity, normal regular
ARTERIES,
LUNGS, Chest, Symmetry, Expansion, Yes Fairly 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, Genitals normal: lacerated perineum; rectocele: cysts: cocle: uterus dextro-retroflexed movable: cervix lacerated; eroded, herpes, vaginalis, cervicitis, leucorrhoea, urethral caruncle, hemorrhoids
MENSTRUATION, — hemorrhoids; left inguinal hernia; wears a truss.
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 good physical condition: well developed & nourished. Mentally patient is very quiet: remains in bed: sleeps well at nights: is inclined to talk very freely when she can get a listener. Patient seems somewhat feeble mentally. She admits having been married 5 times - two of which were common-law marriages. She also admits having led a very fast life for several years, being frequently an inmate of houses of ill-fame -

Personal and Medical History of Bell Cole

1901

This patient was brought here by Sheriff Phillip Justus, attended by Mrs Bucher, in good physical condition. History of case is rather meagre. Dont know as to any history of consanguinity, number of attack, when, or in what way, first symptoms were manifested, if disease is variable or there are rational intervals, as to previous peculiarities, habits or any history of intemperance. The disease appears to be stationary. Derangement now shown in that she talks to dead father, hears voices, has power to heal & sees angels. Is not disposed to injure others nor suicidal; no filthy or destructive habits; no insane relatives. Is subject to hemiplegia (?). Patient has been in poor-house in Neilsville, Wis, 3 months. Cause of the disease is not stated. On personal examination, memory apparently (impaired?); manner calm & cheerful; realizes intent of the examination, and talks freely about her divine powers of healing.

Feb 19 On admission, was put on T.W. (G.H.N. R'pt. Complexion fair: hair brown: eyes light blue; condition of skin normal; no marks or bruises noted. small scar above left eye: has right inguinal hernia; no vermin but is dirty: the little fingers on both hands are crooked: has 8 upper & 12 lower teeth. She manifests delusions. Behavior quiet.)

Feb 19 to Mch 5 Summary of dar records (Dr Heyerdale) Bathed & put to bed. Temp. pulse & resp. normal during first week: bowels regular: slept well: In good physical condition Very talkative: Expressed some religious delusions: Has inguinal hernia on right side. Second week. Temp. pulse & resp. normal: Slept well: somewhat more rational. Mch 4 Trans. to B3.

Feb 28 Vaccinated - Wt 185 ½# March 4. Patient is still in bed, has many delusions, says she has power to heal the lame. Appetite good. bowels irregular, requires cathartic; sleeps well; habits neat. Mar. 7 complained of cold, has cough. was given expectorant. Mar. 11. complained of pain in abdomen, cathartic given. Transferred Mar. 4 to D.3. Assists with work on ward. Goes riding & walking. Converses readily. General health seems to be good. April 19 went home.

Discharged

Personal and Medical History of

Personal and Medical History of Mabel C. Gould

Whole No. 5768. Resident of State 15 yrs
Residence, St. Paul, Minn. " " County "
Date Admission, 26th February 1901.
Admitted by Dr. O. C. Heyerdale hour, 8 35 P.M.
How Sent, Edmund W. Bazille, J of P. Ramsey County
Sex, Female Age, 46
Civil Condition, married
Children, none
Age Youngest Child, none
Occupation, Housewife: husband, Dentist
Degree Education, College
Profession, Religion, Episcopal
Habits, not intemperate
Nativity, Wisconsin, Durand: parents born in England:
Physicians Committing, W. J. Briggs & H. W. Davis
Correspondents, Dr. L. C. Gould Dentist
office - 230 Lowry Arcade. St Paul
Tel. at night Albert Shunneman Residence 721 Portland Ave. St Paul

No. of Year, 131.
Insane Relatives, none
Cause Exciting, Dont know
Cause Predisposing, not known
Form, Mania acute
Accompanying Bodily Disorder, Seemingly very feeble.
Suicidal or not, not
Date of this Attack, Dec 11th 1900
Duration, about 2 1/2 months
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, about 46
Time of Leaving, March 7 1901.
Time in Hospital, 9 days.
Result, Died. Acute Delirium.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Feb 27/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, will not converse intelligently

Recent Events, " Special Subjects, "

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

REASONING POWER, Ordinary Subjects,

~~Special Subjects~~, Is not rational enough to express

Own Mental State, an opinion of her mental condition.

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Exalted: is noisy & restless, at times.

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 Dec 11. 1900. Eleven weeks

ONSET, Gradual or Sudden, Sudden

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

Father, Died — negative — injured —

Paternal Relatives, family history negative

Mother, Dead — old age

Maternal Relatives, history negative

Brothers and Sisters, well

Children — none —

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

Cerebro-spinal meningitis in 1884 — nine mis-carriages —

HABITS, Drinking and Smoking, Good —

HEADACHES, at time of menstruation, but has not menstruated for about a year

VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework & Literary work.

Detail Date, Duration, and Character of Previous Attack, if any, no previous attack

Sleep, Appetite, and Bowels, Constipated. poor poor

Personal and Medical History of Mabel C. Gould

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, prompt: very thick brownish coating: tongue very dry —

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

SIGHT, good: uses spectacles

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

HEARING, good

COORDINATION, Arms, Could not get ~~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, none fairly strong normal

Apex Beat, Regularity, normal regular

ARTERIES, normal

LUNGS, Chest, Symmetry, Expansion, yes

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, Genitals normal: mucus membrane of vulva and vagina very much congested: cervicitis: uterus retroflexed and adherent: Leucorrhoea.

MENSTRUATION,

~~OPHTHALMOSCOPIC EXAMINATION~~, Slight wasting of left side & weakness of left hand since Cerebro-

~~BLOOD, Corpuscles, Hæmoglobin~~, Spinal meningitis 17 years ago.

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 is in fair physical condition: Tongue very dry & thickly coated: bowels very constipated: patient is restless, during daytime & sleepless at night: at times is noisy. Talks in an incoherent manner, but, at times, seems to understand what is said to her. Her language is occasionally vulgar & profane but mostly incoherent & rambling. She takes very little nourishment or liquids & is fed by tube. —

Personal and Medical History of Mabel C. Gould

1901

This patient was brought here by Deputy Sheriff Johnson, attended by husband L. C. Gould, in fair physical condition & with following history of case. There is no history of consanguinity, heredity, disposition to injure others, or to suicide, filthy or destructive habits, previous peculiarities, or intemperance in any form, nor of any severe disease &c or head-injury. This is first attack; symptoms manifested Dec 11th 1900, by acute mania. Disease appears stationary; not variable, no rational intervals. Derangement now shown by her being, at times, boisterous; at other times, extremely silent, refusing to talk. Restraint or confinement has been employed; has had constant watching. Dont know cause of the disease; has been treated by sedatives. On personal examination, there are observed extreme restlessness, insomnia & no lucid intervals. ——

Feb 26 On admission. was put on T.W. (G.H.N.R'Pt. Complexion dark: hair brown, partly gray: Eyes brown: Condition of skin normal: no marks scars or bruises noted. Is clean, excepting her head; hair matted so it could not be combed. Little finger of right hand is crooked: She has full set of upper teeth with 1 gold crown and 13 lower teeth. Behavior quiet; refused to talk.

Feb 26 to Mch 12 Summary 14 da record by Dr Heyndale. On admission bathed & put to bed: hair badly matted. Feb 27. Stupid & resistive: bowels very constipated: Given enema: Temp. pulse & resp. about normal. Slept well during night: did not converse: Feb 28. Noisy: speaks single words: Does not talk intelligently: tongue coated with thick brownish coating. Fed by tube: would not talk afterward for several hours. Feb 28 & Mch 1-4 Temp. ranged from 101^2-105^8. Pulse 98-116. Resp. 24-32. Fed mechanically: Bowels regular with aid of enemata & cathartic: Noisy & resistive during this time: Talk incoherent: occasionally profane & vulgar: Mouth washed with listerine frequently. Untidy in habits. Coughs some: Sponge baths given frequently. Mch 5-6-7 Continued to grow progressively weaker: fed by tube & nutritive enemata given 1/40 gr. doses strychnia given hypodermically Bowels moved by laxative Temp. as high as 105^4. until Mch 7. when it ranged from 105-107^3. Died at 2:15 PM. During last few days began to develop bed sores in spite of care taken to prevent them. Mch. 5 Visited by husband & sister who remained with her until the end. Remains prepared by Undertaker Johnson & taken by husband to St Paul for interment

Cause of death acute delirium.

Died.

Personal and Medical History of

Personal and Medical History of Mary Larson #3

Whole No. 5769.
Residence, Hastings, Minn
Date Admission, 28th February 1901.
Admitted by Dr. L. A. Linton — hour, 7th P.M.
How Sent, Thos. P. Moran. Jos P. Dakota Co.
Sex, Female Age, 63 years
Civil Condition, Married
Children, —10—
Age Youngest Child, 21 years
Occupation, Doing housework; husband, farmer
Degree Education, Can read & write
Profession, Religion, Lutheran Church
Habits, not known
Nativity, Norway: Parents also born there.
Physicians Committing, Dr. Van Kappellen & H. G. Van Beeck
Correspondents, no relatives or near friends that we know of.

No. of Year, 132.
Insane Relatives, Dont know see exam*
Cause Exciting, Dont know
Cause Predisposing, probably age
Form, Senile Dementia
Accompanying Bodily Disorder, nervousness
Suicidal or not, not
Date of this Attack, (probably) a few years ago
Duration, probably a few years
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, probably 60.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Mar 1/1901

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 & quite Correct
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, Does not think she is insane
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal
DELUSIONS, Systematized, Transitory, Special Subjects, has ideas of persecution: says she stepped upon a worm in the woods, at one time & then the worm grew up through her body to her nose: says she sees flames come out of her nose. —
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, addicted to use of liquor: Dead.
Paternal Relatives,
* Mother, addicted to use of liquor: Dead: was insane & placed in asylum at Madison, Wis.
Maternal Relatives,
Brothers and Sisters, 1 brother: 1 sister, dead.
10 children: 6 Dead: 4 living boys, and well —
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
none
HABITS, Drinking and Smoking, Smokes occasionally: otherwise apparently good habits —
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework.
Detail Date, Duration, and Character of Previous Attack, if any,
She says "people attempted to send her to an asylum about four years ago" —
Sleep, Appetite, and Bowels,
good good reg.

Personal and Medical History of Mary Larson #3

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, fairly good
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, fair (yes normal slight)
SIGHT, fair: says "they blur some" —
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Good
COORDINATION, Arms, good Legs, good ~~Grasp,~~ other tests good.
TREMORS, Hands, Tongue, Facial Muscles, General, hands, fine tremor: tongue, fine tremor.
PATELLAR REFLEX, present Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, (no fairly strong normal)
Apex Beat, Regularity, (normal yes)
ARTERIES,
somewhat sclerotic
LUNGS, Chest, Symmetry, Expansion, (yes 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, Urethral Carnucle, lacerated perinaeum; cystocele; rectocele; uterus utero-dextro flexed: Cervix hypertrophied, cystic; uterine polypus; endometritis, cervicitis,
MENSTRUATION, Leucorrhoea. —
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 irritable in manner, and behavior: has good appetite, sleeps well at night: answers questions sensibly and intelligently, but, when given a chance to tell her own story, expresses a great many delusions. Says "a worm grew from her toe to her nose". Says "that many-colored flames come out of her nose". Expresses some ideas of persecution —

Personal and Medical History of Mary Larson #3

1901

This patient was brought here by John. C. Hartin, attended by A.L. Hartin, in fair physical condition and with following history of case. No history of consanguinity. As to heredity, habits regarding intemperance &c, unknown. This is 1st attack. When first symptoms manifested is not stated (probably a few years ago); She imagines that she is sick from poisoning; the disease appears to be increasing; not variable: no rational intervals; Derangement was shown in that she claims that, a few years ago, she stepped on a caterpillar, which generated snakes in her nose and covered her with a coat of dirt; inside + outside of the body. Patient is not disposed to injure others; no suicidal; propensity not active. Is of filthy habits. As to any previous peculiarities, not stated. Nasal septum broken by a blow on the nose. She has not been restrained or confined. Dont know cause of the disease. As to treatment, nothing mentioned. On personal Examination, she shows nervousness + incoherency.

Feb 28 On admission was put on T.W. (G.H.N.N.P.) Complexion fair; hair gray; eyes blue; condition of skin normal; no marks, scars or eruptions noted; ulcers on her neck + left leg; no bruises or hernia. Is clean; has 10 lower teeth + none above; behavior quiet; has delusions.

Feb 28 to Mch 14 Summary of da record by Dr Heydale. Bathed + put to bed. First Mrk. temp. pulse + resp. normal; appetite good; cathartic given first day after that not needed. Slept well. Conversed intelligently; seemed well physically + anxious to be out of bed. Mch 7, up on ward; very agreeable + assisted with work. Second week Temp. pulse + resp. normal. Bowels regular, appetite good. Slept well: assisted regularly with ward work. Agreable + pleasant. Mar. to June 1901 Feb. 28. patient recieved on Inf. West, expresses delusions of persecution, is old and somewhat demented, is in good physical condition, Mar. 25 patient assists with ward work, neat in habits and appearance, bowels regular, eats and sleeps well, takes out door exercise, quiet in behavior, at times very disagreeable and interferes with the treatment of other patients, is very officious, Mar. 25 tran. to C1, Mar 30 tran C.3, patient assists in Center dining room May 29 Wt. 138 1/2 #.

June to Sept. Aug. 30 no change Wt, 140#. Sept. to Dec. Works in center dining room, general health good, very well mentally, inclined to be very meddlesome and disagreeable.

Dec to Mar 30-1902 No change. Wt 143 1/2 # Neat in appearance, clean in habits: General health good. Takes exercise; works in dining room: appetite good: sleeps well: bowels regular: does not menstruate. Is rather inclined to be meddlesome + quarelsome with the other patients at times. Inclined to be officious on the ward. Dec 1st Wt 141 #.

Personal and Medical History of

Personal and Medical History of Sarah. A. Simons

Whole No. 5770. Became resident of Minn. abt 1863 County Waseca 1889

Residence, Janesville, Minn.

Date Admission, March 2nd 1901.

Admitted by Dr. E. Z. Wanous hour, 4th P.M.

How Sent, Geo. A. Wilson, Jof P. Waseca County

Sex, Female Age, 38

Civil Condition, married

Children, -3-

Age Youngest Child, 5½ years

Occupation, Housewife: husband, a farmer

Degree Education, Common school.

Profession, Religion, not a church member.

Habits, not intemperate

Nativity, Minnesota: father's, Ohio: mother's, Ont Know

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

Correspondents, Henry Simons (husband) Elysian Minn

No. of Year, 133

Insane Relatives, none * see exam

Cause Exciting, Puerperal infection

Cause Predisposing, previous attacks.

Form, Acute Melancholia (delusions)

Accompanying Bodily Disorder, none mentioned

Suicidal or not, yes & propensity now active

Date of this Attack, Feby 24/1901

Duration, -6 Days-

No. of Attack, Not 1st: Seemingly 3rd

No. of Admission, 3rd

Age First Attack, about 32

Time of Leaving, 29th May 1901.

Time in Hospital, 2 mos 29 Ds.

Result, Recovered: Discharged Nov 22/1901.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of March 7/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, good

Recent Events, good Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive. Alert

REASONING POWER, Ordinary Subjects, good

Special Subjects,

Own Mental State, Thinks she has been insane, but not this time.

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

DELUSIONS, Systematized, Transitory, Special Subjects, Has a fear of her husband; thought he was wronging her & that he was attempting to poison 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,

ONSET, Gradual or Sudden,

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption). * Aunt on mother's side is insane in a hospital in Indiana - several of mother's brothers & sisters died of consumption -

Father, Living; well

Paternal Relatives, weakly family

Mother, Died: cancer

Maternal Relatives, Consumptive

Brothers and Sisters, 6 sisters: 3 living, well. 3 children - well — 2 brothers - 1 living - well.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Had a surgical operation here -

HABITS, Drinking and Smoking, Good

HEADACHES, VERTIGO, OR CONVULSIONS, Has had considerable headache at times occasionally, mild -

OCCUPATION, Healthy or not, Housework

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

Sleep, Appetite, and Bowels, poor poor somewhat constipated -

Personal and Medical History of Sarah. A. Simons

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in PRESENT WEIGHT, 114½ lbs USUAL WEIGHT, NUTRITION, poor

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt: slight white coating -

PUPILS, Equality, Size, Response to Light, and Accommodation, yes normal good good

SIGHT, good

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

HEARING, good

COORDINATION, Arms, good Legs, good Grasp, other tests good or fairly good.

TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor fine tremor

PATELLAR REFLEX, present Other Reflexes, Elbow & wrist

ARTICULATION, Slurred, Hesitating, Slow, Clear

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none strong normal

Apex Beat, Regularity, normal regular

ARTERIES, normal

LUNGS, Chest, Symmetry, Expansion, yes good

Breath Sounds, normal

Dullness in right apex

CRANIAL MEASUREMENTS.

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, Genitals normal: uterus retroflexed: adherent: cervicitis; endometritis: herpes vaginalis; leucorrhoea.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin, memo. St Peter - 1895 - 2 mos

SLEEP, Present Amount and Character, R.S.H. 3 or 4 times

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. Is nervous, but quiet in behavior: somewhat sleepless at night - Patient talks rationally & sensibly; takes her nourishment very well. Says "she thinks she has been insane at previous times, but not this time" - Says "she was afraid of her husband - thought he wanted to poison her" -

Personal and Medical History of Sarah. A. Simons

1901

This patient was brought here by Deputy Frank Collins, attended by Annie Tafer, in fair physical condition, with following history of case. There is no history of consanguinity, or heredity, previous peculiarities, intemperance, severe disease &c or head-injury; this is not 1st attack; (seemingly the 3rd); others having occurred in May 1896 and April 1899, when she was sent to Rochester, and was returned apparently well. First symptoms of this attack were manifested Feby 24th 1901, in the destruction of her clothing and attempts at running away. The disease seems increasing; variable & with rational intervals, but these periods not regular. Derangement is now shown by such acts as the destruction of her clothing, attempts at suicide &c. She is not disposed to injure others; has attempted suicide by drowning herself; propensity now active. Is disposed to filthy & destructive habits. She has been at State Hospital at Rochester, twice. Cause of the disease, puerperal infection. Has only received hospital treatment. On personal Examination, she has physical appearance of health; there are noted her conversation and a form(?) of mental derangement. Commitment recommended: because we consider the same essential to her recovery". ——.——

N.B. Patient here twice before. For 1st Commitment (July 6/96 – Feb 19/98) see Vol 30 p 221 No 4439 (was then transferred from St. Peter) For 2nd " " (Apl 21/99 – Aug 19/99) " " 40 " 221 " 5289. She was discharged, in each case, as Improved. ——.——

Mar 2 On admission was put on T.W. (G.H.N. Rpt. Complexion dark: hair black: eyes brown: condition of skin normal: no marks scars &c noted. Is clean: has 7 lower teeth: no upper ones: Is quiet and talks intelligently.

Mch 2 to Mch 16. Summary 14 da. record (Dr Heyerdale) Bathed & put to bed: Quiet: Slept well: Temp. pulse & resp. normal during first week: Appetite fair: given cathartics occasionally: Quite restless & nervous: neat in habits: quiet: at times somewhat resistive & inclined to be disagreeable: Does not like to take medicine & sometimes refuses it: Talks rationally & intelligently. Says she is very nervous & thinks she is insane: Says she thought husband intended to poison her. Second week. Temp. pulse & resp. normal: Appetite fair: occasional cathartics given: Mch 10 Dressed & up on ward: Takes outdoor exercise: Sleeps fairly well at night. Somewhat resistive: Mar. to June Patient seldom converses: is quite sarcastic in her remarks especially to the nurses: assists with ward work at times: sleeps well: takes gynecological treatment three times a week: is quiet: Apr. 23: May 20 menstruated: neat and clean in habits and appearance: complains a good deal of head ache: converses intelligently: gradually becoming more pleasant and agreeable: May 29 visited by husband and taken home.

—Discharged—

Personal and Medical History of

Personal and Medical History of Christina E. W. Bierbaum

Whole No. 5771. Resident of state, all her life / " County, all her life

Residence, Viola, Minn.

Date Admission, 5th March 1901.

Admitted by D. O. C. Heuerdale hour, 11:30 Am

How Sent, J. A. Leonard, Jo P. Amated County

Sex, Female Age, 31 Years

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, Housework; father, a farmer

Degree Education, Common School

Profession, Religion, Evangelical —

Habits, no history of intemperance —

Nativity, Viola, Minnesota: parents born in Germany.

Physicians Committing, Chas. T. Granger & R. C. Degan

Correspondents, See (Father) C. H. Bierbaum } Viola. Minn
(Brother). H. C. Bierbaum }

No. of Year, 134

Insane Relatives, — None

Cause Exciting, Do not Know

Cause Predisposing, "Chronic"

Form, Melancholia Chronic

Accompanying Bodily Disorder, None mentioned.

Suicidal or not, Yes: attempted poisoning: propensity now active

Date of this Attack, Several years ago (5 or 6 yrs)

Duration, — Several years —

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, not stated

Time of Leaving, July 3 — 1901.

Time in Hospital, 3 mos 28 ds

Result, Improved
Discharged July 5 — 1902
By Bd of C

EXAMINATION ON ADMISSION BY DR. O. C. Heuerdale *Date of* May 7/1901.

MENTAL CHARACTERISTICS.

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

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

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Correct

REASONING POWER, Ordinary Subjects, Fair
Special Subjects,
Own Mental State, Doesn't think that she is insane.

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Wants dead sister to come back: talks a great deal on this subject.

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 5 or 6 years

ONSET, Gradual or Sudden,

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

Father, Well

Paternal Relatives, negative history

Mother, Dead

Maternal Relatives, negative history

Brothers and Sisters, Living: one dead.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
had uterine operation in 1895 at St. Mary's Hospital.

HABITS, Drinking and Smoking, good

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework

Detail Date, Duration, and Character of Previous Attack, if any,
Began 5 or 6 years ago

Sleep, Appetite, and Bowels, quite regular.
Poor fair

Personal and Medical History of Christina E. W. Bierbaum

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, prompt: slight white coating.

PUPILS, Equality, Size, Response to Light, and Accommodation, Yes Normal Fair good

SIGHT, good

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

HEARING, good

COORDINATION, Arms, good Legs, good Grasp, Right hand, good.

TREMORS, Hands, Tongue, Facial Muscles, General, Hands: fine: tongue, fine tremor.

PATELLAR REFLEX, present Other Reflexes, Elbow, very marked: wrist, present.

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, None Strength, Sounds, Strong Size, Normal
Apex Beat, Regularity, Normal regular

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Yes good

Breath 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, Genitals normal: hymen intact: uterus retroflexed: free: slight endometritis: herpes vaginalis: Double "Alexander" has been performed. —

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 seeming much depressed: sleepless at night: appetite poor: cries occasionally & says she wishes to go home: that she is not insane" and blames no one but her. Her trouble began 6 yrs ago, when she was disappointed in love, but was acutely manifested after the death of a sister over a year ago: since which time she has been melancholy, worried over her sister and talked about her coming back. Her father thinks she has periodic Dementia praecox, at times.

Memo. 6 yrs ago. disappointed in love Death in 1900 - one -

Personal and Medical History of Christina. E. W. Bierbaum

1901

This patient was brought here by Sheriff Vue, attended by father C. H. Bierbaum and brother J. C. Bierbaum, in fair condition, and with following history of case. There is no history of consanguinity, or heredity, filthy or destructive habits, intemperance, severe disease or a head-injury. This is first attack: first symptoms manifested several years ago, by melancholia. The disease appears increasing: is constant. Derangement is now shown by melancholia with suicidal tendency. Patient is not disposed to injure others but has attempted suicide: attempted by poisoning: propensity now active. Previously, she showed religious impressions. Patient has been confined at home. Do not know cause of the disease. Has been treated by general tonics. On personal Examination, there is evidence of melancholia. ——

Mar 5 On admission, was put on T.W. (G.H.N. Rft. Complexion fair: hair light: eyes blue: Condition of skin normal: no marks scars or bruises noted: a few eruptions on back: Is clean: has 15 upper and 14 lower teeth. Resisted when being taken to ward. Talks very little, but intelligently. —

Mch 5 to Mch 9 Summary 14 da. record by Dr. Hyndal. Patient admitted, bathed & put to bed. Very quiet but restless in manner: awake most of night: First week. Temp. pulse & resp. normal: occasional cathartics given for bowels: Restless at night: Very melancholy & cries some. Says she is not insane & wants to go home that she worried a great deal about her sister but that is no reason why she should be here. Mch 11. Dressed & up on ward: Second week: Temp. pulse & resp. normal: appetite fair: bowels regular: Continues very melancholy Quite restless at night: cries: very anxious to go home.

Mar to June. Patient admitted on ward Mar. 5 very melancholy, cries a great deal, wants to return home, also talks about her dead sister and weeps for her. Mar. 14 & 15 visited by father and brother. Mar. 18 up and about the ward, assists with the work, is agreeable, takes out door exercise, Mar. 21 menstruating, Mar. 29 visited by brother-in-law, Apr. 3 & 9 visited by relatives Apr. 9 given massage by nurse Elizabeth Walsh, massage continued regularly every other day, May 6 visited by relatives, given electrical treatment, which was continued every other day also gynecological treatment given, given cathartics and hypnotics when needed. May 29 patient still continues very nervous and melancholy, has improved some, converses intelligently, neat in habits and appearance, assists with the ward work. May 30 Wt. 103½#. June to Sept. May 7 visited by relatives and friends, June 21 by father, July 31 taken home by father this evening, very much improved.

Discharged.

Personal and Medical History of

Personal and Medical History of Frances van Dyk

Whole No. 5772.
Residence, St. Cloud, Minn
Date Admission, 5th March 1901.
Admitted by Dr O.C. Heyerdale hour, 7 45 Pm.
How Sent, Edmund W. Bazille, J. of P. Ramsey County
Sex, Female Age, 40 years
Civil Condition, Married. (Married at 18)
Children, Two *Twins Dead
Age Youngest Child, Ten years *and 2, yrs respectively
Occupation, Housewife: husband's, Draughtsman
Degree Education, Common school
Profession, Religion, Unitarian
Habits, reticent: father intemperate.
Nativity, Virginia USA: father's, England: mother's, USA
Physicians Committing, Dalton Preve * W. Archibald
Correspondents, Husband's Address
Mr Dirk Van Dyk, Annandale, Wright Co. Minn.
4 miles N.E.

No. of Year, 135.
Insane Relatives, None
Cause Exciting, Congenital
Cause Predisposing, Chronic
Form, Paranoia.
Accompanying Bodily Disorder, none mentioned
Suicidal or not, Yes, hyperion: there is danger still
Date of this Attack, In 1890
Duration, Eleven years
No. of Attack, Not 1st (one occurred in 1891)
No. of Admission, 1st here (was in Meerenberg, Holland)
Age First Attack, abt. 30 years
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O.C. Heyerdale Date of March 6/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear: Quick
MEMORY, Past Events, Good
Recent Events, Good Special Subjects, Good
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, Does not think she is insane
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal
DELUSIONS, Yes Systematized, Transitory, Special Subjects, Gives history of systematized delusions of persecution since a child of eleven.
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).
*No insanity in family.
Father, *is a hard Drinker: living - well (Gives no history)
Paternal Relatives,
Mother, *living - well
Maternal Relatives,
*3 Brothers and Sisters, *1 Brother dead - typhoid *children very well - (2 Boys - well - healthy)
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke,
Head Injuries, and Surgical Operations), *no head injury. (No)
*one severe illness: lung fever when 22 yrs.
*HABITS, Drinking and Smoking, *much headache for years but not very severe. For last 4 Years has had a great deal of
*HEADACHES, VERTIGO, OR CONVULSIONS, *& sick headache with vomiting
*has not worked hard: kept a girl.
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Good Poor had Dysentery, a great deal.

Personal and Medical History of Frances van Dyk

PHYSICAL CHARACTERISTICS.

Mrs. Frances Van Dyk interviewed by Dr. Heyerdale on March 7th, stated as follows:-

Said she was born and lived in West Virginia until 12 years old when she came to Minnesota with her mother, step-father and sisters. Met her husband and married him when 17 years old. Said that she had had attempts made upon her life since she was 11 years old, and gave detailed account of seven. 1st. When 11 years old was in field with two sisters who sent her to a spring for water, a man was lying near spring and a priest standing near by; the presit told man to kill her with a hatchet which he had in his hand, man said he was not able, looked sick and priest and another man carried him away. She did not know what happened to him, said she never asked any questions.
2nd. After coming to Minnesota she was alone in house with her sister one evening and someone shot at her breaking window and lamp, putting out light. 3rd. She took dinner to men working in the field and was chased by a priest, She hid under bank and heard him telling someone to kill her. Said priest insulted her. She waited two hours and then went home . Thought mother, sisters and priest were in a conspiracy.
4th. After marrying Mr Van Dyk she staid with sister one night and someone tried to break in house during night. 5th. Was sitting with husband one evening and he opened window and asked her to sit in front of it said he would read to her. He sat back in the room and she heard something crash, thought somebody shot at her but did not know, said she never found bullet hole, never looked for it. 6th. Sent out in yard by husband to hang up some clothes and a man shot at her. 7th. When on way to Holland husband tried to push her overboard.
Said husband had never been a pleasant man to live with; had been very peculiar and acted crazy at times. Said he would pretend to cut throat with razor etc. and she used to take razor and ax away from him.
Said he was always pessamistic and unhappy. That he acted a little better while in Holland. Thought he had never cared for her but had entered into a conspiracy and had married her for money, and after evading questions for a while she said that she had supernatural powers given her by God, that she was not responsible for them but God used her as a medium and that put her on a level with Christ, and as He was the foundation of the Catholic Church, the priests were anxious to do away with her and she thought they bribed her husband to kill her.
She seemed absolutely indifferent to attempts made, said she never paid any attention to them and was not afraid, and had never worried about the conspiracy. Said while in Hospital in Holland the dead came and spoke to her also angels. Said she did not talk but fell asleep and they spoke to her. Her father came to her very often.

NUTRITION, fair
Teeth, good

MEASUREMENTS.
Horizontal,
Vital,
Index,
Diameter,
Volume,
Peculiarities in Shape,

Apl 12/1901

EXAMINATION URINE, Quantity, Sp. g. Reaction, Color, Appearance,
Albumen, Sugar,
Casts and Crystals,
*ulceration of uterus (?)
GYNECOLOGICAL EXAMINATION, Perineum lacerated: uterus retro-flexed, free: cervix lacerated, hypertrophied Cervicitis, Endometritis, leucorrhoea.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Quite good.
BOWELS, Present Condition, fairly 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 admitted in fair physical condition. Genetic habit & appearance: quiet & refined in behavior & manner. Talks freely & sensibly on all topics, except when led to discuss her own troubles, when she gives history of "delusions of persecution", dating from eleven years of age. Patient rests well, at night: has good appetite; assists some on ward. Reads and does fancy work. —

Personal and Medical History of Frances Van Dyk

Whole No. 5772.

Residence, St. Cloud.

Date Admission, 5th March

Admitted by Dr. O. C. Heyer

How Sent, Edmund W. Bazin

Sex, Female

Civil Condition, Married

Children, Two

Age Youngest Child, Seven

Occupation, Housewife

Degree Education, Common

Profession, Religion,

Habits, not stated

Nativity, Virginia.

Physicians Committing,

Correspondents, Mr. Dirk Van Dyk

miles

EXAMINATION ON ADMISSION BY DR. HEYER 1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Clear: Quick

MEMORY, Past Events, Good

Recent Events, good Special Subjects, Good

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Alert

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State, Does not think she is insane

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Normal

DELUSIONS, Yes Systematized, Transitory, Special Subjects, Gives history of systematized delusions of persecution since a child of eleven.

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.

LENGTH INVASION.

ONSET, Gradual or Sudden,

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

Father, is a hard Drinker: living - well

Paternal Relatives,

Mother, living - well

Maternal Relatives,

Brothers and Sisters, 3 / 1 / 2 Brothers dead - 2 stillborn children very well - (2 Boys - well - healthy)

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke,

Head Injuries, and Surgical Operations), no head injury. (no)

one severe illness: lung fever when 22 yrs.

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Much headache for years but not very severe. For last 4 years has had a great deal of sick headache with vomiting

OCCUPATION, Healthy or not, Housework

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

Sleep, Appetite, and Bowels, Good Poor Had dysentery, a great deal

Personal and Medical History of Frances van Dyk

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6in PRESENT WEIGHT, 132 lbs USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal

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

PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal Good good

SIGHT, good: eyes are weak

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

HEARING, good

COORDINATION, Arms, Good Legs, Good Grasp, other tests good.

TREMORS, Hands, Tongue, Facial Muscles, General, Fair Fair

PATELLAR REFLEX, present: Elbow + wrist present Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Clear + Distinct -

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, None Strong Normal

Apex Beat, Regularity, Normal regular

ARTERIES,

Normal

LUNGS, Chest, Symmetry, Expansion, Fair

Breath Sounds, Normal

Lungs have troubled her since lung fever when 22 yrs: but no tuberculosis husband says part of one lung is gone.

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,

ulceration of uterus (?)

GYNECOLOGICAL EXAMINATION, Perineum lacerated: uterus retro-flexed, free: cervix lacerated, hypertrophied Cervicitis, Endometritis, Leucorrhoea.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Quite good.

BOWELS, Present Condition, fairly 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 admitted in fair physical condition. Generate habits + appearance: quiet + refined in behavior + manner. Talks freely + sensibly on all topics, except when led to discuss her own troubles, when she gives history of "delusions of persecution", dating from eleven years of age. Patient rests well, at night: has good appetite, assists some on ward. Reads and does fancy work. —

Personal and Medical History of *Frances van Dyk*

1901

This patient was brought here by Deputy Johnson, attended by husband Dirk van Dyk and (nurse) Miss C. Veenstra, in fair physical condition, with following history of case. There is no history of consanguinity or heredity. This is not 1st attack; one occurred in 1891, duration up to the present time: was in hospital at Meerenberg, Holland: result negative. First symptoms of this attack manifested in 1890, by insomnia, nervousness; was apprehensive. The Disease seems stationary: variable & with rational intervals, but these not at regular intervals. Derangement now shown by delusions of persecution. Patient is not disposed to injure others; but has attempted suicide, by poison, and there is danger now. No filthy or destructive habits. No peculiarities shown before accession of the disease. As to her habits, nothing stated, but father was intemperate. No history of any severe disease &c, or head injury. She has been restrained or confined for 9½ years. Supposed cause of the disease is Congenital. Has had hospital treatment. On personal Examination, is delusional, apprehensive; is afraid of her husband; imagines that she is persecuted by Priests. N.B. Particulars marked * were furnished by husband when coming with her. * Patient always very energetic; a great worker. Education limited but naturally bright. First attack manifested during visit to Holland 10 years ago, by delusions of persecution by Jesuits & others: was put in Asylum and husband stayed 3 years, hoping she would recover. (She later had delusions of wealth); & grew worse; when husband returned to America, she was in bed, with lung trouble & growing worse. During intervening years, she has tried constantly to elope; succeeding 8 times: violent when returned; once, knocked down night-watch took keys & escaped: another time, jumped over high fence, while out walking. Made three attempts at suicide. (1st): Jumped from 3rd story window, falling on balcony & spraining ankle: — (2nd). Tore up sheet & fastened strips to window & around neck; cut down unconscious. — (3rd): Attempted hanging. Was given several trials outside. Delusions now principally concerning husband. Says "he is not her husband: another man is father of her children &c". Think, is not insane, and is wrongfully kept in Hospital. In better health, physically, than 10 years ago. One lung weak: no tuberculosis. Gave little trouble, en route. Appt good: sleeps well; bowels regular. *

Mar 5 On admission, put on T.W. (G.H.N.R.'s): Complexion dark: hair black: eyes blue: condition of skin normal. No marks scars or bruises noted. Is clean. Has upper plate with 3 teeth & has, of her own, 12 upper & 12 lower teeth. Behavior quiet. Talks intelligently.)

Mch 5 to 19. Summary of 14 da. record (Dr Heyerdale) Bathed & put to bed: Mental condition one of Paranoia & she expresses systematized delusions of persecution (See attached slip) on other subjects is rational & intelligent: Quiet: Assists with work. First week appetite good: Bowels regular: Temp. pulse & respiration normal: Conversed freely. Second week. Temp. pulse & resp. normal: Appetite good: bowels regular: slept well. 17 & 18 complained of headache & sore throat & pains through entire body. Condition one of La Grippe. Mar. to June 1901 Neat in habits and appearance, converses intelligently, has many delusions of persecution and spiritualism and expresses them, general health good, is a good worker and very agreeable on ward; takes massage and gynaecological treatment

Personal and Medical History of

1901

May 30 Wt. 132#. June to Sept. Is occasionally sick in bed for a day or two during menstration Aug. 30 Wt. 135#. Sept. to Dec. Menstruates regularly. No change during quarter Nov. 31 Wt. 137#.

Dec. to Feb. 1903 No change. Wt 138½#. May 12th Visited by friends. Jan. 22nd '01, Visited by friends - also on July 29th.

Personal and Medical History of Jennie Anderson

Whole No. 5773. Resident of State 29 yrs ago " " County 13 " "
Residence, St. Paul. Minn:
Date Admission, 6th March 1901.
Admitted by Dr. O. C. Heyerdale hour, 7 15 P.M.
How Sent, Edmund W. Bazille, Jos P. Ramsey Co.
Sex, Female Age, 32
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, None
Degree Education, Grammar School
Profession, Religion, Lutheran
Habits, No history of intemperance
Nativity, Sweden: parents also born there.
Physicians Committing, Arthur Sweeney & J. O. Cavanaugh
Correspondents, Sister's address: Mrs. O. Thorsen. 745 Carroll St. St. Paul Minn
Brother's address, Reynard Anderson, Halleck Minn

No. of Year, 136.
Insane Relatives, None
Cause Exciting, unknown
Cause Predisposing, "Chronic"
Form, Chronic Melancholia
Accompanying Bodily Disorder, none mentioned
Suicidal or not, propensity now active
Date of this Attack, 3 years ago
Duration, 3 years
No. of Attack, 1st —
No. of Admission, 1st —
Age First Attack, — 29 —
Time of Leaving, August 22 — 1901.
Time in Hospital, 5 mos 16 ds.
Result, Improved —
Discharged, by Board of Control Feby 26 — 1902

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* March 8/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Seems clear; at times, refuses to talk.
MEMORY, Past Events, seems good
Recent Events, seems good Special Subjects, seems good
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert
REASONING POWER, Ordinary Subjects, good
Special Subjects,
Own Mental State, She thinks she is insane.
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, 3 years
ONSET, Gradual or Sudden, gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father died of consumption —
Father, Dead — Consumption
Paternal Relatives, Negative
Mother, living: very nervous: somewhat is inclined to hysteria
Maternal Relatives, negative
Brothers living, well and Sisters, 3 living, well —
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
No
HABITS, Drinking and Smoking, good
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, housework & seamstress
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, quite regular.
poor poor

Personal and Medical History of Jennie Anderson

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8 PRESENT WEIGHT, 118# USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, normal: healthy
TONGUE, Coatings or Promptness of Movement, prompt: white coating
PUPILS, Equality, Size, Response to Light, and Accommodation, good
Eyes normal good
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, good Legs, good ~~Grasp,~~ other tests, good —
TREMORS, present Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, present Other Reflexes, elbow & wrist
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, none Murmurs, strong Strength, Sounds, normal Size,
normal Apex Beat, Regularity, regular
ARTERIES,
normal
LUNGS, Yes Chest, Symmetry, good 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, Genitals normal: hymen intact: uterus retroverted: adherent: Cervix hypertrophied: Eroded: herpes vaginalis: cervicitis, endometritis, leucorrhoea.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION, Memo. Sister says "has always been of melancholy disposition;
BLOOD, Corpuscles, Hæmoglobin, Disappointment in love, twice; 6 and 3 years ago —
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 very quiet & depressed. Sleep is poor. appetite is poor. Is reticent about answering questions; at times, refusing to say anything. Patient says trouble began about 2 years ago. She began to worry about a certain young man, with whom she was in love —

Personal and Medical History of Jennie Anderson

1901

This patient was brought here by Deputy Johnson, attended by Mrs Hayward, in fair physical condition, & with following history of case. There is no history of consanguinity or heredity, filthy or destructive habits, intemperance, severe disease &c or head injury. This is first attack; symptoms manifested by brooding over imaginary troubles, three years ago. Disease appears increasing: is variable & with rational intervals. Derangement now shown in that she believes that she is in danger from unknown enemies & that her sister is being killed. She is melancholy & sleepless. Patient is not disposed to injure others; has not attempted suicide, but propensity is now active. Before accession of the disease, was always eccentric. She has not been restrained or confined. Cause of the disease is unknown: has been under general tonic treatment. On Personal Examination, it is brought out that she speaks & walks during night, account of delusions: Decided views in favor of suicide. ——— " ———

Mar 6 On admission put on T.W. (G.H.M. R.P.) Complexion fair; hair light: eyes gray: Condition of skin normal, no marks, scars or bruises noted. Is clean: no bodily peculiarities noticed: has 12 upper & 11 lower teeth. Is quiet, but obstinate; talks very little, but intelligently).

Mch 6 to Mch 20. Summary 14 da. record by Dr Heyerdale. Received on ward: bathed & put to bed: Slept two hours. First week. Temp. pulse & resp. normal: Occasionally requires cathartics & hypnotics. Bowels regular. Slept fairly well during night. Very resistive: Refused sleeping dose Mch 12 dressed & up. Second week: Temp. pulse & resp. normal: Fed mechanically. Mch 13-16 inclusively. Rest of week took small amount of nourishment: given malt & cod liver oil. 3 x day. Slept quite well. Very melancholy: rarely speaks but answers questions but

Mar to June 1901 Neat in habits and appearance, general health good; is very quiet & listless: at times is resistive and violent, May 29 visited by relatives Wt. 102 3/4#. June to Sept. July 8 visited by sister, continues very resistive is otherwise very quiet; When out walking frequently attempts to elope. Aug. 22 is more cheerful and assists some with the ward work, Aug 22 went home.

Discharged

Personal and Medical History of

Personal and Medical History of Julia Doherty

Whole No. 5774. Resident of State: Born here. " " County: 12 years ago.
Residence, St Paul, Minn.
Date Admission, 9th March 1901.
Admitted by Dr. O. C. Heyerdale hour, 7.30 P.M.
How Sent, E. W. Bazille, J. of P. Ramsey County
Sex, Female Age, 33.
Civil Condition, married
Children, - seven -
Age Youngest Child, Eight months -
Occupation, Housewife: husband, a laborer.
Degree Education, Common school
Profession, Religion, Catholic
Habits, no history of Intemperance -
Nativity, Minnesota; parents born in Ireland.
Physicians Committing, F. L. Beckley & Arthur Sweeney
Correspondents, Husband, Thomas Doherty
176 East Indiana Ave. St Paul

No. of Year, 137.
Insane Relatives, none
Cause Exciting, Overwork
Cause Predisposing, not stated
Form, Agitated Melancholia Acute
Accompanying Bodily Disorder, Is much "run down"
Suicidal or not, not
Date of this Attack, Four weeks ago
Duration, Four weeks
No. of Attack, 1st —
No. of Admission, 1st here (was at St Joseph's)
Age First Attack, 33 -
Time of Leaving, 1st June 1901 -
Time in Hospital, 2 mos 22 Ds
Result, Recovered: Discharged Nov 2/1901.

EXAMINATION ON ADMISSION BY DR. L. A. Linton Date of Mar 11/1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Varied: sometimes clear & rather sluggish: at others, Confused
MEMORY, Past Events, apparently good, when mind is clear.
Recent Events, " " Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Variable: somewhat dull: sometimes Correct
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, says "she is not sick but worried"
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed
DELUSIONS, Systematized, Transitory, Special Subjects,
Delusions of persecution
HALLUCINATIONS, of 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, Sudden
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Died of rheumatism
Paternal Relatives, —
Mother, Living, well
Maternal Relatives, —
Brothers and Sisters, 4 2 well
7 Children - well -
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Typhoid fever, when a girl.
HABITS, Drinking and Smoking, not ascertained
HEADACHES, VERTIGO, OR CONVULSIONS, subject to severe
OCCUPATION, Healthy or not, that of Housewife
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, fair fair Constipated

Personal and Medical History of Julia Doherty

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in PRESENT WEIGHT, 131# 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
SIGHT, fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, fair
COORDINATION, Arms, good Legs, good ~~Grasp,~~ other tests good
TREMORS, Hands, Tongue, Facial Muscles, General, none none Fine tremor of hands: tongue, none -
PATELLAR REFLEX, exaggerated Other Reflexes, elbow & wrist
ARTICULATION, Slurred, Hesitating, Slow, good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, aortic stenosis & regurgitation
Apex Beat, lowered to the left, Regularity, strong regular
ARTERIES,
Atheromatous
LUNGS, Chest, Symmetry, Expansion, sym 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, Genitals normal, except for partial lacuation of perinaeum: small rectocele & cystocele: uterus free: retroverted: Cervix lacuated, eroded: cervicitis, herpes, leucorrhoea
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, 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). Has been much depressed & agitated since admission: cries a great deal & is disturbed, both day & night, though she has become much quieter, & at times, talks rationally, about home & children. Her statements, at such times, agree with those made by her husband, at time of admission. She imagines that she is being talked about and maligned & thinks she sees people in her room who are doing things to annoy her. Also describes pictures on the wall of her room that are not there.

Personal and Medical History of Julia Doherty

1901

This patient was brought here by Deputy Geo. F. Kroeger, attended by husband, Thomas Doherty, in poor physical condition, and with following history of case. There is no history of consanguinity, or heredity, previous peculiarities, intemperance or other habits; is not disposed to injure others nor suicidal. no filthy or destructive habits. This is the first attack: first symptoms manifested four weeks ago; She had an epileptic attack, followed by coma, and by delusions. Disease appears increasing: not variable: no rational intervals. Derangement now shown in that she believes that people are trying to kill her, calling her names and depriving her of liberty. Patient has been sick for some time, culminating in an epileptic attack, followed by loss of memory and delusions. She has not been restrained or confined. Supposed cause of the disease is overwork. Has been treated at St Joseph's Hospital; result unsatisfactory. On personal Examination, patient is much run-down talks freely of her delusions and believes that people are trying to kill her.

Mar 9 On admission was put on T.W. (G.H.N. 16 pt. Complexion dark: hair dark, partly gray; eyes gray: Condition of skin normal: no marks scars or bruises noted: has vermin; is dirty: has 13 lower teeth, and an upper plate. Is quiet, but a little resistive: has delusions).

Mch 9 to Mch 23 Summary 14 da. record (by Dr Heyerdale) Mch 9 Received on ward bathed & put to bed: Very dirty. Suffering from agitated melancholia: noisy: has delusions: hallucinations & illusions; urine showed albumen: Kept in bed: given cathartics hypnotics phosphorus & tonics. Highest temperature 100°. Pulse 88. Resp. 24. By mch. 3 became much quieter: Answered questions intelligently rested somewhat better: memory of past returning. Conversed freely & intelligently about home & family matters. After Mch 16 Stomach washed daily; Seems to have much gastric trouble mouth very foul. Improved greatly under this treatment. Bowels regular: Mar. to June 1901 Apr. 25 Menstruating, converses intelligently and freely, at times is hysterical and somewhat violent towards nurses, May 8 much improved trans. to A. 2, May 31 Wt. 133#.

June to Sept. Patient quiet and agreeable much improved physically, June 1st. taken home by husband.

Discharged.

Personal and Medical History of

Personal and Medical History of Mrs Mary Ogilsbee

Whole No. 5775. Became resident of State. 1852 " " of County. 1866

Residence, St. Paul: Minn.

Date Admission, 9th March 1901.

Admitted by Dr. O. C. Heyerdale hour, 7.30 pm

How Sent, Edmund W. Bazille, Jo P. Ramsey County

Sex, Female Age, 87.

Civil Condition, Widow

Children, Three

Age Youngest Child, Fifty Two

Occupation, Laborer

Degree Education, Common School

Profession, Religion, Episcopal.

Habits, unknown

Nativity, England: parents also born there.

Physicians Committing, Burnside Foster & Talbot Jones

Correspondents, none given in papers

No. of Year, 138.

Insane Relatives, unknown

Cause Exciting, Senility

Cause Predisposing, probably age

Form, Senile Dementia

Accompanying Bodily Disorder, heart disease, arteriosclerosis and beginning cataract of both eyes –

Suicidal or not, not

Date of this Attack, unknown

Duration, probably long

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, unknown.

Time of Leaving, Mch. 28 '1901.

Time in Hospital, 19 da,

Result, Discharged – Sent out of State. May 1 '1901

EXAMINATION ON ADMISSION BY DR. L. A. Linton *Date of* March 12/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Seems good

Recent Events, " " Special Subjects,

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

REASONING POWER, Ordinary Subjects,

Special Subjects, fair

Own Mental State, does not appreciate it

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

DELUSIONS, Systematized, Transitory, Special Subjects,
none determined

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, Unknown

ONSET, Gradual or Sudden,

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

Father, Died of pneumonia

Paternal Relatives, ——

Mother, Died in child-birth.

Maternal Relatives, 5 sisters. 1 Died of lung fever – 2 Died as result of bearing too many children (one having had 20) – 3 brothers. 1 Died of cancer (?) 1 one of pneumonia one of apoplexy

Brothers and Sisters, 3 children

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Head hurt by fall.

HABITS, Drinking and Smoking, good

HEADACHES, VERTIGO, OR CONVULSIONS, vertigo

OCCUPATION, Healthy or not, formerly a milliner

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

Sleep, Appetite, and Bowels, poor good Constipated

Personal and Medical History of Mrs Mary Ogilsbee

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in PRESENT WEIGHT, 111 # USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, Slight Coating: prompt

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

SIGHT, poor

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Cataract of both eyes.

HEARING, fair

COORDINATION, Arms, good Legs, Good Finger to nose, eyes shut, good: standing on one foot, poor: turning quickly ~~Grasp~~, poor: standing eyes shut, fair

TREMORS, Hands, Tongue, Facial Muscles, General, of Hands. fine tremor: tongue, facial muscles, general – none

PATELLAR REFLEX, Other Reflexes, absent

ARTICULATION, Slurred, Hesitating, Slow, good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, aortic stenosis, regurgitation mitral – regurgitation weak:

Apex Beat, Regularity, regular

lowered to left.

ARTERIES, Sclerotic: small

Aneurism in right side of neck.

LUNGS, Chest, Symmetry, Expansion, Sym 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, Genitals normal: uterus and cervix atrophied: uterus dextro-retroflexed – adherent: senile vaginitis.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, 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).

no special note made

Personal and Medical History of Mrs Mary Ogilsbee

1901

This patient was brought here by Deputy Emanuel Johnson, attended by Mrs Emma Johnson, in fair physical condition, & with following history of case. As to consanguinity, heredity, intemperance & other habits, any severe disease &c or head-injury, all is unknown. This is first attack: when first symptoms were manifested, or in what way, is unknown. Disease seems increasing - not variable, no rational intervals. Derangement now shown by various delusions - Patient is disposed to injure others, but not suicidal - has filthy and destructive habits. No previous peculiarities shown. She has not been restrained or confined - Supposed cause of the disease is senility - Has had no treatment. On personal examination, she is found to have Heart disease, arterio-sclerosis and beginning cataract of both eyes.

Mar 9 On admission, was put on I.W. (G.H.N. R/pt. Complexion dark: hair gray: eyes gray: condition of skin, hot and dry: marks, scars or bruises, none noticed; says she has hernia, but it is not noticeable. No vermin. Is clean. Has a swelling on upper part of left arm, curvature of spine, some enlarged veins on legs, and some deformity of the toes: has 7 lower teeth & an upper plate. Behavior quiet, but she is talkative: think she has delusions.) —

Mch 9 to Mch 23. Summary 14 da record (Dr. Heyerdale) Admitted on ward: bathed & put to bed. Has varicose veins & toes deformed. Conversed readily: Quiet in behavior. Kept in bed until Mch 20. during this time highest temperature 100°. Pulse 96. Resp. 22. Given cathartics daily: on liquid diet: hypnotics given at night & general tonic treatment. Bowels regular: Mch 20 up on ward: Quiet: has some delusions: Converses readily & intelligently: case one of senility. Mch. 28 Taken to Burlington Iowa by daughter & son-in-law who came here for her as they wished to care for her.

Discharged.

Personal and Medical History of

Personal and Medical History of Tillie Aberg

Whole No. 5776. Resident of State eight ago (8)
Residence, St. Paul. Minn " County —
Date Admission, 11th March 1901.
Admitted by Dr. L. A. Lipston hour, 7 25 PM
How Sent, E. W. Bazille. J. of P. Ramsey County
Sex, Female Age, 32.
Civil Condition, Married
Children, - Two -
Age Youngest Child, four -
Occupation, Housewife: husbands, laborer
Degree Education, Slightly educated
Profession, Religion, Goeta Lutheran Church
Habits, No history of intemperance -
Nativity, Sweden; parents also born there
Physicians Committing, Dr. H. Ogden & W. G. Dickeson
Correspondents, Mrs Swan Johnson
677 York St. St. Paul, Minn

No. of Year, 139.
Insane Relatives, None
Cause Exciting, unknown
Cause Predisposing, Previous attack
Form, Dementia Primary.
Accompanying Bodily Disorder, Nervousness
Suicidal or not, - Not -
Date of this Attack, 10 days ago
Duration, - 10 days -
No. of Attack, 2nd (1st in winter of 1900) -
No. of Admission, 1st
Age First Attack, about 31.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* March 14th 1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Sluggish & Confused
MEMORY, Past Events, Poor
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Dull
REASONING POWER, Ordinary Subjects,
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,
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, Well
3 Children: 2 living: 1 dead.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
HABITS, Drinking and Smoking, Probably moderated occasional glass of beer or wine.
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Poor Good Quite regular.

Personal and Medical History of Tillie Aberg

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5in PRESENT WEIGHT, 121lb USUAL WEIGHT, NUTRITION, Fair
WOUNDS, Abnormalities and condition of Skin, Normal
TONGUE, Coatings or Promptness of Movement, Prompt: Slight white Coating
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes Normal Good Good
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal
HEARING, Good
COORDINATION, Arms, Good Legs, Good Grasp, Other tests good.
TREMORS, Hands, Tongue, Facial Muscles, General, Fine None
PATELLAR REFLEX, Present Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Mitral regurgitant murmur Weak Normal
Apex Beat, Regularity, Normal regular
ARTERIES,
LUNGS, Chest, Symmetry, Expansion, Yes 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, Lacerated Perineum and Cervix; small Cystocele; uterus retroverted flex. Cervix patulous, Endometritis, Cervicitis, Leucorrhoea, uterus & cervix Enlarged.
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. Somewhat restless at night. takes nourishment well: Seems confused & bewildered mentally: has a peculiar idea that she must touch certain pillows of the bed, which catch her eye, also certain articles about the nurses' clothing & ornaments in their hair. Does not give any reason, therefore.

Personal and Medical History of *Tillie Aberg*

Personal and Medical History of

1901

This patient was brought here by Dep. Shr. Johnson, attended by Tilda Larson, in fair physical Condition, and with following history of case. Not known as to consanguinity. No history of insanity. This is not 1st attack. In winter of 1900, occurred the 1st: duration about 2 weeks: She then remained at home: remained weak and nervous, but mind seemed normal. — First symptoms of this attack manifested ten days ago: was very talkative and imaginative. Disease seems increasing: somewhat variable with occasional rational interval. but these not regular. Derangement now shown in that she thinks she is pursued by black objects; also talks about abuse of her husband, which is real. Patient is not disposed to injure others, nor suicidal: Destroys some of the children's clothing. No previous peculiarities shown. No history of intemperance. Is subject to female troubles. Has not been restrained or confined. Cause of the disease unknown. No treatment. On personal Examination, patient is found to be very nervous and talkative. ———

Mar 11 On admission was put upon I.W. (G.S.H.R.Pt. Complexion fair: hair light: eyes blue: Condition of skin normal: no marks scars or eruptions noticed: left arm appears to have been burned: left arm bruised: no hernia: movements but is very dirty: one upper + 7 lower teeth: Behavior is quiet. Patient is rather incoherent and think she has delusions). ——— · ———

Mar. 11 to Mch 25 Summary 14 da. record. Dr Heyerdale) Bathed + put to bed. Slept quite well during night. First Mch temp. pulse + resp. normal: appetite fair: Takes regular diet. Hypnotics given also cathartics: Bowels regular. Noisy night of 16th Restless + out of bed days. Has habit of touching objects about room + wearing apparel. Says she cannot help it. Second week: Temp. pulse + resp. normal: Appetite good: Bowels regular: Given occasional cathartics + hypnotics: Up on ward on 20th. Quite disturbed + wandered about ward: seemed somewhat dazed, at times rather robust. Has trouble occasionally resulting from habit of touching people. Talk somewhat incoherent: Frequently wants to go home.

Mar to June 1901 Mar. 20. Patient menstruating, is noisy, restless and destructive requires hypnotics, May 30 continues destructive, is in quite good general health Wt. 129#. June to Sept. Patient has a peculiar habit of touching everyone who comes near her says she cannot help it. June 3 Tran. to C.3. July 4 visited by friends. Aug. 31 Wt. 135#. Sept. to Dec. Patient improving slightly, laughs a great deal to herself. talks seldom, menstruates regularly, expresses delusions. Nov. 23. Wt. 143½#. general health good.

Dec to Feb 1902 Patient is in good physical health, sleeps well: bowels regular: appetite good: menstruates regularly: takes out door exercise: does no work. Sometimes is effected by the delusion that her leg is effected so that she cannot walk. Habits and appearance cleanly and neat. She does not voluntarily converse and rarely answers questions.

Dec. 1st Wt 144#

Personal and Medical History of Wilhelmina Schmidt

Whole No. 5777.
Residence, Wells, Rice County — Minn
Date Admission, 14th March 1901.
Admitted by Dr. O. C. Heyerdale hour, 4.30 P.M.
How Sent, James Hunter, Jo P. Rice County
Sex, Female Age, 33.
Civil Condition, married
Children, four -
Age Youngest Child, born Dec 24th 1900.
Occupation, Farmer's wife; husband, farmer
Degree Education, Common School -
Profession, Religion, Lutheran -
Habits, No history of intemperance —
Nativity, Germany; parents also born in Germany
Physicians Committing, P. Albert Smith & Roscoe N. Jackson
Correspondents, (Husband): Ferdinand Schmidt (6 miles north) Faribault, Minn

No. of Year, 140.
Insane Relatives, (No.) Brother (Frank Seymour) Comm'd to day
Cause Exciting, Brother's ivrd behavior
Cause Predisposing, puerperal state
Form, Lactational Insanity acute melancholia
Accompanying Bodily Disorder, Nervous: very apathetic.
Suicidal or not, Not: tried to burn house.
Date of this Attack, March 10th 1901.
Duration, 4 Days
No. of Attack, 1st —
No. of Admission, 1st
Age First Attack, — 33 —
Time of Leaving, 29th April 1901.
Time in Hospital, 1 Mo, 15 Ds
Result, Recovered: Discharged Mar 22/1901.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of March 15/1901.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, "
Recent Events, Poor Special Subjects, "

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

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

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

DELUSIONS, Systematized, Transitory, Special Subjects, Thinks people are attempting to poison 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,

ONSET, Gradual or Sudden, Gradual

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption). — one brother Insane —
Father, Dead: pneumonia -
Paternal Relatives,
Mother, Living: well
Maternal Relatives,
Brothers and Sisters, 4 sisters; all well; 3 brothers; one Insane
4 children: 2 boys & 2 girls - well.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), gives no history -

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, occasional headaches

OCCUPATION, Healthy or not, Housework

Detail Date, Duration, and Character of Previous Attack, if any, Sleep for last week poor: previously good:

Sleep, Appetite, and Bowels, good Constipated.

Personal and Medical History of Wilhelmina Schmidt

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in PRESENT WEIGHT, 147# 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, Yes normal Good good

SIGHT, Good

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

HEARING, Good

COORDINATION, Arms, Good Legs, Good Grasp, other tests, good.

TREMORS, Hands, Tongue, Facial Muscles, General, fine fine

PATELLAR REFLEX, Knee-Jerk diminished Other Reflexes, wrist present; Elbow absent.

ARTICULATION, Slurred, Hesitating, Slow, normal

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none Strong normal
Apex Beat, Regularity, normal regular

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Yes 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, Perinaeum lacerated: rectocele; cystocele; uterus retroverted; adherent; cervicitis 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). Patient admitted in fair physical condition. Is confused & sluggish mentally; restless at night. Has ideas that the other patients intended to do her harm: attacked & choked one patient & struck several others; has delusions of "persecution". Takes nourishment well: appetite good: frequently asks to be taken home. Floating kidney on left side. —

Personal and Medical History of *Wilhelmina Schmidt*

1901

This patient was brought here by Sheriff J.B. Thompson, attended by husband Ferdinand Schmidt, in fair physical condition, and with following history of case. There is no history of consanguinity, or heredity - (but see): intemperance, severe disease or head-injury. This is first attack: first symptoms manifested Sunday, March 10th 1901: General delusions as to diseases put on them by others; exorcised by Priest &c. The disease appears to be increasing; not variable: no rational intervals. Derangement now manifested as above, and fear of bodily harm, always praying &c. Patient is not disposed to injure others, nor suicidal: propensity not active. Tried to burn house. With every confinement, she has been a little delirious, exacting, very nervous &c. She has not been restrained or confined. Supposed Exciting Cause of the disease is brother's wild behavior: supposed predisposing cause, puerperal state. Nothing given by way of treatment. On personal examination, is very apathetic: this morning, melancholy.

Mar 14 On admission, was put on T.W. (G.H.N.Rpt. Complexion dark: hair light brown: eyes gray: condition of skin hot and dry: no marks scars &c noted: Is dirty: has 16 lower and 13 upper teeth: Behavior quiet: Talks very little: answers some questions fairly well) ——— .. ———

Mch 14 to Mch 28 Summary 14 da record by (Dr Heyerdale) Admitted on Infirmary, bathed & put to bed: First meet Temp 99°-100° Pulse & Resp. about normal; Appetite good: Bowels moved by cathartics. Occasional hypnotics given: Malt & cod liver oil 3x day. Very melancholy & sleeps poorly at night Had been nursing baby & breasts require daily attention. Patient misconstrues remarks made & thinks people wish to do her harm. Is restless At times violent. Attempted to choke Mary Crow on 19th & violent toward C. Billings on 20th. Second week Temp 98°-102°. on 24th & 99 on 27th Mch 21-27 Took liquid diet: after that regular diet: Bowels regular with aid of occasional cathartic. hypnotics given.
Pulse 70-110. Resp. 18-25. Patient quite violent threw herself on floor & against wall: attacked nurses on 22nd. put in restraint Bath given at 8 P.M. Slept 2 hrs. Quite restless during night also day: Developed quite extensive herpetiform eruption on face. 27th Somewhat more rational: Talks freely & expresses fewer delusions

Mar. to June 1901 Quite agreeable on the ward, assists with the work, takes medicine, goes out of doors for exercise, is quite agreeable converses intelligently, sleeps well, appetite good, has improved since admission. Apr. 29 visited by husband and taken home.

Discharged

Personal and Medical History of

Personal and Medical History of Margaret Faulhaber
al. Maggie Berry

Whole No. 5781. Became resident of State 34 yrs ago
Residence, Watopa, Minn " " County 34 yrs ago
Date Admission, 18th March 1901.
Admitted by Dr. L. A. Linton hour, 7 30 P.M.
How Sent, Malcolm Kennedy, Jos P. Wabasha County
Sex, Female Age, 34.
Civil Condition, Married
Children, — Five —
Age Youngest Child, Ten weeks —
Occupation, Housewife: husband a farmer
Degree Education, Common School
Profession, Religion, Catholic
Habits, Probably good: no history of intemperance
Nativity, Minnesota (Minnesota); parents born in Ireland
Physicians Committing, J. T. Tinney & J. F. Board
Correspondents, John Faulhaber (made proof of residence)

No. of Year, 1444.
Insane Relatives, None
Cause Exciting, Childbirth —
Cause Predisposing, previous attacks
Form, Chr. Mania
Accompanying Bodily Disorder, none mentioned
Suicidal or not, Not: but will injure others.
Date of this Attack, Jany 10th 1901
Duration, about 9 weeks
No. of Attack, 3rd
No. of Admission, 3rd
Age First Attack, about 25 —
Time of Leaving, June 28th 1902.
Time in Hospital, 1 yr 3 mos 10 Ds
Result, Improved: Disgd. Dec 17/02
By Bof C.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of none given

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear: Quick
MEMORY, Past Events, Fair
Recent Events, Fair 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,
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,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters,
5 Children living — well —
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, Somewhat Constipated

Personal and Medical History of Margaret Faulhaber
al. Maggie Berry

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in PRESENT WEIGHT, 140 lb USUAL WEIGHT, NUTRITION,
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, Slight coating: prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes Normal Good Good
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal
HEARING, Good
COORDINATION, Arms, Finger to nose, eyes shut, good Legs, Standing on one foot, good Grasp, Turning quickly, would not do. Standing, eyes shut, would not do.
TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor fine tremor
PATELLAR REFLEX, Exaggerated Other Reflexes, Elbow, present: urist, present.
ARTICULATION, Slurred, Hesitating, Slow, normal
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Normal Strong Normal
Apex Beat, Regularity, Normal regular
ARTERIES, Normal
LUNGS, Chest, Symmetry, Expansion, Yes 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,
Color and Appearance,

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

GYNECOLOGICAL EXAMINATION, Uterus retro-verted; adherent on left side; cervix lacerated; congested; hypertrophied; herpes vaginalis; cervicitis; endometritis; leucorrhoea; hemorrhoids.
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 good physical condition: sleeps well at night; appetite good: very nervous, & at times, hysterical in behavior. Says "she overworked & had to come back to hospital" —

Personal and Medical History of Margaret Faulhaber
al Maggie Berry

1901

This patient was brought here by Deputy Jeff. McClarney, attended by John Faulhaber, in fair physical condition, and with following history of case. There is no history of consanguinity or heredity: this is not the first attack; (seemingly the 3rd); the 1st attack occurred in 1893: the 2nd, July 13/99: duration nine months, last attack: was here (Rochester Hospital), brought home in April: discharged in November 1900. First symptoms of this attack manifested Jan. 10th 1901, by illusions and use of profane language. Disease seems increasing, but with rational intervals, but these are not regular. Derangement now shown by crying, laughing, imagining husband trying to kill children and poison her. Patient has shown disposition to injure others, but is not suicidal: no filthy or destructive habits. Before the accession of the disease, she showed jealousy. No history of intemperance in patient or parents: no history of any severe disease &c or head injury. She has not been restrained or confined. Supposed cause of the disease is Child-birth. Treatment, none. On personal Examination, Thes melancholy, shows illusions, and is hysterical.—

N.B. Patient was here, 1st time, as "Maggie Berry" from June 2 to Sep 28/93. (See Vol 24 p 13 No 3359) and " " " 2nd " al "Maggie Berry" " July 14/99 to Apl 3/1900. (See " 40 " 337 " 5359) was then discharged Nov. 7/1900. Improved.—

Mar 18 On admission, was put on Infy (G. H. N. R/pt. Complexion fair: hair light brown: eyes hazel:— Condition of skin normal: no marks, scars or eruptions noted: small bruise on inner side of right knee: Is dirty. Has 13 lower teeth & 2 roots, and 10 upper and 2 roots. Quiet: talks intelligently).

Mch 18 to Apr 2 Summary 14 da record by Dr Heyerdale. Patient received on Infirmary: bathed & put to bed. Slept well. First week: Temp. pulse & resp. normal. Appetite good: on regular diet: Cathartics given: bowels moved daily. Patient was nursing baby & breasts received regular attention. Patient very nervous & hysterical: resistive at times: Slept well: Dressed & up on 7th. Second week. Temp. pulse & resp. normal. Appetite good: Given occasional cathartics: Slept well: Quite disagreeable at times & resistive: Talked freely: & quite intelligently. Quite depressed.

Mar-June. Patient received on infirmary Mar. 18: quiet in behavior. Breast pump used several times a day to relieve breasts of milk. Appetite fair: bowels generally constipated requiring cathartics: sleeps well takes out of door exercise: attends chapel. Neat in habits but is sometimes careless in appearance. Converses quite intelligently: sometimes uses vile and profane language. May 19 visited by friends. Complained of not feeling well May 22 and remained in bed during the day. May 26 very much disturbed. Transferred to D. 3. She generally assists in dining room. May 31 Wt. 121 1/2 #. June to Sept. June 4 became violent and fought nurses: is at times quite noisy: latter part of July had cold and expectorated: assists with ward work: attends chapel and amusements: takes out door exercise: menstruates regularly: July 26 trans. to D 1: Sept. first Wt. 133#. Sept. to Dec. Is at times hysterical otherwise quiet: Nov. 30 Wt 120 1/2 #.

Personal and Medical History of

Dec to Mar. 1902. Patient is neat in habits but rather careless in appearance: still continues to talk to herself a great deal: scolds about the way she is treated both at the hospital and at home: is at times hysterical: is lacking in selfcontrol appetite is good: sleeps well: takes out door exercise: complains of many physical ailments Feb. 22 Wt. 129#. Mar to June same as above May 31 Wt 128 1/2 Is very indolent never assists with ward work June 28 went home.

Personal and Medical History of Mary A. Stroup

Whole No. 5786 Became resident of State 36 yrs ago
Residence, Lake City, Minn " " of County 20 " "
Date Admission, 23rd March 1901.
Admitted by Dr. O. C. Heyerdale hour, 7.30 P.M.
How Sent, Malcolm Kennedy, J of P. Wabasha County
Sex, Female Age, 69
Civil Condition, widowed
Children, Five
Age Youngest Child, Thirty-four
Occupation, Midwife -
Degree Education, Common School
Profession, Religion, not a church member
Habits, no history of intemperance -
Nativity, New York State: father's. US: Mother's, England.
Physicians Committing, Wm. F. Wilson & W. J. Cochrane
Correspondents, Daughter's address. Ida M. Sullivan, Lake City
Son's address, Elvin Stroup 519. 3rd ave N.E. Mpls Minn

No. of Year, 149.
Insane Relatives, none, so far as known
Cause Exciting, worry & loss of sleep. -
Cause Predisposing, previous attack
Form, Senile Dementia
Accompanying Bodily Disorder, Feebleness.
Suicidal or not, not: but disposed to injure others.
Date of this Attack, March 12th 1901.
Duration, - about 10 days -
No. of Attack, 2nd (one, 25 years ago)
No. of Admission, 1st here (was at St Peter)
Age First Attack, about 44 years.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Mar 27/1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick: Confused
MEMORY, Past Events, Poor
Recent Events, " Special Subjects, "
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert: illusive
REASONING POWER, Ordinary Subjects,
Special Subjects, Poor
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted
DELUSIONS, Systematized, Transitory, Special Subjects,
Her talk is incoherent & constant: rambles on, from one subject to another.
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, Two weeks
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,
was at St Peter, 25 years ago.
none for 2 weeks very poor, for 2 weeks
Sleep, Appetite, and Bowels, constipated.

Personal and Medical History of Mary A. Stroup

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 feet PRESENT WEIGHT, 122# USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, prompt: white coating
PUPILS, Equality, Size, Response to Light, and Accommodation, poor
yes normal good
SIGHT, seems good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, good Legs, good Grasp, other tests, good
TREMORS, Hands, Tongue, Facial Muscles, General,
fine fine
PATELLAR REFLEX, right absent: left diminished Other Reflexes, Elbow present: wrist present.
ARTICULATION, Slurred, Hesitating, Slow, normal
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
normal fairly strong normal
Apex Beat, Regularity, regular
normal
ARTERIES,
normal
LUNGS, Chest, Symmetry, Expansion,
yes 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, Lacerated perinaeum; haemorrhoids, Bartholini ducts enlarged congested, senile pupillary vaginitis: uterus & cervix atrophied cervicitis
MENSTRUATION, Leucorrhoea.
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 very poor physical condition: has eaten almost nothing for 2 weeks. Talks constantly: is incoherent; sleeps but little. Condition one of delirium from auto-intoxication. Urine shows a very large amount of granular casts. -

Personal and Medical History of *Mary A. Stroup*

1901

This patient was brought here by deputy P. J. Lange, attended by (son) Eben Stroup, in poor physical condition, and with following history of case. No history of consanguinity or of heredity, so far as known. This is not 1st attack; had one attack 25 years ago; duration two years; was sent to St Peter, and discharged as well. First symptoms of this attack manifested about March 12th 1901, by rambling talk, insomnia, and etc. Disease seems increasing. No rational intervals. Derangement now shown by disconnected talk; suspicion of those around her; refusal to take nourishment; at times, unmanageable & violent. Is disposed to injure others, but not suicidal. No filthy or destructive habits manifested. At intervals, since the first attack, she has seemed on the verge of another attack. There is no history of intemperance. No severe disease &c, since first attack. Was confined 2 years in St Pete, as stated before. Supposed cause of the desease is worry & loss of sleep. Sedative treatment has been given. On personal Examination, She talks constantly and disconnectedly; takes but little nourishment, and sleeps but little. Is very suspicious of those near her: at times, violent.

Mar 23 On admission, was put on Infirmary Ward. (G. H. R. Rpt. Complexion dark: hair gray: Eyes brown; condition of skin: hot and dry: small brown mark on left leg: no scars &c noted. Is rather dirty — A few enlarged veins on legs: has very poor teeth; 7 in upper jaw and 7, lower. Talks a great deal, but quiet otherwise. Remarks incoherent.

Mch 23 to Apr 7. Summary 14 da record by Dr Heyerdale. Received on ward: bathed & put to bed. Refused nourishment. Fed mechanically: Son states that she has taken only about a quart of milk in two wks. 24 Fed night & morning: 1½ pts. eggnog: Cathartics also given: Talk incoherent. Teeth very bad: has hemorrhoids. During first three days fed mechanically: given cathartics & sleeping dose: fourth night slept quite well. During remainder of week: Temp. pulse & resp. only slightly above normal: Took nourishment quite well. Hypnotics given. Mch 30 - 31 & Apr 1. on liquid diet & sleeping dose on night of 30th. Awake all night. Night of Apr 1. Slept until 12:30 then noisy. Apr 2 Fed by tube. Vomited some after feeding: Stomach irritable & odor very offensive Apr 3. Fed by tube: Slept quite well: Talks constantly. Apr 4 & 5, Temp. slightly above normal: Bowels moved by cathartic. Examination of urine showed large amount of casts: Is quite feeble.

Apr. 26 & 27 visited by daughter and son in law. May 22 much quieter tran. to A. 3 West. May. 26. became violent during the night and broke window light with her shoe trans. to Inf. West. May 30 Wt. 121½#. June to Sept. Patient quiet and somewhat stupid. Aug. 30 no change in condition Sept Wt 118#

Sept. to Dec. Oct. 1 tran. to A. 3 West taken some out door exercise. Nov. 29 visited by friend, Nov. 20 Wt. 129#.

Dec to Aug-1902 No change. Wt. 128#. May 14th visited by a friend also on July 24th.

Personal and Medical History of *Mary A. Stroup.*

Patient is neat and clean in habits rather careless in appearance. At times eats on a tray in the Bay. Appetite good. Bowels inclined to be constipated: sleeps well. takes exercise: sometimes assists with the work: Is at times quite annoying on the ward acts in a very childish and silly way: inclined to be hysterical. When disturbed uses profane and obscene language. Occasionally goes to bed: sometimes feigns to faint after receiving a dose of medicine. Converses voluntarily and at times answers questions quite intelligently. Dec. 1st Wt 124 #.

Personal and Medical History of Barbra Cole
Barbara

Whole No. 5789. Became resident of State 18 years ago
" " " of County 18 " "
Residence, Manchester, Minn
Date Admission, 1st April 1901.
Admitted by Dr. E. J. Warnow hour, 7th P.M.
How Sent, Herman Backmer, Jaff. Freeborn Co.
Sex, Female Age, 50
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Housework: father, a farmer
Degree Education, Common school education
Profession, Religion, Catholic
Habits, No history of intemperance.
Nativity, Germany: parents also born there
Physicians Committing, G. H. Garck & Oscar O. Benham
Correspondents, Chas. Baker, Albert Lea Minn (nephew)

No. of Year, 152
Insane Relatives, Not known
Cause Exciting, not known
Cause Predisposing, previous attack
Form, Chronic Melancholia
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Suicidal & propensity, not now active
Date of this Attack, about 5 years ago
Duration, about 5 years
No. of Attack, 2nd (one, 5 one years ago).
No. of Admission, 1st here (was at St Peter)
Age First Attack, 20 years (?)
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Apl 3/1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear & Quick
MEMORY, Past Events, Captionally good
Recent Events, good Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert
REASONING POWER, Ordinary Subjects, good
Special Subjects,
Own Mental State, Does not think she is insane
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed
DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks people wish to kill 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,
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Dead - some liver trouble: 78 years (Brother died from Consumption - Consumption on mother's side - Sisters succumbing next)
Paternal Relatives, negative
Mother, Dead: Cholera: 42 years
Maternal Relatives, negative
Brothers and Sisters, 5 girls: 6 boys.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
negative
HABITS, Drinking and Smoking, She says good
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
was at St Peter, 16 years ago
very low fever
Sleep, Appetite, and Bowels, regular.

Personal and Medical History of Barbra Cole

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3½ PRESENT WEIGHT, 111# USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt: quite clear
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal normal fair
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal
HEARING, good
COORDINATION, Arms, Good Legs, good Grasp, other tests good.
TREMORS, Hands, Tongue, Facial Muscles, General, fair tremor fair tremor
PATELLAR REFLEX, exaggerated Other Reflexes, elbow: wrist: exaggerated -
ARTICULATION, Slurred, Hesitating, Slow, Clear
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, initial regurgitation strong normal
Apex Beat, Regularity, normal regular
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, Yes fairly 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, Vulva dark: labia & clitoris enlarged: uterus retroverted: cervix eroded, fistulous, cervicitis, 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).

Patient admitted in poor physical condition; has a sallow appearance: is very restless: haggard & nervous: expresses delusion that she has been brought here to be killed: at times, is very much agitated: appetite is rather poor. Patient is surly & irritable, & several times, called the physicians & nurses "Devils" -

Personal and Medical History of *Barbra Cole*

1901

This patient was brought here by Deputy C. M. Wilkinson, attended by Charles Baker, in poor physical condition, with following history of case. There is no history of consanguinity: as to any insane relatives, not known. This is not 1st attack; commenced about 5 years ago & continued all since: was at St. Peter Hospital; temporary cure for about 15 years. First symptoms of this attack manifested about 5 years ago; she commenced to talk incoherently and talk and act strange. Disease seems increasing; she has rational intervals, but they are not regular. Derangement now shown on no subject in particular: she feels depressed, all the time. Patient is not disposed to injure others; has attempted suicide, in no particular way; propensity not now active. No filthy or destructive habits: no previous peculiarities: no history of intemperance: 30 years ago, she had brain-fever: was confined at St. Peter for 5 years. Cause of the disease is not known: no treatment, except at St. Peter. On personal examination, she appears melancholy & despondent.

1st Apl On admission was put on I.W. (G.H.N. 2 pt. Hair brown; partly gray); eyes brown; Condition of skin rough & dry: no marks noted: a few small scars on her back. no eruptions &c noted. Is clean: Has no teeth out: 16 upper & 16 lower. Behavior is quiet & she talks intelligently.)—

Apr. 1-1901 Summary of 14 day record, Dict. by Dr. Heyerdale

Patient received on Inf. W. bathed & put to bed, no abnormalities noticed. T., P & R. first week about normal, sleepless was given hypnotics. 2d week T. P. & R. normal, appetite fair bowels regular, is disagreeable & melancholy untidy about her person. Mar. to June Apr. 26. trans. to C. 3 West. answers questions quite intelligently, sleeps well, patient uses vile, obscene and profane language, May 29 Wt. 97#. June to Sept. Patient is cross and quarrelsome and has suicidal tendencies, Aug. 30 Wt. 103#.

Sept. to Dec. Sept. 2 trans. to B. 3. West. very melancholy, cries a great deal frequently asks to go home, dirty in habits. no change Nov. 29.

Dec to Feb 1903 No change. Wt about 112#.

Personal and Medical History of

Personal and Medical History of Laura B. Sullivan

Whole No. 5793.
Residence, Rosemount, Minn
Date Admission, 6th April 1901.
Admitted by Dr. A. F. Kilbourne hour, 1.30 P.M.
How Sent, Thos. P. Moran, J. of P. Dakota County
Sex, Female Age, 18 Years
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, none: father, a farmer.
Degree Education, 2nd Year, High School.
Profession, Religion, Not a church member.
Habits, probably good.
Nativity, Minnesota: father N.Y.: mother's, Minnesota
Physicians Committing, J. C. Fitch & Am. Adsit.
Correspondents, address of father: Wm Sullivan, Rosemount, Dakota Co. Minn: address of Grandfather: Hon. M. H. Sullivan, Hastings, Minn.

No. of Year, 156.
Insane Relatives, none
Cause Exciting, Ill-health
Cause Predisposing, previous attacks
Form, Adolescent Insanity
Accompanying Bodily Disorder, has tubercular disease
Suicidal or not, - not -
Date of this Attack, 2nd or 3rd of March
Duration, about 5 weeks
No. of Attack, 3rd —
No. of Admission, 2nd —
Age First Attack, 15 Years
Time of Leaving, 1st June 1901 -
Time in Hospital, 1 mo. 25 ds
Result, ~~Recovered~~ Improved Discharged Nov 30/1901. By B of C.

EXAMINATION ON ADMISSION BY DR. A. C. Heyerdall *Date of* April 12/1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick: Clear
MEMORY, Past Events, seems quite good
Recent Events, good Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert: Quick
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted: irritable: fretful.
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.

From previous Examination May 24/99 by Dr A. F. Stricker

HISTORICAL.

LENGTH INVASION, Several Years
ONSET, Gradual or Sudden, Sudden
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, l. nervous
Paternal Relatives, —
Mother, living
Maternal Relatives, Maternal aunt insane
Brothers and Sisters, —
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
She has dispnoea, more marked at times; & is said to have always had asthma. —
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, has worked about a farm.
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, good
always wakeful & restless: bowels regular.

Personal and Medical History of Laura B. Sullivan

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6½ PRESENT WEIGHT, 83½ lb USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, slight coating; prompt
PUPILS, Equality, Size, Response to Light, and Accommodation, good good
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, not tested Legs, " " Grasp, " "
TREMORS, Hands, fine of hands Tongue, Facial Muscles, General,
PATELLAR REFLEX, present Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, none Strength, fairly strong Sounds, normal Size, normal
Apex Beat, Regularity, regular
ARTERIES,
LUNGS, Chest, yes Symmetry, fair Expansion,
Breath Sounds, bronchial in upper lobes.
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; hymen intact; rigid: all parts very small: uterus free. —
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. Is very fretful & peevish & acts like a spoiled child. Patient has a rather poor appetite & is quite restless, at night. Has a suppurating tubercular gland in axilla (right), from which she is inclined to remove dressings. Both lungs show dullness in apices and are, doubtless, tubercular.

Personal and Medical History of *Laura. B. Sullivan*

1901

This patient was brought here by W. J. Sullivan, attended by Mrs Jno. Gilman, in poor physical condition, and with following history of case. There is no history of Consanguinity, hereditary, intemperance, Venereal disease &c, or head-injury. This is not 1st attack: others occurred, one, three years since and one, 2 years prior: duration of 1st, three months; 2nd attack, about 7 months: She was at this (Rochester hospital + very much improved. First Symptoms of this attack manifested on the 2nd or 3d of March: incoherency in Conversation. Disease seems increasing; variable + with rational intervals, but these are not regular. Derangement now shown in that She Complains of trouble in the head: imagines there are bees in her ears. Patient is not disposed to injure others: not suicidal: propensity not active: no filthy or destructive habits. No previous peculiarities, only always has been nervous. - Has been in Hospital about 7 months. Supposed cause of the disease is ill-health. Has received treatment for general Conditions. On personal examination, is excitable, incoherent, constantly talking and in motion: does not sleep well; does not menstruate: has tubercular disease - N.B. Patient was here before, from May 23/99 to Dec 9/99: + discharged July 27/1900: Recovered. See letter attached in that case-Book, regarding her case. (Vide, Vol 40 Page 261 No 5312)

Apl 6 On admission, was put on T.W. (G.H.N.R.Pt. Complexion fair: hair brown: eyes blue: Condition of skin hot and dry: no marks: small scar on right arm: no eruptions: ulcer under right arm: no bruises, hernia &c: is clean: behavior quiet, but very nervous: talks intelligently.)—

Summary of 14 day record Dict by Dr. O.C. Freyendale.

Apr. 6. 1901 received on Inf. W. bathed and put to bed, quite disturbed mentally, has tubercular ulcer under right arm, coughs and expectorates, has pulmonary tuberculosis. First week patient continued disturbed and noisy, complains a great deal, complains a great deal that room is filled with gas and smoke. During 14 days Tem. ran from 99° to 102°. Second week complained great deal, is somewhat hysterical, noisy, and irritable, ulcer dressed regularly. Mar. to June May 20 visited by grandfather, May 30 Wt. 69#. Patient gradually failing, June 1 went home.

Discharged.

Personal and Medical History of

Personal and Medical History of Ella Stummel

Whole No. 5794. Resided in State of Minn: 4 yrs
Residence, St Paul: Minn: " County — same
Date Admission, 8th April 1901
Admitted by Dr. O. C. Heyerdale hour, 7 30 P.M.
How Sent, E. W. Bazille, J of P. Ramsey County
Sex, Female Age, 27
Civil Condition, single
Children, —
Age Youngest Child, —
Occupation, Servant: father's, Laborer (Dead)
Degree Education, Common School
Profession, Religion, Catholic —
Habits, probably good: no history of intemperance
Nativity, Iowa: parents born in Germany —
Physicians Committing, O. W. Archibald and F. A. Vanten
Correspondents, none given in papers.

No. of Year, 157
Insane Relatives, None
Cause Exciting, Unknown
Cause Predisposing, not given
Form, Acute Melancholia with delusions.
Accompanying Bodily Disorder, Nervous: anaemic.
Suicidal or not, Not —
Date of this Attack, 3 or 4 months ago
Duration, — 3 or 4 months —
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 26+
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* Ap 9/1901 (?)

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

REASONING POWER, Ordinary Subjects, Fair

Special Subjects,

Own Mental State, Does not think she is insane

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Has delusions about a young man, where she worked
Thinks he loved her & says he expressed his love through telepathy

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).
one sister was paralyzed —
Father, Dead

Paternal Relatives, —

Mother, Dead

Maternal Relatives, —

Brothers and Sisters, 1 brother — 4 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, good until last few nights, Appetite, good and Bowels, constipated —

Personal and Medical History of Ella Stummel

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in PRESENT WEIGHT, 124 3/4 lbs USUAL WEIGHT, NUTRITION, poor

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement,

PUPILS, Equality, Size, Response to Light, and Accommodation, Good
yes normal good

SIGHT, good

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

HEARING, somewhat deaf

COORDINATION, Arms, Good Legs, good Grasp, other tests, good

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

PATELLAR REFLEX, exaggerated Other Reflexes, Elbow present

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size,
normal strong normal

Apex Beat, Regularity, regular
normal

ARTERIES,
Slight sclerosis
Chest rather hollow

LUNGS, Chest, Symmetry, 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, Genitals normal: uterus free: slight anteflexion; endometritis cervicitis, 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 poor physical condition. Is thin, pale & anaemic. Is very stoop shouldered
Expresses delusions about a young man, where she worked. Thought that he expressed his love through telepathic influences —

Personal and Medical History of *Ella Stummel*

1901

This patient was brought here by Deputy Johnson, attended by Mrs. Johnson, in poor physical condition, and with following history of case. There is no history of consanguinity, heredity, previous peculiarities, intemperance, severe disease &c or head-injury. This is 1st attack; first symptoms manifested by delusions, about 3 or 4 months ago. Disease seems increasing: is variable & with rational intervals, but these are irregular. Derangement is now shown by the idea (?) that a young gentleman wants to commit suicide, other account. Patient is not disposed to injure others, nor suicidal: no filthy or destructive habits: she has not been restrained or confined. Cause of the disease is unknown: has been given nerve sedatives to produce sleep. On personal examination, she is nervous, anaemic & weeping continuously.

Apl 8 On admission, was put on T.W. (G.T.N.R.Ft: Complexion fair: hair brown: eyes gray: condition of skin normal: no marks: scars on left cheek: no eruptions, bruises &c noted: is dirty: has 12 upper and 12 lower teeth, and some are in a bad condition: behavior quiet: has some peculiar ideas: "thinks she hears people talking about her.") _____ . _____ . _____

Summary of 14 day record, Dict. by Dr. Meyerdale.

Apr. 8-1901, Patient received on Inf. W. bathed and put to bed. First week Tem. P. & R. about normal, appetite poor, sleeps fairly well, bowels regular. Second week. T. P. & R about normal, appetite poor, takes tonic and occasional cathartic, slept quite well at night, is very melancholy, converses but little, will answer questions. Mar. to June Still continues very melancholy neat in habits, very quiet, frequently fed mechanically as she refuses nourishment, takes out door exercise, assists with the ward work, attends chapel, takes electrical treatment and massage, May 29 Wt. 121 #. June to Sept. No change Aug. 31 Wt. 121½ #. Sept. to Dec. Menstruates regularly shows no change during quarter Nov. 29 Wt. 118 3/4 #.

Dec to Feb-1903 No change. Wt. about 100 #.

Personal and Medical History of

Personal and Medical History of *Katie Lange*

Whole No. 5795. Became resident of State – 1880.
Residence, St Paul. Minn. " " of County – 1880
Date Admission, 11th April 1901.
Admitted by Dr. L. A. Linton hour, 7 10 P.m.
How Sent, E. W. Bazille, Sh. P. Ramsey County
Sex, Female Age, 30 Years
Civil Condition, married
Children, five
Age Youngest Child, Eight Months
Occupation, Housewife: husband's - two walk business
Degree Education, Common School
Profession, Religion, Catholic —
Habits, Probably good: no history of intemperance.
Nativity, New York State: Parents born in Poland –
Physicians Committing, A. W. Dunning & V. J. Hawkins
Correspondents, Mr. J. Lange (Husband) 513 Van Buren St. St. Paul

No. of Year, 158.
Insane Relatives, one sister in a similar State.
Cause Exciting, Rapid child-bearing –
Cause Predisposing, previous attacks.
Form, Manias (Mild) Sub acute
Accompanying Bodily Disorder, None mentioned.
Suicidal or not, – not –
Date of this Attack, Some weeks ago: gradual increase
Duration, – Some weeks –
No. of Attack, 3rd
No. of Admission, 1st here (has been at St Luke's)
Age First Attack, about 28 –
Time of Leaving, March 29th 1902
Time in Hospital, 11 Mos 18 Ds
Result, Improved: Discd Sept 11 – 1902 By Bd of G.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* Apl 11 1901

Answers to Questions Sent. *

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick
MEMORY, Past Events, Good
Recent Events, Good Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, Does not think he is insane; thinks it was weakness. —
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Somewhat Exalted
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 – no – no
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Dead; died of Rapid Consumption. Age 35 – my wife then 15 years of age —
Paternal Relatives, no
Mother, Dead; died at the age of 45 with cancer in Stomach
Maternal Relatives,
Brothers and Sisters, 5 1 None well
Children 3 girls: 3 boys
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
no
HABITS, Drinking and Smoking, Has been in the habit of drinking a little wine a bed ocasionally
HEADACHES, VERTIGO, OR CONVULSIONS, Suffered considerably this last 4 years: Dizziness: Confusion: Pressure in head: Sleeplessness: Nervousness: Fearful dreams: retiring and late rising
OCCUPATION, Healthy or not, Housework, all her life
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Good Good Good moved regular – Say once day for more was good until 2 years ago

Personal and Medical History of *Katie Lange*

Committed to Rochester.

In the committing of Mrs. Kate Lange, the wife of a laborer living at 513 Van Buren street, to the asylum for the insane at Rochester, yesterday, the crowds who gathered in the probate court room were treated to a pathetic sight. With hair disheveled and singing at the top of her voice a lullaby, while rocking an imaginary baby, she stubbornly refused to answer any of the questions put by the commission of physicians surrounding her. Song followed song, any breathing spell that ensued being given over to a torrent of imprecation directed at her family, interspersed with expressions of basphemy that put the spectators to shame. She was stubborn to a degree, and in her trip to and from the court room she had to be carried in a chair. The physicians unhesitatingly pronounced her insane. The pathetic picture of the case is the fact that the woman is only thirty years of age and is the mother of six children, the youngest of whom is only eighteen months old. She has had two similar attacks.—St. Paul Globe.

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 155½ lbs. USUAL WEIGHT, NUTRITION, Good
s and condition of Skin, normal.
romptness of Movement,
Good
Response to Light, and Accommodation, Light
Good
ht, Arcus Senilis, or other troubles, Normal
Good
s, Good Legs, good Grasp, Both tests good
ue, Facial Muscles, General,
Present Other Reflexes,
ed, Hesitating, Slow, Prompt; normal
, Paretic, Sad, Etc.
SENSIBILITY, Normal
HEART, Murmurs, Strength, Sounds, Size, Strong Normal
Apex Beat, Regularity, Regular
ARTERIES, Normal
LUNGS, Chest, Symmetry, Expansion, Yes 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, Urethral Carnucle, Haemorrhoids, lacerated perinaeum, uterus adherent hypertrophied, cervix patulous, eroded, endometritis, Glandular, ovaries, tenderness
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 good physical condition. Is of nourishment well: pulse restless, strength. Is impudent & saucy in her remarks and in answer to questions. Is obstinate in manner & inclined to be loud & boisterous. Says her husband is not kind to her & that, if he had been, she would be all right (Whether this is a delusion or not is impossible to state, at this time). —

Personal and Medical History of *Katie Lange*

Whole No. 5795. Became resident of State - 1880.
Residence, St Paul, Minn. " " of County - 1880
Date Admission, 11th April 1901.
Admitted by Dr. L. A. Linton hour, 7 10 Pm.
How Sent, E. W. Bazille, Jof P. Ramsey County
Sex, Female Age, 30 Years
Civil Condition, married
Children, five
Age Youngest Child, Eight months
Occupation, Housewife: husband: - Sidewalk business
Degree Education, Common School
Profession, Religion, Catholic —
Habits, Probably good: no history of intemperance.
Nativity, New York State: Parents born in Poland —
Physicians Committing, A. W. Dunning & V. J. Hawkins
Correspondents, M. J. Lange
(Husband) 513 Van Buren St. St Paul

No. of Year, 158.
Insane Relatives, one sister in a [illegible]
Cause Exciting, Rapid child-bea[illegible]
Cause Predisposing, previous
Form, Manias Mild
Accompanying Bodily Disorder, none
Suicidal or not, — not —
Date of this Attack, some [illegible]
Duration,
No. of Attack, 3d
No. of Admission, 1st here
Age First Attack, about 28
Time of Leaving, March 29th. 1902
Time in Hospital, 11 Mos 18 Ds
Result, Improved: Dispd Sept 11-1902
By Bd of C.

Eye on Royal.
London, April 13.—Great
has not yet definitely
money indemnity she des
to pay. A representative of
clated Press is informed the
can be gained by insisting up
payments from China, and tho
possibly be a cause for delay.
government regrets that the British
tinues to China, Sir Ernest Satow,
and indice the powers to agree
demand for greater trading privi
instead of money. The government
of the opinion that the opening of
those rich provinces hitherto closed
much greater benefit to the nations
concerned and to China herself than
the extraction of lump sums of money.
Regarding Japan's attitude toward
Russia, opinion in Downing street is
common with that of other powers, is
satisfied with what is termed as Rus-
sia's "backdown," but that Japan will
continue to keep a sharp eye on Korea
and have no hesitation in threatening
hostilities should Russia menace that
country.
VICEROY CONGRATULATED.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* April 11th 1901.
Answers to Questions Sent. *

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick
MEMORY, Past Events, Good
Recent Events, Good Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, does not think he is insane; thinks it was weakness. —
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
somewhat Exalted
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; died of Tubercular Consumption - age 35 - my wife then 15 years of age —
Paternal Relatives,
Mother, Dead; died at the age of 44 yrs. with cancer in Stomach
Maternal Relatives,
Brothers and Sisters, 5 1 none
Children 3 girls - 3 boys well
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
no
HABITS, Drinking and Smoking, has been in the habit of drinking a little wine a bed & ate.
HEADACHES, VERTIGO, OR CONVULSIONS, suffered considerably these last 4 years: dizziness: faintness: fear bad every little sleep returning 3rd Sat. OCCUPATION, Healthy or not, Housework, all her life
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, good good good moved regular - Say once day for some was good until 2 years ago

Personal and Medical History of *Katie Lange*

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken PRESENT WEIGHT, 155½ lbs USUAL WEIGHT, NUTRITION, Good
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal Good Light
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, Good Legs, good Grasp, other tests good
TREMORS, Hands, Tongue, Facial Muscles, General, Coarse tremor, fine tremor
PATELLAR REFLEX, present Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, prompt; normal
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, normal Strong normal
Apex Beat, Regularity, normal regular
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, Yes 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, Urethral Caruncle, Haemorrhoids, Lacerated Perineum, uterus subinvolute hypertrophied, Cervix patulous, eroded, endometritis, Cervicitis, Ovaritis, Leucorrhea
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 good physical condition. Takes nourishment well. Rather restless, at night. Is impudent & saucy in her remarks and in answer to questions. Is obstinate in manner & unclean & obscene & vociferous. Says her husband is not kind to her & that, if he had been, he would be all right (whether this is a delusion or not is impossible to state, at this time). —

Personal and Medical History of Katie Lange

1901

This patient was brought here by Dep. Sheriff E. Johnson, attended by M. J. Lange, in fair physical condition, and with following history of case. There is no history of consanguinity: one sister is in a similar state: this is not 1st attack; seemingly the 3rd; (others having occurred in Sept 1899 & October 1900); duration about 2 months; was sent to St. Luke's hospital: complete recovery from first attack; partial from second. First symptoms of this attack were manifested by gradual increase, for some weeks. Disease seems increasing: is variable and with rational intervals: but these, not regular. Derangement now shown by mania, violence and obscenity. — Patient is not disposed to injure others, nor suicidal; no filthy or destructive habits. She was always quick-tempered. There is no history of intemperance, nor of any severe disease &c or head injury. Has been confined at Hospital. Supposed cause of the disease is rapid child-bearing. Has been treated by Tonics, reconstructives and forced feeding. ——

On personal examination, nothing further was brought out in the case. —

Apl 11 On admission, was put on I.W. (G. H. N. R'pt. Hair brown: eyes blue: Condition of skin, rough & dry: scars on left arm, from vaccination; no eruptions, bruises &c noted: is dirty: has a Goitre; — 9 upper and 10 lower teeth: Behavior obstinate and resistive: would not talk). ——

Summary of 14 day record. Dict. by Dr. O. C. Heyerdale.

Apr. 12-1901 Patient admitted on Inf. W. bathed and put to bed, quite resistive and was restless all night. First week T. P. & P normal, appetite fair, bowels regular, inclined to be rather violent and resistive, slept fairly well is rather sarcastic in her remarks, is somewhat exalted. Second week same as first.

Mar to June May 26 quite exalted and somewhat delusional, considerably improved and taken home by husband.

June to Sept. June 28 patient admitted on ward quiet in behavior, July 4 menstruating, visited by friend, July 22 trans. to C. 3 West, patient talks intelligently has improved considerably mentally is less sarcastic and delusional, Aug 8. visited by husband also Sept. 7. Sept. to Dec. Oct. 16 tran. to B. 3. West. patient works in center dining room, menstruates regularly, Oct. 26-27 visited by husband, Nov. 14 trans. to A. 2 W. Dec. to Mar. 1902 Jan. 2 patient very well, visited by husband, menstruated regularly, assists with work in Center Dining room, Jan. 2 1902 taken home by husband.

Dec to Feb 1903 No change.

Personal and Medical History of

Personal and Medical History of Mary Elizabeth Darcy

Whole No. 5796. Became resident of state about 24 years ago

Residence, Wabasha County — " " County about 24 yrs ago

Date Admission, 11th April 1901.

Admitted by Dr. L. A. Linton hour, 7 10 P.M.

How Sent, Malcolm Kennedy, J of P. Wabasha County

Sex, Female Age, 24.

Civil Condition, single —

Children, —

Age Youngest Child, —

Occupation, Work on farm; father a farmer.

Degree Education, Common School —

Profession, Religion, Catholic —

Habits, as to intemperance, yes: father Intemperate

Nativity, Chester Wabasha Co. Minnesota: father's Ireland: mother's Illinois

Physicians Committing, W. H. Lincoln and J. F. Bond (?)

Correspondents, James. J. Darcy (Brother) Mazeppa, Minn

No. of Year, 159.

Insane Relatives, Father

Cause Exciting, Heredity

Cause Predisposing, Heredity

Form, Acute Melancholia - religious delusions

Accompanying Bodily Disorder, None mentioned

Suicidal or not, not

Date of this Attack, 2 months ago

Duration, 2 months

No. of Attack, 1st —

No. of Admission, 1st —

Age First Attack, — 24 —

Time of Leaving, 23d July 1901.

Time in Hospital, 3 mo 12 D

Result, Recovered — Disgd. Nov 22/1901.

EXAMINATION ON ADMISSION BY DR. O. C. Hayerdale *Date of* Apl 12/1901

MENTAL CHARACTERISTICS.

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

DELUSIONS, Systematized, Transitory, Special Subjects, Religious Delusions.

HALLUCINATIONS,

ILLUSIONS,

The gross signs above being lacking, specify concerning Power of Attention, Moral and Ethical Failure, Slowness or 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, was insane: Dead —

Paternal Relatives, —

Mother, Living

Maternal Relatives, Thinks grandmother was consumptive

Brothers and Sisters, 5 brothers: 2 sisters

Children — none —

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

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework

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

Sleep, Appetite, and Bowels, fair good 2

Personal and Medical History of Mary Elizabeth Darcy

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2 in PRESENT WEIGHT, 122 lb USUAL WEIGHT, NUTRITION, good

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement,

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

SIGHT, good

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

HEARING, Good

COORDINATION, Arms, good Legs, good Grasp, Turning quickly, good.

TREMORS, Hands, Tongue, Facial Muscles, General, tremor of tongue

PATELLAR REFLEX, present Other Reflexes, Elbow present

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none strong normal

Apex Beat, Regularity, regular normal

ARTERIES, normal

LUNGS, Chest, Symmetry, Expansion, well-developed yes 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, Genitals normal: uterus free: slightly anteflexed. hymen intact: Cervicitis, 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 good physical condition: is quiet in manner & behavior: is slow & rather obstinate in answer to questions. Expresses some "delusions of persecution" — Thinks that a certain Catholic sister persecuted her. Has also some religious delusions but will not express them freely —

Personal and Medical History of *Mary Elizabeth Darcy*

1901

This patient was brought here by James. J. Darcy, in fair physical condition & with following history of case. There is no history of Consanguinity: father was insane. This is first attack: first symptoms manifested 2 months ago, in her talk and sleeplessness. Disease seems increasing; not variable; no rational intervals. Derangement now shown on religion. Patient is not disposed to injure others, nor suicidal; propensity not active: no filthy or destructive habits. Previous to accession of the disease she showed religious impressions. As to intemperance, yes - father intemperate: No history of any severe disease &c or head-injury. She has not been confined or restrained. The supposed cause of the disease is heredity: no treatment: On personal examination, she manifests religious impressions and talkativeness.

Apl. 11 On admission, was put on T.W. (G.H.N.R.St. Complexion dark: hair brown: eyes brown: Condition of skin: hot and dry: no marks, scars bruises &c noted: is clean: has 13 upper & 10 lower teeth: Quiet: has delusions.)

N.B. See letter on file from James. J. Darcy, May 1/1901. "Along last fall, she began to talk out of the way and act very strange, by times. A little later on, got so she would not do anything around the house, to speak of; but would sit up stairs alone & read: talked of going away to the Sisters to work. Seemed to have a hatred towards her mother & claimed she wanted to go away & her mother would not let her go. (Just a notion of hers) - Would go to Church last fall & stay in church all day, if the folks did not ask her to come out & come home. About 2½ months ago, she seemed to grow worse; would burst out crying; look at mother & say "You folks had better look out for me or there will be a funeral here, pretty soon". Then she would say "dont excite me now". "Oh it is all right; there wont be any blood shed". The last week she was home, she would get up in the night & call the family up & say "it was time to go": "that the Sisters was a waiting for her" - Always claimed that everybody was talking about her: would hang a blanket up at the window & say "that she did not want them to see her". The last day or two she talked religion all the time & she would waive her hand at everybody & give them her blessing. She talked about Christ & the Priest & Saints & Sister - seemed to be all gone on religion. Seemed to realize, by times, that she was not well & wanted to go to Rochester".

Summary of 14 day record. Dict. by Dr. O.C. Heyerdale.

Apr. 11-1901 Admitted on Inf. W. bathed and put to bed, very quiet in behavior, melancholy, has hallucinations of sight and hearing. First week T. P. & R. above normal, appetite fair, slept quite well part of week, is reticent about conversing. Second Week T. P. & R. about normal appetite fair, bowels regular, is very much depressed. May 29 Wt. 113#.

Mar. to June takes out door exercise, neat in habits and appearance, converses with those about her, has improved some mentally, May 17 tran. to A 3 West, menstruates regularly, takes electrical treatments, June to Sept. June 22 visited by brothers, July 23 visited by brother and taken home.

Discharged.

Personal and Medical History of

Personal and Medical History of Mary Martin

Whole No. 5799 Resident of State 45 yrs
Residence, St Paul " of County 45 yrs.
Date Admission, 23rd April 1901.
Admitted by Dr. O. C. Heyerdale hour, 7.30 P.M.
How Sent, Edmund W. Bazille, Jos P. Ramsey County
Sex, Female Age, 45 years.
Civil Condition, Married (?)
Children, —
Age Youngest Child, —
Occupation, Domestic
Degree Education, not stated
Profession, Religion, R. Catholic
Habits, Probably bad habits —
Nativity, U. S.; that of parents not stated —
Physicians Committing, Arthur B. Aucker & C. Eugene Riggs
Correspondents, (Friend) F. McCarthy 378 W. Water St.
(Daughter) Mrs Geo. Hall Manan. Wis

No. for Year, 162
Insane Relatives, not stated
Cause Exciting, Dont know
Cause Predisposing, not stated
Form, General Paresis.
Accompanying Bodily Disorder, Burn: Eruptions.
Suicidal or not, not
Date of this Attack, not stated
Duration, not stated
No. of Attack, not stated
No. of Admission, 1st here (was in C & C Hosp.)
Age First Attack, not stated
Time of Leaving, July 11 - 1901.
Time in Hospital, 2 mos: 18 DS
Result, Died: Chronic Nephritis

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* Apl 26/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
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, Is too demented to have any opinion
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,
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 Mary Martin

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2 in PRESENT WEIGHT, 147 3/4 USUAL WEIGHT, NUTRITION, rather poor
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, white coating: prompt
PUPILS, Equality, Size, Response to Light, and Accommodation, yes normal poor ✓
SIGHT, Seems fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Seems fair
COORDINATION, Arms, would not Legs, make tests 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, none fairly strong normal
Apex Beat, Regularity, normal regular
ARTERIES,
LUNGS, Chest, Symmetry, Expansion, yes 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, Urethra inflamed & filled with pus: slight laceration of perinaeum uterus free, hypertrophied; cervix lacerated, eroded, herpes vaginalis, cervicitis, endometritis
MENSTRUATION, purulent leucorrhoea.
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; appetite poor: seems to have some difficulty in swallowing: seems to have some paresis of vocal & throat muscles — is very dirty in habits. Restless & out of bed frequently. Removes her clothing, when up in ward. Mentally, she is very demented: does not seem to understand what is said & does not talk or act intelligently. —

Personal and Medical History of *Mary Martin*

1901

This patient was brought here by Deputy Johnson, attended by Mr. St. Pierre, in poor physical condition with following history of case. Particulars are very meagre. There is no mention made as to consanguinity, heredity, previous peculiarities, severe disease &c, or head-injury. No particulars given as to number of attack, or if others occurred, or duration &c, nor when first symptoms of this attack were manifested nor in what way. Disease seems increasing; not variable. No rational intervals. Derangement now shown by her being demented. Patient is not disposed to injure others, nor suicidal. She is troubled with incontinence of urine and feces. Probably of bad habits. She has not been restrained or confined. Dont know cause of the disease: no treatment. On personal examination, it is found she was sent to City & County Hospital Feby 27th 1901, for burns; having fallen on stove: has been there ever since & demented, when admitted. N.B. "Social history sheet" accompanied papers from which it appears patient was at C & C Hospital since May 29 1901: treated for burns.

Apl 23 On admission, was put on I.W. (S.F.N. Hpt. Complexion dark: hair brown: eyes blue: condition of skin rough and dry: no marks noted: scars over stomach: has the appearance of a burn: small eruptions on legs: no ulcers: a few small bruises on legs: is very dirty: has 8 upper and 12 lower teeth: behavior quiet: does not speak plainly). Mar. June. Apr. 23 patient received on ward; very dirty in appearance, several small bruises on different portions of the body, has large burn over region of stomach. Is untidy in habits, quite restless and does not converse. Is mentally indifferent to her surroundings whether from some impediment or from mental condition cannot be ascertained. Bowels inclined to be constipated requiring cathartics: eats fairly well and sleeps quite well. During her stay on Infirmary she was very restless and sometimes noisy was kept in bed with difficulty, very resistive in deportment. Tem. usually normal never higher than 100:4 P. ranging from 72 to 99. R. 16 to 24. Was put on regular diet & given cathartics, hypnotics and iodides. Patient was affected with gonorrhoea. May 29. Wt. 98 #

June Physical condition poor: eats and sleeps poorly: bowels requiring laxatives Mentally is indifferent to surroundings: untidy in appearance and habits. Does not converse but sometimes mutters to herself: is inclined to undress herself and picks at her clothing. July 2 was noticed to be ailing did not seem able to sit up. Was put to bed. Tem. 100.8. Bowels quite constipated, put on liquid diet. July 5 sent to Infirmary. Rapidly grew weak refusing both nourishment and medicine calling for mechanical feeding. Examination of urine showed large amount of albumin and casts: stomach washed out daily before feeding: circulation very poor: the whole body, especially the face and neck very much congested. July 11 Tem. ran up to 110.4 and patient died at 3:00 P.M. of Nephritis.

Dead

Personal and Medical History of

Personal and Medical History of Fannie Trusdell or Frances E. Trusdell

Whole No. 5800.
Residence, Northfield, Minn
Date Admission, 25th April 1901.
Admitted by Dr. C. L. Chapple hour, 8.00 P.M.
How Sent, James Hunter, Jos P. Rice County
Sex, Female Age, 56.
Civil Condition, single
Children, —
Age Youngest Child, —
Occupation, Has none.
Degree Education, Is educated
Profession, Religion, not a church - member
Habits, no knowlege as to intemperance
Nativity, Ohio: parents born in New York.
Physicians Committing, Wm Greaves and W. A. Hunt
Correspondents, Mrs Adelaide Silk (sister) Northfield, Minn

No. of Year, 163.
Insane Relatives, not as known: sister an epileptic; mother eccentric
Cause Exciting, natural mental instability &c: worry
Cause Predisposing, previous attack (?)
Form, Paranoia.
Accompanying Bodily Disorder, none mentioned.
Suicidal or not, not
Date of this Attack, six or seven years ago.
Duration, practically continuous
No. of Attack, not 1st (one, 3 yrs ago: practically continuous)
No. of Admission, 2nd
Age First Attack, about 50 (49 years)
Time of Leaving, 13th November 1901
Time in Hospital, 6 mos 19 ds.
Result, Recovered: Discharged Dec 10/1901. by B of C.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdall *Date of* Apl 30/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Clear: Quick
MEMORY, Past Events, good
Recent Events, good Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive. Alert: Quite Correct
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, Does not think this insane
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, many years
ONSET, Gradual or Sudden, Gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption). sister has epilepsy: one brother had epilepsy.
Father, Dead — La Grippe
Paternal Relatives, —
Mother, Dead — old age
Maternal Relatives, —
Brothers and Sisters, 9 brothers: 3 sisters
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Typhoid fever at age of 22: sunstroke when a child
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 regular

Personal and Medical History of Fannie Trusdell or Frances E. Trusdell

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in PRESENT WEIGHT, 141# USUAL WEIGHT, NUTRITION, fairly good
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, White Coating: prompt.
PUPILS, Equality, Size, Response to Light, and Accommodation, equal normal good poor
SIGHT, fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, good Legs, good Grasp, other tests good
TREMORS, Hands, Tongue, Facial Muscles, General, coarse tremor fine tremor
PATELLAR REFLEX, present Other Reflexes, Elbow, wrist present
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, none normal normal
Apex Beat, Regularity, normal regular
ARTERIES, very slight sclerosis
LUNGS, Chest, Symmetry, Expansion, Us 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, except laceration of perinaeum: uterus free hypertrophied: cervix lacerated: two large mucous polypi project from external os; cervicitis
MENSTRUATION, endometritis: patient is self-abusive to a marked degree.
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 good physical condition. appetite good: talks freely. Is inclined to be very fault finding: condition seems about the same, as when she was sent out of the Institution 8 months ago. Patient is feeble-minded - Is a degenerate. —

Personal and Medical History of Fannie Trusdell
or Frances E. Truesdell

1901

This patient was brought here by Deputy W. E. Hibbard, attended by Mrs W. E. Hibbard, in fair physical condition, and with following history of case. There is no history of consanguinity, as to insanity, not as known; sister an epileptic; mother eccentric. This is not 1st attack: She had one 3 years ago; duration practically continuous; was sent to this (Rochester) Hospital; result was temporary improvement. First symptoms of this attack manifested six or seven years (ago): imaginary trouble over lost property. Disease appears increasing: variable & with rational intervals, but these, not regular, only when excited over real and imaginary wrongs. Derangement now manifested on the subject of property rights. Patient is not disposed to injure others, nor suicidal: no filthy or destructive habits. Is a person of limited mental capacity. As to any history of intemperance, no knowledge of same. She has had brain fever: has been confined at Hospital (Insane), Rochester. Supposed cause of the disease is natural mental instability & worry: treatment, none at home. On personal examination, nothing further brought out.

Apl 25 On admission, transferred to W. (G. H. N. Hosp. Complexion dark: hair brown, partly gray: eyes blue; condition of skin normal: no marks, scars or bruises noted: is very dirty: has 11 lower & 4 upper teeth all in a bad condition. Behavior quiet: talks intelligently.) —(N.B. Patient here before, from April 16/98 to March 24/1900, and discharged Sept 24/1900. Vol 38 (page 229 to 232).)

Summary of 14 day record: Dict. by Dr. O. C. Fryerdale

Apr. 25-1901 Admitted on Inf. West bathed and put to bed; During first week T. P. & R. about normal, appetite good, bowels regular, expresses many ideas of persecution, general health good, condition appears practically the same as when on previous admissions. Second week same as first. Patient very disagreeable on ward, constantly telling how people are taking advantage of her. May 30 Wt. 129#. June to Sept June 28 patient up on ward: neat and clean in habits and appearance: converses intelligently: takes out door exercise: July 3 trans. to D 3 W. condition remains about the same in every way during the summer: Sept. 1st. Wt. 131#. Sept. to Dec. Sometimes disagreeable on ward: imagines people mistreat her; otherwise has no delusions apparently: Went home Nov. 13th. 1901

—Discharged—

Personal and Medical History of

Personal and Medical History of Ellen Carroll

Whole No. 5803.
Residence, Caledonia Tp.
Date Admission, 27th April 1901.
Admitted by Dr. E. Z. Wayous hour, 3.30 P.M.
How Sent, L. Predahl, J. of P. Houston County
Sex, Female Age, 18
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Housework: father is farmer.
Degree Education, Public School
Profession, Religion, Roman Catholic.
Habits, no history of intemperance
Nativity, Caledonia, Minn. father Nystate: Mother Caledonia Minn
Physicians Committing, W. E. Browning and D. A. Shines
Correspondents, Mrs Bridget Carroll (mother) Caledonia Minn
Family Physician W. E. Browning M.D. Caledonia Minn

No. of Year, 166.
Insane Relatives, None
Cause Exciting, amenorrhoea
Cause Predisposing, not stated
Form, Uraemia. Acute Mania
Accompanying Bodily Disorder, amenorrhoea (?)
Suicidal or not, not
Date of this Attack, April 18th 01.
Duration, 8 Days
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, — 18 —
Time of Leaving, August 12 — 1901
Time in Hospital, 3 mos — 16 Ds
Result, Recovered. Discharged by Superintendent Feby 7 — 1902

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Apl 30/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Confused
MEMORY, Past Events, poor
Recent Events, poor Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive. Illusive
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, Is not capable of judging
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Depressed
DELUSIONS, Systematized, Transitory, Special Subjects, Thinks there is poison in the medicine. Imagines there is a fire about her. "Fear of fire" —
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 April 18 — 1901
ONSET, Gradual or Sudden, sudden
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Living (blind) — negative —
Paternal Relatives, —
Mother, Living — well —
Maternal Relatives, —
Brothers and Sisters, 2 brothers — 4 sisters
Children none
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), None
HABITS, Drinking and Smoking, has been rather an excessive drinker of strong coffee —
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 Ellen Carroll

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 3/4 PRESENT WEIGHT, 130½ lbs USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal, except for a slight eruption on face & back.
TONGUE, Coatings or Promptness of Movement, Slight coating; Prompt —
PUPILS, Equality, Size, Response to Light, and Accommodation, poor (yes, normal, poor)
SIGHT, Seems good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Seems good
COORDINATION, Arms, Could Legs, not get Grasp,
TREMORS, Hands, Tongue, Facial Muscles, General, none
PATELLAR REFLEX, Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, none fairly strong normal
Apex Beat, Regularity, regular normal
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, yes 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, Genitals normal; hymen intact; annular, dilatable, uterus free, retroverted cervicitis, leucorrhoea.
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, very poor.
BOWELS, Present Condition, very 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. Appetite poor: bowels very constipated. Is confused: talks incoherently: seems fearful: expresses fear of fire & poison. Restless & out of bed frequently: very resistive. Patient had a great many head-lice upon admission. Urinalysis shows the presence of large amount of albumen & pus. Had not slept for over a week before coming & has slept very little since coming to Hospital —

Personal and Medical History of Ellen Carroll

1901

This patient was brought here by J. H. Evans, attended by Bridget Carroll, in poor physical condition and with following history of case. There is no history of consanguinity nor heredity. This is the 1st attack; first symptoms manifested April 18th 01. Disease seems stationary: variable: will often answer questions rationally. Derangement now shown by fear of fire &c. Patient is not disposed to injure others, nor suicidal: has been slightly nervous, at times: no history of intemperance: nor of any severe disease &c or head-injury. She has been confined or restrained since 18th April 1901. Supposed cause of the disease is Amenorrhoea: has been given nerve sedatives — On personal Examination, she is restless; nervous movements: some loss of flesh: said Ellen Carroll is committed because of Sec. 3. No 5.

Apl 27 On admission, was put on T.W. (G. H. Rpt. Complexion dark: hair brown: eyes hazel: no marks: — a few small scars on back: eruptions on back & face: no ulcers, bruises or herniae: has vermin and is very dirty: has 9 upper teeth & 15 lower: Behavior quiet: remarks incoherent.) —

Mar. June 1901 Patient received Apr. 27 very dirty and untidy, kept in bed until May 18. Bowels very constipated; sleeps well, appetite good. Is quiet, does not converse but answers questions: resistive. Has slight eruption on face & back put on liquid diet, egg nog. and given plenty of water to drink. Was given cathartics, hypontics, stimulants and tonics, was quite enemic: has not menstruated for sometime, perspires profusely. Urine shows both pus and blood together with albumin. Tem. during time on Infirmary did not rise above 100.6: P. 120: R. 24. Was transferred to B1 May 25. Appears to be very much brighter and converses, but is still very untidy. Helps with the ward work; takes out of door exercise. Marked improvement both mentally & physically. May 29 Wt. 129½ #

June to Sept. June 30 patient is quite sensible, speech is silly and incoherent, is inclined to be untruthful about minor affairs, now and then complains of head ache, trans. to A. 2 West, July 3 visited by mother, July 18 menstruating, Aug. 12 Wt. 162#. patient assists with work in center dining room, has improved very much in weight, is very well mannered, appetite good, bowels regular. Aug. 12 went home this A. M.

Discharged

Personal and Medical History of

Personal and Medical History of Bridget Quinn

Whole No. 5805. Resident of State, always of County.
Residence, St Paul: Ramsey County
Date Admission, 29th April 1901.
Admitted by Dr. O. C. Heyerdale hour, 7.30 P.M.
How Sent, Edmund W. Bazille, Jr. P. Ramsey County
Sex, Female Age, 42.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Domestic
Degree Education, Common School
Profession, Religion, Catholic.
Habits, Intemperate yes: father —
Nativity, St Paul Minn: parents born in Ireland.
Physicians Committing, J. A. Quinn & Talbot Jones
Correspondents, none given in papers

No. of Year, 168.
Insane Relatives, yes: mother.
Cause Exciting, Heredity
Cause Predisposing, heredity & previous attacks.
Form, Mania Chronic —
Accompanying Bodily Disorder, none mentioned
Suicidal or not, not —
Date of this Attack, April 22d 1901.
Duration, a week.
No. of Attack, 4th —
No. of Admission, 3rd here (has been at St Peter also)
Age First Attack, ? about 26 (probably)
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. L. A. Linton *Date of* May 1/1901.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events,
Recent Events, Poor Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert: sometimes correct; at others, illusive.

REASONING POWER, Ordinary Subjects,
Special Subjects, Impaired
Own Mental State, Does not appreciate

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Patient reticent & obstinate: Could not determine or detect any. —

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).
Could not determine —
Father, Dead
Paternal Relatives, ?
Mother, Insane
Maternal Relatives, ?
Brothers and Sisters, ?
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Said "head was injured by fall, when a child.
HABITS, Drinking and Smoking, ?
HEADACHES, VERTIGO, OR CONVULSIONS, ?
OCCUPATION, Healthy or not, Housework.
Detail Date, Duration, and Character of Previous Attack, if any,
1885 — 1891. 1897.
Sleep, Appetite, and Bowels, ?

Personal and Medical History of Bridget Quinn

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1½ PRESENT WEIGHT, 117½ lbs 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 normal yes yes
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Good
COORDINATION, Arms, Good Legs, " Grasp, —
TREMORS, Hands, Tongue, Facial Muscles, General, fine hemor: fine " none none
PATELLAR REFLEX, present Other Reflexes, Elbow: wrist
ARTICULATION, Slurred, Hesitating, Slow, Good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, haemic murmurs strong normal
Apex Beat, Regularity, Irregular normal

ARTERIES, normal

LUNGS, Chest, Symmetry, Expansion, Ogen 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, Genitals normal: hymen intact: uterus retroverted, adherent

MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleeps poorly: requires hypnotics.
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 has gradually become more restless, so will not remain in bed. Has also been destructive, tearing up sheets &c. Is kept in seclusion.

Personal and Medical History of *Bridget Quinn*

1901

This patient was brought here by Mr. Geo. Kroeger, attended by Mr. Mullen, with the following history of case. There is no history of consanguinity, but of heredity, yes: mother insane. This is not 1st attack: one occurred 16 years ago & three subsequent: duration one year: one 9 months. Has been at St Peters & Rochester Hospitals, and she was discharged. First symptoms of this attack manifested April 22d 1901, by various delusions. Disease appears to be increasing; not variable; no rational intervals, (occurring at regular intervals?). Derangement now shown in that she has worried and fretted herself into insanity. Patient is disposed to injure others, but is not suicidal; no filthy or destructive habits. No previous peculiarities noted: true history of intemperance, as father is intemperate: no severe disease &c or head-injury. She has been confined at Rochester one year; again for 8 months: St Peters, 8 months. Supposed cause of the disease is heredity: what treatment has been pursued, unknown. On personal examination, this is reticent, palpably insane. N.B. Patient here twice before: 1st time, from Dec 19/91 to July 19/92 - see Vol 14 pp 193 No 2903. 2nd time, from May 28/97 to March/98 - See Vol 34 p 224 No 4776.

Apl 29 On admission, was put on T.W. (G.H.N. Kpt. Complexion dark: hair black: eyes blue; condition of skin normal: no marks, scars or burns noted: is clean: has 12 upper + 11 lower teeth: Behavior quiet: talks very little). -

Summary of 14 day record Dict. by Dr. O.C. Heyerdale.

Apr. 29-1901 Patient admitted on Inf. W. bathed and put to bed, resistive and noisy, untidy in habits. First week Tem. P. & Res. about normal, appetite fair, given occasional hypnotics; very active, restless, noisy, and untidy. Second week same as first week but is growing a little more quiet in behavior, expresses many delusions, at times violent. May 15 trans. to B.2 West. May 29 Wt. 94#. June to Sept. Aug. 20 Wt. 106#.

Talks constantly, is irrational, is very mischievous, takes out door exercise.

Sept. to Dec. 1901 Is very troublesome, no change during quarter, Nov. 28 Wt. 103½#.

Dec. to Feb. 1903 No change. Patient very maniacal & disturbed.

Personal and Medical History of

Personal and Medical History of Hannah Joyce

Whole No. 5806. Became resident of State 74 yrs ago " " County

Residence, St Paul

Date Admission, 29th April 1901.

Admitted by Dr. O. C. Heyerdale hour, 7 30 PM

How Sent, Edmund W. Bazille Jo. P. Ramsey County

Sex, Female Age, 36.

Civil Condition, married

Children, six

Age Youngest Child, Three months

Occupation, Housewife: husband, a teamster

Degree Education, Can read & write

Profession, Religion, Catholic

Habits, No history of intemperance -

Nativity, Wisconsin: parents born in Ireland.

Physicians Committing, C. F. Sweeney and Arthur Sweeney

Correspondents, none given on papers

No. for Year, 169

Insane Relatives, none

Cause Exciting, unknown

Cause Predisposing, previous attack

Form, "(Recurrent)" Mania Acute

Accompanying Bodily Disorder, none mentioned

Suicidal or not, not attempted; as to propensity, unknown

Date of this Attack, about 3 weeks ago

Duration, about 3 weeks.

No. of Attack, 2nd (one, 9 years ago) -

No. of Admission, 2nd -

Age First Attack, about 27.

Time of Leaving, May 23 - 1901

Time in Hospital, ~~1 month~~ 24 days.

Result, Dead - Cancer of Stomach

EXAMINATION ON ADMISSION BY DR. L. A. Linton *Date of* May 1st 1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events,

Recent Events, poor Special Subjects,

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

REASONING POWER, Ordinary Subjects,

Special Subjects, poor

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects, Could not determine anything

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 Hannah Joyce

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in PRESENT WEIGHT, 126 lbs USUAL WEIGHT, NUTRITION, Fair

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, coated prompt papillae very prominent

PUPILS, Equality, Size, Response to Light, and Accommodation, unequal: right small; left about normal: vertical diameter of left pupil greater than the horizontal: just the reverse condition in right pupil - yes yes

SIGHT,

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

HEARING, Good

COORDINATION, Arms, good Legs, " Grasp, —

TREMORS, Hands, Tongue, Facial Muscles, General, none fine tremor tremor none

PATELLAR REFLEX, present Other Reflexes, also elbow & wrist

ARTICULATION, Slurred, Hesitating, Slow, Good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Aortic Stenosis mitral regurgitation sounds & strong: heart enlarged

Apex Beat, Regularity, regular

ARTERIES, Sclerotic

LUNGS, Chest, Symmetry, Expansion, Sym 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, Genitals normal except lacuation of perineum: uterus normal, free, cervix eroded, cervicitis, leucorrhoea

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps poorly.

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, for the first few days, was very restless & talkative: kept in bed, with difficulty: sings a great deal: did not sleep without hypnotics. Under the influence of bromides & sedatives, she has begun to improve slightly & often gives intelligent answers to questions. At the time of examination, she was incoherent, so that little or nothing could be determined concerning her mental condition.

Personal and Medical History of Hannah Joyce

1901

This patient was brought here by Deputy Sheriff Johnson, attended by Mrs Johnson, in poor physical condition, with following history of case. Patient was, on 25th April 1901, committed to the Detention State Hospital for alleged insane in Ramsey County and by Arthur Sweeney, C.H. Sweeney, Arthur B. Aucker (Supt of St. Hosp.) and Jos. Bazille Certify this a fit subject for the State Institution). There is no history of consanguinity nor heredity. This is not 1st attack; one occurred nine years ago; duration about one week, when she was sent to this (Rochester) hospital; result of treatment, recovery. First symptoms of this attack were manifested about three weeks ago; she began to pray & talk religion. Disease seems increasing: variable and with rational intervals, but these, not regular. Derangement now shown as religion: prays and calls on the Saints. She is disposed to injure others: has not attempted suicide, but, as to propensity being now active, unknown. No filthy or destructive habits. Previously, she showed peculiarities: had an idea that everyone else was doing wrong: was always of strong religious tendency. There is no history of intemperance, nor of any severe disease or a head injury. She has not been restrained or confined. Cause of the disease is unknown. treatment, none. On personal examination, patient talks irrationally; is occasionally violent; talks on religious subjects a great deal. (Was then sent to Detention Hospital).

N.B. Patient was here before from July 20/93 to Aug 9/93. - See Vol 2 P 137 No 3429 -

Apl 29 On admission, was put on TW. (S. & N. B.'s) Complexion fair: hair red: eyes blue: Eruptions on her back; bruises on both eyes & her chin & right leg. Is dirty: has 6 upper teeth & 9 lower: all in a bad condition. Behavior maniacal: is incoherent).

Received on ward Apr. 29 bathed & put to bed. Number of bruises about the eyes and nose and limbs were noticed. Very noisy and restive. Appetite poor. Sleeps fairly well; habits neat. Patient incoherent and expresses delusions. Was given sedative treatment, cathartics. Temperature during the time varied from 96.8° to 105°, at time of admission was 99.4°. May 12. Temperature began rising and continued high until time of death with no remission. The pulse varied from 76 to 178, was extremely rapid for the last week. Respiration from 16 to 40. Breasts were noticed to be caked; they were massaged and in this way considerable milk was removed. Patient was restless and restive. Bowels were inclined to be constipated requiring both cathartics and etometa. May 12 refused medicine and food and was then fed by means of stomach tube. May 19. complained of pain in abdomen. Tongue, teeth and lips coated with a dark brown coating, began coughing and expectorating a purulent substance. Frequent sponge baths given to reduce temperature. Patient vomited greenish colored liquid; stomach washed every morning. Stomach alkaline, showed it to be in a dilated and very prolapsed condition and extending down to the liver and ilium. Breath very offensive; Stools slimy & greenish in color and very offensive.

Patient has been the last few days in a stuporous condition; extremities much congested; feet cold. Examination of urine showed large quantities of albumin. There was also

Personal and Medical History of

prolapsis of the liver and an area of dullness over the gastric region, showing a probable malignant involvement of the stomach. There was pain and a marked tenderness over this area. Patient died at 1:10 P.M. May 23d. 1901

- Dead -

Personal and Medical History of Cathie J. Bertrand

Whole No. 5807	No. of Year, 170.
Residence, Dodge County, Minnesota.	Insane Relatives, none known
Date Admission, 30th April 1901.	Cause Exciting, Family troubles
Admitted by Dr. L. A. Linton hour, 4.00 P.M.	Cause Predisposing, previous attack
How Sent, T. J. Hunt, JofP. Dodge County	Form, Melancholia Acute
Sex, Female Age, forty years	Accompanying Bodily Disorder, none mentioned
Civil Condition, single (divorced)	Suicidal or not, — not —
Children, one	Date of this Attack, about March 1st 1901
Age Youngest Child, Three years old	Duration, about 2 months.
Occupation, House keeper; (husband, farmer)	No. of Attack, not 1st: (seems 2nd)
Degree Education, Common School	No. of Admission, 2nd (here before as Cathe Jones)
Profession, Religion, S. D. Baptist	Age First Attack, — 30 —
Habits, no history of Intemperance	Time of Leaving,
Nativity, Dodge Co. Minnesota: (parents born in New York State)	Time in Hospital,
Physicians Committing, S. W. Ranson and C. S. Bigelow	Result,
Correspondents, D. T. Roundsville (Guardian) Dodge Center	

EXAMINATION ON ADMISSION BY DR. L. A. Linton Date of May 1st 1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, Negative

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, Indifferent

DELUSIONS, Systematized, Transitory, Special Subjects, Could not determine any

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 Cathie J. Bertrand

44/233
5807

M. Cathie J. Bertrand

Copy of Order for Hearing Petition of E. S. Ellis for appointment of D. T. Rousesville as guardian for Cathie J. Bertrand insane; served and service admitted 3d May 1901.

(Papers filed with commitment papers.)

no copy received

44/233
No. 5807

In the matter of the Commitment of Fanny Bertrand (a minor under 10 years of age) to the custody of the Children's aid Society of Minnesota.

Citation to appear before Probate Court, County of Dodge, in the Courthouse, Mantorville, Minn. on Wednesday 5th of March 1902, at 11 A.M. to show cause why said minor child should not be adjudged by this court as being dependent upon the public for support and or has been abandoned by her parents (its mother Cathie J. Bertrand, now in the State Hospital, at Rochester Minn & her father's residence unknown & also to show cause why order should not be made to commit said minor child &c &c — Dated Mantorville 21st Feby 1902 T. J. Hunt JofP

Due Service acknowl. 22 Feb 02 [illegible]

ACTERISTICS.

SUAL WEIGHT, NUTRITION, fair

oated

al

Grasp, —

TREMORS, Hands, Tongue, Facial Muscles, General,

& wrist

MENTS.

LUNGS, Chest, Symmetry, Expansion, Gym Good

Breath Sounds, Normal

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 excavation of perinaeum, haemorrhoids, uterus retroverted and adherent on left side

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, at first did not sleep well, but does now, without hypnotics.

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). Nothing whatever could be determined from the patient, during examination: her answers to questions were wary & misleading. She seemed desirous of concealing her identity in every particular & denied that she had ever been married. She seems stolid & indifferent; is very quiet on the ward, & as soon as allowed her freedom on the ward, began to assist in the lighter work.

Personal and Medical History of Cathie J. Bertrand

Whole No. 5807
Residence, Dodge County, Minn
Date Admission, 30th April
Admitted by Dr. L. A. Light
How Sent, T. J. Hunt. Jr
Sex, Female
Civil Condition, Single (divorced)
Children, One
Age Youngest Child, Three years old
Occupation, House keeper; (husband, farmer)
Degree Education, Common School
Profession, Religion, S. D. Baptist
Habits, No history of Intemperance
Nativity, Dodge Co. Minnesota; (parents born in New York State)
Physicians Committing, S. M. Lauson & C. A. Bigelow
Correspondents, D. T. Koundsville
Dodge Center
(Guardian)

No.
Age First A.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. L. A. Linton Date of May 1st 1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

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

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

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

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Could not determine any

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 Cathie J. Bertrand

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6½ PRESENT WEIGHT, 135 lbs 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, normal, Yes

SIGHT, good

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

HEARING, Good

COORDINATION, Arms, Good Legs, " Grasp, "

TREMORS, Hands, Tongue, Facial Muscles, General, fine, none, none none

PATELLAR REFLEX, Diminished Other Reflexes, slight of elbow & wrist

ARTICULATION, Slurred, Hesitating, Slow, Good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none weak slow normal
Apex Beat, Regularity, Normal regular

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Fair 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, Slight laceration of perinaeum, Haemorrhoids, uterus retro-vertet and adherent on left side

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, at first did not sleep well, but does now, without hypnotics.

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). Nothing whatever could be determined from the patient, during examination: her answers to questions were vague & misleading. She seemed desirous of concealing her identity in every particular & claimed that she had ever been married. She seems stolid & indifferent; is very quiet on the ward, & as soon as allowed the freedom of the ward, began to assist in the lighter work.

Personal and Medical History of Cathie J. Bertrand

1901

This patient was brought here by Sheriff Joel Tucker, attended by Mary Tappan, in fair physical condition, and with following history of case. There is no history of consanguinity; as to any heredity, none known. This is not 1st attack; another occured in February 1889. Was sent to this (Rochester) Hospital, Minn, (under name of "Cathie Jones"), and returned apparently cured.- First symptoms of this attack were manifested about March 1st 1901, by manifesting undue excitement about ordinary affairs. Disease appears to be increasing, variable & rational intervals, but these are irregular. Derangement is now shown by dementia, with mental excitement.- Patient is not disposed to injure others, nor suicidal; no filthy or destructive habits. She had previously been peculiar. There is no history of intemperance, nor of any severe disease or head-injury. Has not been confined or restrained in this attack. Supposed cause of disease is family troubles; treatment, none. On personal examination, she gives irrational, incoherent answers. N.B. Patient has been before, as "Catha Jones" from Febry 5/89 to July 5/89, and discharged Nov 7/89, improved. See Vol 11 page 171 No. 1971.

Apl 30 On admission, was put on I.W. (G.P.I. Rpt. Complexion dark: hair brown; eyes brown; condition of skin normal; no marks, scars or bruises noted; is very dirty; no upper & lower teeth: Behavior quiet. Admits she has delusions, but would not express them freely.)

N.B. See letter on file from Lula B. Ellis, Dodge Centre, Minn. 5/1/1901. "She has no near relatives living only a mother 83 years old, and a little girl 3 years old, last March. She was taking care of her aged parents & getting along nicely, when she got acquainted with an old man, about 20 years older than herself. He made her & her parents believe he was a real nice, clever man: the consequence was they were married. She soon found out he was a miserable, drunken husband & made home very unpleasant: ran her in debt & deceived her in many ways: found she was about to lose all her property: 2 years ago, she got a divorce. Her mother being very feeble required this daughters care, & her worrying to pay up her debts unbalanced her mind. She did not seem to be ugly, but was kind to the baby & her mother: never tried to hurt anyone but seemed to have lost all reason & judgment, and now, for a week or more, she has been driving around almost every night trying to find some one help do her work. If got so people were afraid she would accidentally kill either her baby or mother, for that is the cause of her being sent there. (ask about advisability of keeping baby down to see her &c &c)"

May June. Received Apr. 30. patient was very dirty; had a great many small bruises on her lower limbs: is quite stubborn and resistive. Gives evasive answers to all questions. Habits untidy; sleeps fairly well: appetite good: bowels regular: urinates regularly: is given cathartics, occasionally hypnotics. May 12 was up on ward: assists with ward work; takes out of door exercise: attends chapel: neat in habits but careless in appearance: is at times disturbed sometimes being kept in the bay. May 20 was visited by guardian. May 30 Wt. 127#.

June to Sept. June 14 visited by lady friend, July 11 by friends, Aug 26. trans. to C.3. West Aug. 30 Wt. 140#. Sept. to Dec. Patient in good general health, at times noisy, assists with the ward work, expresses delusions, talks to herself a great deal. Sept. 6 visited by lady friends also Nov. 8 Nov. 30 Wt 153#.

Personal and Medical History of Cathie J. Bertrand.

Dec to Feb. 1903 No change. July 1st to 8th, 1902, patient went camping at Oronoco. July 19th was visited by two friends — also on Aug. 8th.

Personal and Medical History of Bertha Pankratz

Whole No. 5810 Became resident of State 1882 " " County 1882
Residence, St Paul, Minn
Date Admission, 30th April 1901.
Admitted by Dr. L. A. Linton hour, 7 pm
How Sent, Edmund W. Bazille, Jos P. Ramsey County
Sex, Female Age, 31.
Civil Condition, married
Children, Three
Age Youngest Child, - 3 -
Occupation, Housewife; husband, baker
Degree Education, Common School
Profession, Religion, Lutheran
Habits, no history of intemperance
Nativity, Germany; parents also born there -
Physicians Committing, Louis M. Benepe and E. W. Buckley
Correspondents, Fred. Pankratz (husband)
1203 Fauquier St. St Paul

No. of Year, 173.
Insane Relatives, none, so far as known.
Cause Exciting, unknown
Cause Predisposing, not stated
Form, acute Melancholia, agitated.
Accompanying Bodily Disorder, nervousness -
Suicidal or not, suicidal & propensity active.
Date of this Attack, Two months ago
Duration, - Two months -
No. of Attack, 1st -
No. of Admission, 1st -
Age First Attack, - 31 -
Time of Leaving, 5th September 1901.
Time in Hospital, 4 mos 6 ds
Result, Recovered; Discharged Nov 22/1901

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* May 1/1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear : quick
MEMORY, Past Events, fair
Recent Events, " Special Subjects, "
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert
REASONING POWER, Ordinary Subjects,
Special Subjects, poor on subject of her delusions
Own Mental State, says "she is not insane".
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
much depressed

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks the devil has possessed her: that she has done great wrong & that she must now 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, 2 months
ONSET, Gradual or Sudden, —
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, her father an inebriate. Dead -
Paternal Relatives, —
Mother, Dead
Maternal Relatives, —
Brothers and Sisters, 1 3 well
3 children - well
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
had rheumatism, year ago: probably muscular: was not confined to bed
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, with vertigo
Severe headaches, at times. has been troubled greatly
OCCUPATION, Healthy or not, Housework -
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, very poorly Appetite, poor and Bowels, Constipated.

Personal and Medical History of Bertha Pankratz

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 10 in PRESENT WEIGHT, 113 lbs USUAL WEIGHT, NUTRITION, fair physical.
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement,
PUPILS, Equality, Size, Response to Light, and Accommodation, good fair
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles,
HEARING, good
COORDINATION, Arms, good Legs, good Grasp, other tests, good
TREMORS, Hands, present fine tremor Tongue, Facial Muscles, General,
PATELLAR REFLEX, present Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, normal
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, mitral regurgitation fairly strong normal normal
Apex Beat, Regularity, regular
ARTERIES, normal
yes: very well developed
LUNGS, Chest, Symmetry, 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; otherwise genitals normal: uterus normal. free; cervix hypertrophied & lacerated. old papillary erosion; endometritis cervicitis, leucorrhoea
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). Patient admitted in good physical condition: takes nourishment well: sleeps very poorly, at night: requires hypnotics. Patient is extremely melancholy. says "she has sinned & must die". Has attempted suicide 3 times. Is very restless & out of bed, frequently. Answers questions & expresses her delusions freely. -

Personal and Medical History of *Bertha Pankratz*

1901

This patient was brought here by Deputy Sheriff Johnson, attended by Fred Pankratz, in fair physical condition, and with following history of case. Patients parents were related distantly; no history of insanity so far as known: this is 1st attack; first symptoms manifested two months ago, by attempting suicide. Disease seems increasing, but variable with rational intervals, but these not regular: severe symptoms at any time. Derangement now shown by suicidal tendencies with attempts when opportunity is offered. Is not disposed to injure others. Has attempted suicide by cutting wrist and taking Lysol and attempting hanging: propensity now active. No filthy & destructive habits. No previous peculiarities noted: no history of intemperance nor of any severe disease &c or head injury: has not been confined or restrained: only home care. Cause of the disease is unknown. No treatment. On personal examination, nothing further brought out.

Apl 30 On admission, was put on T.W. (G.H.N. Rpt. Complexion dark: hair black: eyes blue; condition of skin normal: no marks: scars on left wrist: no eruptions &c: is clean: has 15 upper & 15 lower teeth. Is quiet but nervous. Thinks she has committed some sin & cannot be forgiven). —

Summary of 14 day record. Dict. by Dr. O.C. Heyendale.

Apr 13 1901 Patient admitted on Inf. W. bathed and put to bed, very melancholy, threatens suicide, scar on left wrist. During 14 days. Tem. Pl. & Res. about normal, appetite good, given occasional hypnotic, was kept in bed for three days, patient cries a great deal says she is the cause of others being here, expresses delusions, illusions and hallucinations, assists occasionally with ward work. May 30 Wt. 103½#.

June to Sept. July 4 visited by husband, improving very much, not clean in habits, assists regularly with ward work, is somewhat melancholy, converses intelligently, receives gynecological treatment, Aug 31 Wt. 114½#.

Sept to Dec. Patient continues to improve physically and mentally, menstruates regularly, very pleasant and agreeable. In good physical condition and very well mentally, patient went home Sept. 5.

— Discharged —

Personal and Medical History of

Personal and Medical History of Bernice Galloway (Colored)

Whole No. 5811. Became resident of State 1895. of County 1895.
Residence, St Paul Minn
Date Admission, 2nd May 1901.
Admitted by Dr. O. C. Heyerdale hour, 7.30 PM
How Sent, E. W. Bazille, Jo P. Ramsey County
Sex, Female Age, 14 years
Civil Condition, single
Children, —
Age Youngest Child, —
Occupation, School-Girl; father, a waiter
Degree Education, Common School
Profession, Religion, Episcopal
Habits, probably good: no history of intemperance.
Nativity, Kansas City. Mo: father's Mo: mother's Palmyra Mo.
Physicians Committing, C. Eugene Riggs and John B. Brimhall
Correspondents, Mrs. Bertie Galloway 213 Granite St. (mother) ~~100 E 12th Street~~ St Paul Minn

No. for Year, 174.
Insane Relatives, Uncle on mother's side
Cause Exciting, — Overstudy —
Cause Predisposing, Heredity
Form, Adolescent Insanity - Chorea
Accompanying Bodily Disorder, twitching of muscles
Suicidal or not, — not —
Date of this Attack, 3 weeks ago
Duration, — 3 weeks —
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, — 14 —
Time of Leaving, 5th April 1902
Time in Hospital, 11 mos - 3 Dy
Result, Recovered: Discharged October 17/02 by Supt.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of May 3/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events,
Recent Events, ✓ Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive. Dull

REASONING POWER, Ordinary Subjects,
Special Subjects, Poor
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, Two months

ONSET, Gradual or Sudden, Sudden

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Uncle on mother's side, Insane — from hard-drinking
Father, Living — well
Paternal Relatives, —
Mother, Living — well
Maternal Relatives, —
Brothers and Sisters, 1 sister — 1 brother

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Had scarlet fever, when a child

HABITS, Drinking and Smoking, good

HEADACHES, occasionally from eye - strain — 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 Bernice Galloway (Colored)

44/241

EXAMINATION OF URINE OF M Bernice Galloway

Passed July 10th Examined July 10th
Character Sp. gr. - 1030 Color Yellow
Quantity in 24 hours — Reaction Alkaline
Clear, cloudy, or a sediment Clear & a white flaky dep.

Tests for Albumen.

1. Heat 0 2. Nitric Acid 0
3. Tanrets 0

Tests for Sugar.

1. Fehlings Sol. 0 2. Haines
3. Bismuth 0

Microscopical.

Urates a large amount of amor. urates Phosphates
Mucus Pus
Blood Epithelium
Casts Oxalate Linn
Several Uric acid crystals
Amount Ureu

ERISTICS.

WEIGHT, NUTRITION, fair

Grasp, —

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,

Passed July 10th. Ld. July 10th

EXAMINATION URINE, Quantity, — Sp. g. 1030 Reaction, Alkaline - yellow Color and Appearance, clear and a white flaky dep. — bismuth 0 —
Albumen, Heat 0 Nitric acid 0 Tanrets 0 Sugar, Fehlings Sol: 0
Casts and Crystals, Several uric acid Crystals: a large amount of amor. urates.

GYNECOLOGICAL EXAMINATION, Began menstruating at 13 years of age - Mens regularly for 4 or 5 days, at a time: had cramps first day of menstrual period.

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 confined to her bed: does not talk: has paralysis of vocal & throat muscles. has difficulty in swallowing: has twitching of arms legs & neck, resembling Chorea: occasionally flops up & out of bed on to floor. Her mother states her sickness began about 2 months ago by twitchings of right hand: this extended to right side: and finally involved left side to some extent, & with some paresis on both sides —

Personal and Medical [illegible]

Whole No. 3811. Became pe[illegible]

Residence, St Paul. Minn

Date Admission, 2nd May 19[illegible]

Admitted by Dr. O. C. Heyerdale

How Sent, E. W. Bazille, Jof P.

Sex, Female Age, 1[illegible]

Civil Condition, Single

Children,

Age Youngest Child,

Occupation, School-Girl; father, a waiter

Degree Education, Common School

Profession, Religion, Episcopal -

Habits, probably good: no history of intemperance.

Nativity, Kansas City, Mo: Father's, Mo: Mother's Palmyra, Mo:

Physicians Committing, C. Eugene Riggs & John B. Brinkhall

Correspondents, Mrs. Bertie Galloway, 213 Granite St. (Mother) 100 E 12th Street St Paul Minn

Accompanying Bodily Disorder, [illegible]-nsibility-Chorea, twitching of muscles

Suicidal or not, - not -

Date of this Attack, 3 weeks ago

Duration, - 2 weeks -

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, - 14 -

Time of Leaving, 5th April 1902

Time in Hospital, 11 mos - 3 Days

Result, Recovered: Discharged October 17/02 by Supt.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* May 3/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

✓

MEMORY, Past Events,

Recent Events, ✓ Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Dull

REASONING POWER, Ordinary Subjects,

Special Subjects, Poor

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, two months

ONSET, Gradual or Sudden, Sudden

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

Father, Living — well — Uncle on mother's side, Insane - from hard-drinking

Paternal Relatives,

Mother, Living — well

Maternal Relatives,

Brothers and Sisters, 1 sister - 1 brother

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

Had Scarlet Fever, When a Child

HABITS, Drinking and Smoking, Good occasionally from eye - Strain -

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 Bernice Galloway (Colored)

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,

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

SIGHT,

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

HEARING,

COORDINATION, Arms, Could not get 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, mitral regurgitation fairly strong: normal

Apex Beat, Regularity, regular Normal

ARTERIES, normal

LUNGS, Chest, Symmetry, Expansion, Yes 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,

Patient July 10th. Left July 10th

EXAMINATION URINE, Quantity, — Sp. g. 1030 Reaction, alkaline - Color and Appearance, clear and a yellow white flaky dep. —

Albumen, Heat o Nitric acid o Tannic o Sugar, Fehling Sol: o Biuret o -

Casts and Crystals, Several uric acid Crystals: a large amount of amor: urates:

GYNECOLOGICAL EXAMINATION, Began menstruating at 13 years of age - Menses regularly for 4 or 5 Days, at a time: Had Cramps first day of menstrual period.

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 confined to her bed: does not talk: has paralysis of vocal & throat muscles. Has difficulty in swallowing: has twitching of arms legs neck, resembling Chorea: occasionally flops up & out of bed on to floor. Her mother states her sickness began about 2 months ago by twitchings of right hand: this extended right side: and finally involved left side to some extent, & with some paresis in both sides -

Personal and Medical History of *Bernice Galloway* (colored)

1901

This patient was brought here by Deputy Sheriff Johnson, attended by Mr. Geo. Kroeger and Mrs Birdie Galloway, in poor physical condition, and with following history of case. There is no history of consanguinity: uncle, on mother's side, insane. This is 1st attack: first symptoms manifested three weeks ago; began with choreic twitchings. Disease seems increasing; not variable; no rational intervals. Derangement now shown by attacks of incoherent delirium. Patient is not disposed to injure others, nor suicidal: no filthy or destructive habits. Before the accession of the disease, she was irritable and nervous. There is no history of intemperance in patient or parents, nor of any severe disease &c, or head-injury. She has not been vaccinated or confined. Supposed cause of the disease is overstudy: has been treated by tonics and constructives. On personal Examination, there is noticed Chorea, associated with insanity. ——

May 2 On admission, was put on I.W. (G. H. N. Rpt. Complexion dark (colored); hair black; eyes brown; Condition of skin normal: no marks, scars or bruises noted; is clean; has some twitching of the muscles: 14 upper and 15 lower teeth: is resistive: would not talk). ——

Summary of 14 day record, Dict. by Dr. O. C. Heyerdale.

May 2, 1901. Patient admitted on Inf. W. very resistive, has chorea exaggerated, does not converse, untidy in habits. During 14 days Tem. Pl. & Res. about normal constipated given occasional cathartic, fed by tube last three days of first week, slept fairly well at night, at first would not converse at all, later conversed slightly, up on ward on May 12, took out door exercise, May 14 choreaic movements so pronounced that she would throw herself out of bed in an hysterical manner, May 30 Wt. 96½ #. June to Sept. Patient considerably improved, takes regular electrical treatments, neat in habits quiet in behavior, appetite fair, fed by nurse, constipated, assists with ward work, July 2 tran. to A. 3 West, July 4 menstruating, Aug 20 patient taken home by mother, very well. Sept. to Dec. Nov. 16 patient received on ward bathed and put to bed: was quiet conversed intelligently up on ward Nov. 8: given electrical treatments and massage: put on Fowler's Solution: Nov. 13 tooth extracted: neat in habits clean in appearance: toilet arranged by nurses: still has convulsive movements of the limbs on right side of body: has tendency to drop things that she is holding, but condition not so bad as at the time of her first admission: appetite good: bowels regular: sleeps well: takes out door exercise: attends chapel: Nov. 30 Wt. 113 #. Dec to Mar, 1902 Patient has not menstruated since the middle of Sept. complains of head ache and pains in her abdomen: during Jan. examination made and found to be pregnant Feb. 6 visited by mother: during the winter became rather untidy in habits though neat in appearance: became rather irritable and trans. to B. 1 West: spends most of her time making lace: often has quarrels with the other patients: irritability due to her condition: seldom takes exercise: attends no amusements: Apr. 5th. went home: pregnant about seven months

Personal and Medical History of

Personal and Medical History of Mary Hass

Whole No. 5812. Resident of State of Minn: 1857 County 1854.

Residence, Stillwater, Wash Co. Minn.

Date Admission, 4th May 1901.

Admitted by D. O. C. Hesperdale hour, 7.30 PM.

How Sent, Frank. T. Wilson, Jofl Washington Co.

Sex, Female Age, 50 (over).

Civil Condition, Married

Children, Two

Age Youngest Child, - 2st -

Occupation, Housewife

Degree Education, Reads & writes

Profession, Religion, Catholic

Habits, No history of intemperance

Nativity, Germany: Parents also born there.

Physicians Committing, C. E. Clark Wm E. Sydney Bleyn

Correspondents, Martha Radtke (Daughter) 1419 1/2 Ramsey St. Stillwater Minn

No. of Year, 175.

Insane Relatives, None

Cause Exciting, Religion

Cause Predisposing, not given

Form, Melancholia Acute

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Suicidal & propensity active

Date of this Attack, Abont December 1st 1900

Duration, Over 5 months

No. of Attack, 1st —

No. of Admission, 1st

Age First Attack, - 50 -

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. L. N. Linton Date of May 22/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Could obtain nothing on examination

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Alert: illusive

REASONING POWER, Ordinary Subjects,

Special Subjects, Impaired

Own Mental State, Does not realize

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Depressed

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS, of 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,

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

Father, Living

Paternal Relatives, ✓

Mother, Living

Maternal Relatives, ✓

Brothers and Sisters, Said she has three children

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

Small-pox

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, poor poor She said bowels have been regular.

Personal and Medical History of Mary Hass

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2 in PRESENT WEIGHT, 117½ lbs 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 Yes

SIGHT, Good

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

HEARING, Good

COORDINATION, Arms, Good Legs, — Grasp, —

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

PATELLAR REFLEX, present Other Reflexes, elbow & wrist

ARTICULATION, Slurred, Hesitating, Slow, good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, None Strength, weak Sounds, Normal Size, Normal

Apex Beat, Regularity, regular

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Even good

Breath Sounds, Normal — marked prominence of chest at angle of Louis.

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, Prolapse of mucous membrane of urethra; lacerated perineum: rectocele, cystitis, uterus retroflexed and adherent on left: cervicitis; cervix papillary: senile

MENSTRUATION, vaginitis, leucorrhoea.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps poorly —

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 has been very much depressed since admission: appetite is very poor: has been fed by tube, most of the time. This procedure increases & invariably a crying spell is induced. Everything that is done for, is exaggerated by her. Thinks there very much about. At time of examination for reflexes she thought she was being beaten. Nothing reliable could be obtained from her, at time of examination.

Personal and Medical History of Mary Hass.

1901

This patient was brought here by Deputy Sheriff Ignatius Fazendin, attended by Mrs Fazendin in fair physical condition, and with following history of case. There is no history of consanguinity nor heredity. This is 1st attack; first symptoms manifested about Dec 1st 1900; brooding over imaginary crime. Disease seems increasing; not variable: no rational intervals. Derangement now shown in that she thinks she has committed the unpardonable sin. Patient is not disposed to injure others. Has attempted suicide: tried to hang herself, and throw herself in the cistern: propensity now active. Is disposed to burn clothing: has been very religious, before the accession of the disease. There is no history of intemperance. Patient was struck on head with spade, when a child. She has not been restrained or confined; only to keep her from running out, nights. Supposed cause of the disease is religion. On personal examination, she is emotional, crying; claims it is no use; she is doomed.

May 4 On admission, was put on T.W. (G.H.N. Rpt. Complexion dark: hair black: eyes hazel: condition of skin, dry & rough; has a number of small bruises on arms: is quite dirty: has small tumor on forehead & prominent chest: no teeth: is quite resistive; expressed delusions)

Summary of 14 day record Dict by Dr. O.C. Heyerdale.

May 4th. 1901 Admitted on Inf. W. bathed and put to bed, several small bruises on limbs, very nervous and resistive. During 14 days Tem. Pl. & Res. about normal, First week appetite fair, depressed, up and out of bed a great deal, quite sleepless at night, Second Week. Fed by tube part of time, refused most of her medicine and it was given by tube, slept quite well, May 30 Wt 116*.

June to Sept. Patient has not shown very much improvement, is frequently quite disturbed fed either by tube or nurse, slept quite well, seldom converses, quite depressed, July 17 visited by daughter, Aug. 31 Wt. 104#.

Sept. to Dec. Patient still very much disturbed, at times quite violent, and noisy expresses delusions that she is a devil and is going to hell and begs some one to kill her. Nov. 30 Wt 108.

Dec. to Feb. 1903 Gen'l health good: appetite good: sleeps well: appetite good: bowels regular: does no work: very quiet & depressed: rarely volunteers conversation: at times answers questions but generally refuses by a shake of the head. Is neat and clean. Dec. 1st Wt 130½#.

Personal and Medical History of

Personal and Medical History of Mary J. Murphy

Whole No. 5820.
Residence, York. Minn.
Date Admission, 16th May 1901
Admitted by Dr. Arthur F. Kilbourne hour, 3.30 P.M.
How Sent, E. V. Farrington, J. of P. Fillmore County
Sex, Female Age, 38
Civil Condition, married
Children, 3
Age Youngest Child, 4 years
Occupation, Housekeeper: husband a farmer
Degree Education, Common School
Profession, Religion, Roman Catholic
Habits, no history of intemperance
Nativity, Dubuque, Iowa: parents born in Ireland
Physicians Committing, J. H. Phillips and Geo. A. Love
Correspondents, Isaac Murphy (husband) York, Fillmore County

No. of Year, 183.
Insane Relatives, none
Cause Exciting, paralysis, after Childbirth, a year ago
Cause Predisposing, probably Child-bearing
Form, Mania Acute following apoplexy
Accompanying Bodily Disorder, paralysis of left side.
Suicidal or not, Not: but will injure others.
Date of this Attack, about 2 weeks ago
Duration, about 2 weeks
No. of Attack, 1st —
No. of Admission, 1st —
Age First Attack, — 38 —
Time of Leaving, October 7 — 1901.
Time in Hospital, 4 mos 21 ds
Result, Improved. —
Discharged by Board of Control April 14 — 1902 —

EXAMINATION ON ADMISSION BY DR. L. A. Linton *Date of* May 23/1901

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, Delusions
HALLUCINATIONS, of sight & hearing
ILLUSIONS, 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 of kidney trouble
Paternal Relatives, —
Mother, Died in Childbirth
Maternal Relatives, —
Brothers and Sisters, 3 children: one still-born about 9 months ago.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), paralysis of left arm & leg caused by an embolus due to puerperal septicaemia
HABITS, Drinking and Smoking,
HEADACHES, VERTIGO, OR CONVULSIONS, vertigo noticed 2 weeks before admission
OCCUPATION, Healthy or not, Housewife
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, no sleep for 2 weeks: appetite good: bowels constipated.

Personal and Medical History of Mary J. Murphy

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5½ PRESENT WEIGHT, 198 lbs USUAL WEIGHT, NUTRITION, good
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 yes yes
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Good
COORDINATION, Arms, poor Legs, poor Grasp, Did not try "tests" on account of paralysis
TREMORS, Hands, Tongue, Facial Muscles, General, none
PATELLAR REFLEX, present Other Reflexes,
ARTICULATION, Slurred, Hesitating, Slow, Good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, none weak normal
Apex Beat, Regularity, normal regular
ARTERIES, Normal
LUNGS, Chest, Symmetry, Expansion, Dym very 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, Perinaeum lacerated: haemorrhoids: rectocele: uterus anteroidextro vertex. uterus adherent on right: cervix lacerated, eroded: herpes vaginalis, cervicitis: cervix 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). Patient has been noisy & very much disturbed since admission. Talks incessantly & is often profane: has attacked the nurses several times, though she is good-natured through it all. She is self-willed & is resistive when she cannot have her way. At first, she was slept on a mattress on the floor, because she pulled her bed apart & tried to beat the door down. She thinks she is the virgin & sees and talks with god. Has an idea that she is omnipotent. The case appears like brain softening due to embolism.

Personal and Medical History of *Mary J. Murphy.*

1901

This patient was brought here by Andrew Healy, attended by Isaac Murphy, husband, and Mrs Delaney, in fair physical condition, and with following history of case. There is no history of consanguinity nor heredity. This is 1st attack; first symptoms manifested about two weeks ago. became suddenly violent, and it has increased ever since, especially last three days. Disease seems increasing. Not variable; no rational intervals. Derangement now known by General Mania. Patient is disposed to injure others, but not suicidal. No filthy or destructive habits. No previous peculiarities noted: no history of intemperance, nor of any severe disease or head injury. She has not been restrained or confined. Supposed cause of the disease is stated that after childbirth, a year ago, she suffered from paralysis of left side, caused by an embolism. Treatment, none. On personal examination, she is very violent. Commitment of said Mary Jane Murphy recommended because her disease is of such a nature and in such a state as to require regular aid and assistance, while under legal restraint. It is dangerous to herself & others to have her at large. She is now, & has been a resident of Fillmore County, for last 35 years past.

May 16 On admission, was put on T.W. = (G.P.N. Dft. Complexion fair: hair brown & gray: eyes hazel; condition of skin normal: has a number of small bruises on arms, and one on right knee. Is dirty: prominent chest: teeth false. Behavior resistive and inclined to be violent. Talks incoherently).

Summary of 14 day record Dict. by Dr. O.C. Heyerdale.

May 16 1901 Admitted on Inf. W. bathed and put to bed, attacked the nurses was noisy and destructive, left side is partially paralized. During 14 days Tem. Pr. & Res. slightly above normal, took regular diet, appetite good, given occasional cathartic, hypnotic and opiate. During Second Week continued very noisy and disturbed, expresses many delusions, very violent, slept fairly well last week, neat in habits. May 31 Wt. 185 1/2 #.

June to Sept. June 3 trans. to B.2, continues very noisy and violent, no particular change, hypnotics given at night, habits dirty, strikes other patients and nurses kept in her room a great deal of the time, breaks furniture. June 24 patient remains practically the same, taken home by husband. June 29 returned and admitted on B. 2, Aug. 9 trans. to Inf. W. Aug. 10 operated upon by Dr. C. H. Mayo skull trephined and brain explored for cyst, patient had uneventful recovery, very hard patient to take care of, is noisy, restless, delusional & resistive.

Sept. to Dec. Sept. 5 visited by relatives, Sept. 14 trans. to B1 continues noisy and resistive, uses vile language, Sept. 21 visited by husband was much excited. Oct. 1 visited by relatives, continues rather violent at times and strikes other patients, Oct. 7 visited by husband and sister and was taken home, slightly more quiet

— Discharged. —

Personal and Medical History of

Personal and Medical History of Mrs Nora G. Conlin

Whole No. 5822. Became resident of State 1886. of County 1886.
Residence, St Paul; Minn.
Date Admission, 17th May 1901.
Admitted by Dr L. A. Linton hour, 7 PM.
How Sent, Edmund W. Bazille, Jofl. Ramsey County
Sex, Female Age, 35
Civil Condition, Married
Children, Two
Age Youngest Child, 5 years.
Occupation, Housewife; husband a bookbinder
Degree Education, Common School
Profession, Religion, Roman Catholic
Habits, Not Intemperate —
Nativity, Illinois: parents born in Ireland.
Physicians Committing, Frederick Leavitt and L. O. Bacon
Correspondents, Thomas Conlin (husband)
33 Thompson St
St Paul Minn.

No. of Year, 185.
Insane Relatives, none
Cause Exciting, Puerperal
Cause Predisposing, previous attack
Form, Puerperal Insanity
Accompanying Bodily Disorder, acute Mania none mentioned
Suicidal or not, not
Date of this Attack, about a week ago
Duration, about a week.
No. of Attack, not 1st (one occurred 6 years ago)
No. of Admission, 2nd
Age First Attack, abot 29.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. L. A. Linton *Date of* May 24/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused
MEMORY, Past Events, Impaired
Recent Events, Nothing obtainable from Patient Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert: illusive
REASONING POWER, Ordinary Subjects,
Special Subjects, Impaired
Own Mental State, Does not realize
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted
DELUSIONS, Systematized, Transitory, Special Subjects,
has delusions
HALLUCINATIONS, Sight & hearing
ILLUSIONS, has 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, Nothing obtainable
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, Housewife
Detail Date, Duration, and Character of Previous Attack, if any,
one, 6 years ago: of same character
Sleep, Appetite, and Bowels,
Poor

Personal and Medical History of Mrs Nora G. Conlin

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1½ PRESENT WEIGHT, 146# USUAL WEIGHT, NUTRITION, Good
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt: slight coating
PUPILS, Equality, Size, Response to Light, and Accommodation, Equal Normal Yes Yes
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal
HEARING, Good
COORDINATION, Arms, Good Legs, " Grasp, Good
TREMORS, Hands, Tongue, Facial Muscles, General, None
PATELLAR REFLEX, Present Other Reflexes, absent
ARTICULATION, Slurred, Hesitating, Slow, Good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, None Strong Normal
Apex Beat, Regularity, Normal regular
ARTERIES, Normal
LUNGS, Chest, Symmetry, Expansion, Sym 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, Nine made: patient is pregnant (8½ months) — Examined 6 weeks after delivery: hemorrhoids: laceration of perineum of several years standing: uterus in normal position: still enlarged: cervix
MENSTRUATION, —
OPHTHALMOSCOPIC EXAMINATION, — Cystic: Endometritis — Leucorrhoea.
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). Patient is very much disturbed: would not remain in bed: for the first two days, had to be held in bed: was then put in restraint sheet to avoid injury: Talks incessantly: sometimes in a very loud voice: Hypnotics & sedatives have but little effect upon her: is generally incoherent in her raving. Nothing obtainable from patient, in way of history. —

Personal and Medical History of Mrs. Nora G. Conlin

1901

This patient was brought here by Deputy Sheriff Sheean, attended by Miss Clara O'Brien, in good physical condition, with following history of case. There is no history of consanguinity nor heredity - This is not 1st attack: one occurred 6 years ago; duration one year & a half: was sent to this (Rochester) Hospital, and discharged. First symptoms of this attack manifested about a week ago, by delusions. Disease seems increasing; not variable; no rational intervals. Derangement now shown by delusions in general. Patient is not disposed to injure others, nor suicidal; No filthy or destructive habits. Of any previous peculiarities, unknown. No history of intemperance in patient or her parents; nor of any severe disease &c or head injury. Has not been restrained or confined. Supposed cause of the disease is puerperal. Treatment, none. On personal examination, skin is excitable; Insomnia; nervous and talkative. ——— " ———

N.B. Recent admission, as she was here before from Oct 26/95 to Sept 14/96 and discharged May 14/97, as recovered - See Vol 30: page 9: No 4236: ———

May 17 On admission, was put on I.W. G.H.N.R'st: Complexion dark: hair brown: eyes brown: Condition of skin, normal. Is clean. Feet & ankles swollen. Teeth: upper plate; lower, ten: Is quiet: Talk, quite rational).

May 17 admitted to ward; quiet at the time but became extremely noisy and violent during the night, slept but little, was very resistive and was retained in bed with difficulty; appetite good, neat in habits and tidy in appearance; bowels inclined to be constipated requiring either cathartics or enemas. Patient pregnant; confinement expected about June first. For the first two or three days was restrained from doing violence to herself by being held by nurses, after that both day and night was kept in restraint sheet; most of the time when not in restraint would be out of bed climbing over the radiator and pulling her hair; was very restless and in constant motion of some kind. May 22 was dressed and up on the ward, for a time was given hypodermics of morphine; from two to four times during the twenty-four hours, but they had no effect. All ordinary hypnotics were tried but without avail, the patient did not average more than two or three hours sleep during the twenty-four. Slight emesis occurred at times; nourishment was taken well throughout the time. May 29 was taken with labor pains; delivered at 3:30 of a male child. During the time and for a day or two afterward the patient was quite quiet and seemed to realize her condition for the first time, after that time became restless and disturbed again. Lying in period was passed without any complications, lochia continued for about two weeks, but was never very profuse and never at any time of bad odor. Temp. during June 6 and 7 was slightly raised, highest being 101.4 was normal up to that time and afterwards. Was kept on milk diet with egg nogs. The baby died on June 1-1901

Personal and Medical History of

1901

Baby Conlin - On May 29th at 3:30 was born; the birth was a very clean one and rapid occuring before the physician could reach the bedside. The child began crying at once and as soon as possible was dressed after having been thoroughly cleansed and oiled and eyes washed with boric acid, seemed normal in every way. Was put to the breast about 8:30 May 29 and nursed for a time and at frequent intervals during the next two days. Slept well and cried but little, bowels moved on first day urinated on second day. The baby being an object of great interest was made the subject of many visits and during the time it apparently took cold, became restless and cried a great deal: bowels became green in color, nursed with difficulty, on May 31, cried in convulsive way during the night. On June first at 7:50 the baby died, directly after death there was a hemorrhage from nose and mouth. Post mortem examination showed organs apparently normal except the lungs, these were very much congested and sodden with blood, they were dark red in color very much like the spleen in appearance; very little uninvolved tissue was found. Death was apparently due to congestion of the lungs.

Tem. that followed the death of the baby was in all probability due to the accumulation of milk although there was no marked involvment of the breasts. The breasts were massaged twice daily. Vaginal douches were given daily. After the first week hot packs and tepid baths were given in order to induce sleep, these were effectin at first but gradually lost their influence. Mentally the patients condition has not changed materially since her admission. Marked disturbance is continued the only interval at all lucid was just at the time of the birth of the child. Physically she seems to be losing ground, has become thin and pale due to the extreme disturbance and loss of sleep.

June to Sept. July 2 patient continues very destructive and violent, broke dishes in the dining room and stepped on a small piece of glass and cut her foot. healed without difficulty. July 30 trans. to b.2 west, Aug. 30 Wt. 82½#.

Sept. to Dec. Continues very violent, noisy, destructive, and profane, Nov. 25 Wt. 100.

Dec. to Feb. 1903 No change Wt. 100#. Visited by husband on June 8th & 9th

Personal and Medical History of Martha A. Goddard

Whole No. 5923. Became resident of State 1892 of County 1892

Residence, St. Paul, Minn.

Date Admission, 20th May 1901.

Admitted by Dr L A Laiton hour, 7 30 pm

How Sent, Edmund W. Gazelle, Supt. Ramsey Co.

Sex, Female Age, 69

Civil Condition, Widowed

Children, Six

Age Youngest Child, 29 years.

Occupation, Housewife; Husband Engineer

Degree Education, Common School

Profession, Religion, Methodist

Habits, Not intemperate

Nativity, New York: of father & mother. Don't Know

Physicians Committing, Frederick Leavitt and J. T. Bates

Correspondents, None given in papers

Sabri Goddard. St Paul. Minn. Tel. 138 Main

Chicago and Great Western address office of

No. of Year, 186.

Insane Relatives, None

Cause Exciting, - age -

Cause Predisposing, previous attack

Form, Melancholia Chronic

Accompanying Bodily Disorder, Nine mentioned

Suicidal or not, Very Suicidal

Date of this Attack, 3 or 4 months ago

Duration, 3 or 4 months

No. of Attack, Not 1st / one occurred in 1896. (1895)

No. of Admission, 2nd *

Age First Attack, about 51.

Time of Leaving, May 31st. 1901

Time in Hospital, 11 days

Result, Dead - Ulceration Enteritis

* note: Deems 3rd attack: She also had one about 1894

EXAMINATION ON ADMISSION BY DR. L A Laiton Date of May 22/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Somewhat Confused & Sluggish

MEMORY, Past Events, Good in some respects: forgets names. is not sure of the name of her own mother or Relatives —
Recent Events, Special Subjects, forgets dates. —

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

REASONING POWER, Ordinary Subjects,
Special Subjects, Impaired

Own Mental State, at times, is aware that she has delusions.

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Imagines people are trying to kill, or harm her daughter

HALLUCINATIONS, of hearing: hears shrieks & cries

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).
— history of paralysis —

Father,

Paternal Relatives, Nothing obtainable

Mother,

Maternal Relatives,

Brothers and Sisters, 6 children — 2 living

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
no history obtainable from patient: fracture of wrist.

HABITS, Drinking and Smoking, Good

HEADACHES, VERTIGO, OR CONVULSIONS, Vertigo

OCCUPATION, Healthy or not, Housewife

Detail Date, Duration, and Character of Previous Attack, if any,
one 17 years ago, of about 5 years: one, 6 years ago, one or one half months —

Sleep, Appetite, and Bowels,
Sleeps poorly: appetite variable: bowels constipated.

Personal and Medical History of Martha A. Goddard

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3in PRESENT WEIGHT, 130lb USUAL WEIGHT, NUTRITION, Good

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 Yes

SIGHT, poor

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

HEARING, good

COORDINATION, Arms, good Legs, good Grasp, Standing on one foot, fair Standing, eyes shut, good — Finger to nose, eyes shut, good

TREMORS, Hands, Tongue, Facial Muscles, General, Slight tremor Right tremor none

PATELLAR REFLEX, present Other Reflexes, Wrist + Elbow

ARTICULATION, Slurred, Hesitating, Slow, Slow

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Aortic Stenosis + mitral regurgitation

Apex Beat, Regularity, regular Fairly strong

Lge: somewhat enlarged

ARTERIES,
Sclerotic

LUNGS, Chest, Symmetry, Expansion, Dym 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, Genitals normal: urethral carnicle: haemorrhoids: uterus pre: position normal: cervix hypertrophied: os patulous: gaping: uterine polypi: Cervix suspicious: probable

MENSTRUATION, malignant involvement: cervicitis leucorrhoea

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps poorly.

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 is quiet: talks quite sensibly, realizes that her memory fails her in some particulars: her answers to questions are made slowly, apparently from a desire to tell the exact truth, which she finds difficult in account of forgetfulness. Her chief worry seems to be concerning her favorite daughter Sabri, who she thinks, is in danger of being killed. Thinks she hears cries & screams at night. Imagines her daughter is being murdered. —

Personal and Medical History of Martha A. Goddard

1901

This patient was brought here by Deputy Sheriff Johnson, attended by Sabrie Goddard, in fair physical condition, and with following history of case. There is no history of consanguinity, nor heredity. This is not 1st attack; other occurred in 1896 (1895), duration two months; was then at Rochester Hospital, & discharged. First symptoms of this attack manifested three or four months ago, by excitability, hallucinations and delusions. Disease seems increasing:- Is variable and with rational intervals, but these not regular. Derangement now shown by fear of harm to self and family. Patient is not disposed to injure others, but has attempted suicide, by poison &c: propensity probably is now active: no filthy or destructive habits. no previous peculiarities noted: no history of intemperance, nor of any severe disease &c or head-injury. She has not been restrained or confined. Supposed cause of the disease is age: treatment: none. On personal examination, the case appears to be a progressive senile dementia. N.B. Second admission, as she was here before from Feb 28/95 to Apl 15/95, and discharged, recovered, May 1/95.— See Vol 28 page 117 No 4017:— During her stay, was very melancholy, for a time, and had various delusions — She had then also been in the C & C Hospital at St Paul, Minn. Her previous Commitment stated, as cause of the disease, "sudden death of husband, loss of her money & worry over her condition" —

May 20 On admission, was put on I.W. (G.H.N. Rpt. Hair, gray & brown: eyes gray: condition of skin, normal: Is clean. Teeth: lower 13: upper plate: Behavior quiet.)—

Patient received on ward May 20, bathed and put to bed. Noisy: slept two hours. Fits of restlessness continued throughout her stay on the ward. She was at times noisy and restive; sometimes violent. Temperature during the day varied from 97° to 104.4°; pulse 66 to 118 respiration 14 to 44. Was at first given regular diet but appetite was so poor they finally put her on liquids milk and egg nog. Was given hypnotics every night, cathartics and frequently enemas and had anti fermentatives and stimulants. Bowels seemed very much constipated. Mouth and teeth seemed very foul, heavy coating on both; throat also seemed sore so that there was a disinclination to swallow.

May 23 stools thin and hemmorhages; patients abdomen packed in ice and enemas of glycerine + tannin given; washings from the stomach were bloody. Patient became stuperous continued so until day of her death.

May 27 there was emesis; coffee grounds stools; fed with stomach tube

May 30 second large hemmorhage from bowels, blood bright red. Successive enemas resulted in the discharge of large quantities of clay like matter which effervesced on addition of hydrocloric acid which would seem to indicate that patient had swallowed some lime matter before admission.

Patient died May 31st at 3:40 P.M.

Postmortem revealed many large ulcers in the large bowel; some of them beginning to perforate, mucous membrane of the small bowel also eroded as well as the stomach and small intestines, thin and congested. It was afterwards found the patient had swallowed a large quantity of lye just before admission.

Dead.

Personal and Medical History of

Personal and Medical History of Eliza A. Cooper

Whole No. 5834. Became resident of Minnesota 1856 " of County 1856

Residence, Rochester, Minn.

Date Admission, 21st May 1901.

Admitted by D. Arthur F. Kilbourne hour, 11 15 am

How Sent, J. A. Leonard, J. of P. Olmsted County

Sex, Female Age, 73

Civil Condition, widowed

Children, 2

Age Youngest Child, no children living.

Occupation, Has none.

Degree Education, Common School

Profession, Religion, Baptist.

Habits, no history of intemperance

Nativity, Ohio: parents born in Connecticut.

Physicians Committing, A. S. Adams & Chas. T. Granger

Correspondents, Mrs. D. W. Durfey Chatfield (Mr. Durfey is a nephew)

No. of Year, 187.

Insane Relatives, none

Cause Exciting, Senility

Cause Predisposing, probably age.

Form, senile Dementia

Accompanying Bodily Disorder, none mentioned -

Suicidal or not, - not -

Date of this Attack, about two years ago

Duration, about 2 years

No. of Attack, 1st —

No. of Admission, 1st —

Age First Attack, - 71 -

Time of Leaving, June 13 - 1901.

Time in Hospital, 23 Ds

Result, Died: Exhaustion in senile Dementia -

EXAMINATION ON ADMISSION BY DR. L. A. Luiton *Date of* May 23/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Very Poor

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive. Dull

REASONING POWER, Ordinary Subjects,

Special Subjects, Impaired

Own Mental State, Does not appreciate

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

DELUSIONS, Systematized, Transitory, Special Subjects, ✓

HALLUCINATIONS, of hearing: thinks she hears voices

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, nothing obtainable from

Paternal Relatives,

Mother, Patient

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), has large scar on left side of forehead: says Dr. Mayo operated for cancer - 10 years ago -

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Headache

OCCUPATION, Healthy or not, Housewife

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

Sleep, Appetite, and Bowels, good Sleeps poorly: bowels constipated.

Personal and Medical History of Eliza A. Cooper

Mrs. P. M. Mosher of Riceville, Iowa, and Mrs. E. W. Durfey of Chatfield, returned to their homes today, having been here since the death of their cousin, Mrs. Addie Linn.

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 112 1/4 # USUAL WEIGHT, NUTRITION, poor

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt

PUPILS, Equality, Size, Response to Light, and Accommodation, poor (equal, normal, poor)

SIGHT, wears glasses

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

HEARING, fairly good

COORDINATION, Arms, poor Legs, poor Grasp, other tests, poor

TREMORS, Hands, Tongue, Facial Muscles, General, Tremor (Tremor, Tremor)

PATELLAR REFLEX, exaggerated Other Reflexes, elbow & wrist

ARTICULATION, Slurred, Hesitating, Slow, Speaks indistinctly: poor: hesitates; slow

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Mitral regurgitation: aortic stenosis

Apex Beat, Regularity, fairly strong irregular

heart enlarged: impulse area increased & down & left

ARTERIES, Atheromatous

LUNGS, Chest, Symmetry, Expansion, Sym 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, Urethral Carnucle: lacerated perinaeum: haemorrhoids: uterus, especially cervix atrophied: senile vaginitis

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps poorly -

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 has been very much disturbed, since admission. Is noisy: untidy: will not remain in bed: restless & sleepless. -

Personal and Medical History of Eliza A. Cooper

Whole No. 5874. Became resident of Minnesota 1856 " of County 1856

Residence, Rochester, Minn.

Date Admission, 21st May 1901.

Admitted by D. Arthur F. Kilbourne hour, 11 15 am

How Sent, J. A. Leonard, J. of P. Olmsted County

Sex, Female Age, 73

Civil Condition, widowed

Children, 2

Age Youngest Child, no children living.

Occupation, Has none

Degree Education, Common School

Profession, Religion, Baptist.

Habits, no history of intemperance

Nativity, Ohio: parents born in Connecticut.

Physicians Committing, A. S. Adams & Chas. T. Granger

Correspondents, Mrs. D. W. Durfey Chatfield (Mr. Durfey is a nephew)

No. of Year, 187.

Insane Relatives, none

Cause Exciting, Senility

Cause Predisposing, probably age.

Form, senile Dementia

Accompanying Bodily Disorder, none mentioned -

Suicidal or not, - not -

Date of this Attack, about two years ago

Duration, about 2 years

No. of Attack, 1st —

No. of Admission, 1st —

Age First Attack, - 71 -

Time of Leaving, June 13 - 1901.

Time in Hospital, 23 Ds

Result, Died: Exhaustion in senile Dementia -

EXAMINATION ON ADMISSION BY DR. L. A. Luiton *Date of* May 23/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, very Poor

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive. Dull

REASONING POWER, Ordinary Subjects,

Special Subjects, Impaired

Own Mental State, Does not appreciate

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

DELUSIONS, Systematized, Transitory, Special Subjects, ✓

HALLUCINATIONS, of hearing: thinks she hears voices

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, nothing obtainable from

Paternal Relatives,

Mother, Patient

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), has large scar on left side of forehead: says Dr. Mayo operated for cancer - 10 years ago -

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Headache

OCCUPATION, Healthy or not, Housewife

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

Sleep, Appetite, and Bowels, good Sleeps poorly: bowels constipated.

Personal and Medical History of Eliza A. Cooper

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in PRESENT WEIGHT, 112 1/4 # USUAL WEIGHT, NUTRITION, poor

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt

PUPILS, Equality, Size, Response to Light, and Accommodation, equal normal poor poor

SIGHT, wears glasses

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

HEARING, fairly good

COORDINATION, Arms, poor Legs, poor Grasp, other tests, poor

TREMORS, Hands, Tongue, Facial Muscles, General, Tremor Tremor Tremor

PATELLAR REFLEX, exaggerated Other Reflexes, elbow & wrist

ARTICULATION, Slurred, Hesitating, Slow, Speaks indistinctly: poor: hesitates; slow

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, Mitral aequigitation: aortic stenosis

HEART, Murmurs, Strength, Sounds, Size, fairly strong

Apex Beat, Regularity, irregular

heart enlarged: impulse area increased & down & left

ARTERIES, Atheromatous

LUNGS, Chest, Symmetry, Expansion, Sym 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, Urethral Carnucle: lacerated perinaeum: haemorrhoids: uterus, especially cervix atrophied: senile vaginitis

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps poorly -

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 has been very much disturbed, since admission. Is noisy: untidy: will not remain in bed: restless & sleepless. -

Personal and Medical History of Eliza A. Cooper

1901

This patient was brought here by Sheriff Vine, attended by Mrs Mosier, in fair physical condition, and with following history of case. There is no history of consanguinity, nor heredity, previous peculiarities, intemperance, severe disease &c, or head injury. This is first attack: first symptoms manifested about 2 years ago; evidence of senile dementia. Disease seems increasing: not variable: no rational intervals. Derangement now shown by senile dementia; delusions; "believes she is being persecuted". Patient is not disposed to injure others, nor suicidal; no filthy or destructive habits. She has not been restrained or confined. Supposed cause of the disease is senility. Treatment: none. On personal examination, as stated above.

May 21 On admission, was put on I.W. (G. H. N. Rpt. Complexion quite dark: hair gray: eyes hazel: Condition of skin, dry & rough: large & small scar on forehead: Is dirty: right knee somewhat swollen: Teeth: upper, 4: lower: 10: Behavior quiet. Talks quite rational).—

Mar 1 - June 1 - 1901 Patient received on ward bathed & put to bed; scar noticed on right leg, also one on the forehead extending from left side of face half way over the forehead. The latter scar was produced by an operation for cancer performed by Dr. Mayo. Patient at first very much disturbed would not remain in bed. Slept well at night during the time: seems weak and feeble. May 29 - fell out of bed during the night cut small gash in forehead over the left eye in three places. Patient seemed quite weak and debilitated. Very stupid: unable to converse: mumbles incoherently to herself. Is very untidy in habits. Bowels inclined to be loose, stools thin and dark; troubled the first day with nausea and frequent emesis. Temperature at time of admission was 99.2°: pulse. 78: respiration 18 for the next six days there was an increase of temperature, Tem. 101.4° P. 100: R. 26: finally temperature fell to 98° P. 92: R. 10. Appetite was poor. It finally became necessary to feed artifically, was given stimulants during the day, hypnotics at night. Patients remained in bed, was invariably untidy and sleepless requiring hypnotics restless during the day. Has realized nothing since her admission. June 8 visited by friends. June 13 became catamose and died at 4:40 from exhaustion in senile dementia. Wt. 100#

Died

Personal and Medical History of

Personal and Medical History of Emma Swanberg

Whole No. 5826

Residence, Stillwater, Minnesota

Date Admission, 23rd May 1901.

Admitted by Dr L. A. Linton hour, 7 30 PM

How Sent, Frank F. Wilson, Jr P. Washington County

Sex, Female Age, 21

Civil Condition, Single

Children, One

Age Youngest Child, 4 Years.

Occupation, Not stated: living at home father: Stone mason

Degree Education, Common School.

Profession, Religion, Lutheran

Habits, Not stated: father a Drinker

Nativity, Stillwater, Minnesota: parents born in Sweden.

Physicians Committing, B. J. Merrill and T. C. Clark

Correspondents, S. J. Swanberg Stillwater, Minn

No. of Year, 189.

Insane Relatives, unknown

Cause Exciting, unknown

Cause Predisposing, not stated

Form, Pubescent Insanity

Accompanying Bodily Disorder, none mentioned

Suicidal or not, not —

Date of this Attack, November 1900.

Duration, about 6 months

No. of Attack, 1st —

No. of Admission, 1st —

Age First Attack, 20+

Time of Leaving, November 26 – 1901.

Time in Hospital, 6 mos: 3 ds

Result, Improved: Disgd. May 10 – 1902 by B of C

EXAMINATION ON ADMISSION BY DR. L. A. Linton *Date of* May 24/1901

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: generally Correct

REASONING POWER, Ordinary Subjects,
Special Subjects, somewhat impaired
Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Has had delusions of persecution

HALLUCINATIONS, of hearing: thinks some people use profane language directed to 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, Gradual

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

Father, Living

Paternal Relatives, —

Mother, Living

Maternal Relatives, —

Brothers and Sisters, 4 brothers one child

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
— nothing —

HABITS, Drinking and Smoking, apparently 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, regular.
Sleeps poorly: appetite not very good:

Personal and Medical History of Emma Swanberg

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in PRESENT WEIGHT, 124# USUAL WEIGHT, NUTRITION, —

WOUNDS, Abnormalities and condition of Skin, normal

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

PUPILS, Equality, Size, Response to Light, and Accommodation, equal normal yes yes

SIGHT, Good

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

HEARING, Good

COORDINATION, Arms, good Legs, good Grasp, other tests, good

TREMORS, Hands, Tongue, Facial Muscles, General, none

PATELLAR REFLEX, present Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow, Good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none fairly strong normal

Apex Beat, Regularity, normal regular

ARTERIES,
normal

LUNGS, Chest, Symmetry, Expansion, Sym 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, Genitals normal: uterus free: normal in position: enlarged: Cervix congested: patulous: lacerated: Os gaping & eroded: endometritis, leucorrhoea

MENSTRUATION, troubled with

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 *Emma Swanberg*

1901

This patient was brought here by Deputy Peter Haystrom attended by S. J. Swanberg, in fair physical condition, and with following history of case. No history of consanguinity: if any history of insanity, unknown. This is 1st attack: first symptoms manifested in November 1900, by assaulting a neighbor. Disease seems increasing: not variable: no rational intervals: Derangement now shown by delusions of persecution + threatening to do bodily (harm or) injury to neighbors: using obscene + filthy language. Is disposed to injure others but is not suicidal: propensity not active: no filthy + destructive habits. As to any previous peculiarities, not known: father a drinker: as to any severe disease &c or head-injury, unknown: She has not been restrained or confined. Cause of the disease is unknown. Treatment: none. On personal examination, She shows delusions as to persecution; incoherency in conversation, and ideas.

May 23 On admission, was put on T.W. (G.H.N.Pft. Complexion, dark: hair brown: eyes gray: Condition of skin normal: is dirty: Teeth: upper 10 and 2 roots: lower: 13 and 3 roots. - Behavior quiet. Talks quite rational).

Summary of 14 day record Dict. by Dr. O.C. Strycardale.

May 23. 1901 Admitted on Inf. W. bathed and put to bed, during 14 days. Gen. Pl. + Res. about normal, appetite good bowels regular, slept well at night, quiet in behavior, somewhat depressed, May 31 visited by brother assists some with ward work, takes out door exercise. June to Sept July 5 + 6 visited by brother, Aug. 1 menstruating, Aug. 21 became very violent towards nurses, threatened suicide, from that time on she was very bad. Aug 25 menstruating, Aug 31 Wt, 115 1/4 #. Sept. to Dec. Sept. 20 menstruating, receive regular gynecological treatment three times a week, Oct. 17 menstruated, also Nov. 15, Nov. 25 visited by brother, Wt, 123#. Nov. 26 taken home by brother.

Discharged Improved by B.J.C.

Personal and Medical History of

Personal and Medical History of Mary Kelliher

Whole No. 3827 — Because resident of State 3 yrs ago; " " County 3 yrs ago

Residence, St Paul. Minn.

Date Admission, 24th May 1901 (Ex? Apl 27/1901)

Admitted by Dr. C. L. Chapple hour, 7.30 PM

How Sent, Edmund W. Bazille. Jof P. Ramsey County

Sex, Female Age, 35

Civil Condition, married

Children, None

Age Youngest Child,

Occupation, Housewife: Husband, a moulder.

Degree Education, Common School

Profession, Religion, Catholic —

Habits, Not intemperate

Nativity, Ireland: Parents also born there.

Physicians Committing, Arthur Sweeney and Daniel Paul

Correspondents, John J. Kelliher (Husband) 1174 E. Minnehaha St. St Paul

No. for Year, 190.

Insane Relatives, unknown

Cause Exciting, unknown

Cause Predisposing, previous attack.

Form, Melancholia Acute

Accompanying Bodily Disorder, (Skin Dry + scaly)

Suicidal or not, Suicidal propensity active

Date of this Attack, about 6 weeks ago

Duration, — about 6 weeks —

No. of Attack, 2nd: (one, six months ago)

No. of Admission, 1st

Age First Attack, 34+

Time of Leaving, October 14 — 1901.

Time in Hospital, 4 mos - 20 ds

Result, Improved.

Discharged by Board of Control April 14 - 1902

EXAMINATION ON ADMISSION BY DR. L. A. Linton *Date of* May 25/1901

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, appreciates

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks brain gone & skull filled with water —

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). — no —

Father, Died of Heart disease

Paternal Relatives, —

Mother, Died of some alimentary trouble

Maternal Relatives, —

Brothers and Sisters, 2 brothers: 3 sisters (Children nine -)

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

HABITS, Drinking and Smoking, Habits good

HEADACHES, VERTIGO, ~~OR CONVULSIONS~~,

OCCUPATION, Healthy or not, —

Detail Date, Duration, and Character of Previous Attack, if any,
6 months ago, an attack, lasting 2 months.

Sleep, Appetite, and Bowels, Constipated
Bowels — irregular —

Personal and Medical History of Mary Kelliher

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4in PRESENT WEIGHT, 130½ lbs USUAL WEIGHT, NUTRITION, Fair

WOUNDS, Abnormalities and condition of Skin,

TONGUE, Coatings or Promptness of Movement, Prompt: thick, white Coat.

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

SIGHT, Good

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

HEARING, Good

COORDINATION, Arms, Good Legs, good Grasp, other tests, good

TREMORS, Hands, Tongue, Facial Muscles, General, none

PATELLAR REFLEX, present Other Reflexes, Elbow, wrist

ARTICULATION, Slurred, Hesitating, Slow, good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, None Strength, Strong Sounds, Normal Size, Normal
Apex Beat, Regularity, regular

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Yes Good

Breath Sounds, good. 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: uterus gravid: cervix soft: os closed: mucous membrane of vagina and cervix of a characteristic purplish hue. February, time of last menstruation.

MENSTRUATION, Has not menstruated for three months.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Does not sleep

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). Claims to have been sent from Contagious ward of City Hospital, in St Paul. On questionating & history & general appearance point to a recent attack of measles. Says it affected her eyes & that she still sees flashes of light. Patient is somewhat depressed. Thinks her brain gone, because she is dull and cannot use her mind as she formerly did —

Personal and Medical History of *Mary Kelliher*

1901

This patient was brought here by Deputy E. Johnson, attended by John. J. Kelliher in apparently fair physical condition & with following history of case. There is no history of consanguinity; if any heredity, unknown: no history of any previous peculiarities, intemperance, severe disease &c, or head-injury. This is not 1st attack: one occurred 6 months ago, duration two months, when she was sent to St. Joseph's Hospital: treatment apparently beneficial. First symptoms of this attack manifested about 6 weeks ago: began to be melancholy. Disease seems increasing: variable & with rational intervals, but these not regular. Derangement now shown in that she complains that her head is filled with water and believes God is punishing her for sins. Patient is not disposed to injure others. Has not attempted suicide, but propensity is now active. No filthy or destructive habits. She has not been restrained or confined. Cause of the disease, unknown. Has had general medicinal treatment. On personal examination, She is melancholy, desires to die & believes that she has committed some unknown sin, for which God is punishing her. ———

NB. Patient was, on 27th day of April 1901, committed to the Detention State Hospital. Certificate & Warrant to that effect, & also a statement that she has not improved & therefore sent here, for care & treatment. Certificate duly signed May 24/1901 —

May 24 On admission, was put on T.W. (S. A. N. K. H. Complexion dark: hair black: eyes brown: Condition of skin, dry & scaly: Eruptions on body & arms: is clean. Teeth: upper 10: Lower 9. — Behavior, nervous & talkative. (Has delusions) —

Summary of 14 day record Dict. by Dr. O. C. Heyerdale.

May 24. 1901 Admitted on Inf. West bathed and put to bed, patient has eruption of measles on body, is melancholy and very quiet. First Week Tem. Pl. & Res. about normal, appetite good, bowels regular, slept quite well at night, eruption on body anointed with vaseline and gradually disappeared. patient cries a great deal and worries, shows some improvement, Second Week same. May 31 Wt. 120#.

June to Sept. June 28 patient is quite melancholy, takes outdoor exercise, assists some with ward work, is pregnant, July 4 visited by husband Aug. 31 Wt. 147#.

Sept to Dec. Oct. 14 patient considerably improved mentally, neat in habits and appearance, assists with ward work, rather sleepless, at times worries as to the outcome of her pregnancy, Oct. 14 sent home this A. M.

— Discharged —

Personal and Medical History of

Personal and Medical History of Hannah Carlson

Whole No. 5829. Became resident of State 13 years ago. " " County 13 " "

Residence, St Paul, Minn

Date Admission, 27th May 1901.

Admitted by Dr. L.A. Linton hour, 7.30 PM

How Sent, Edmund W. Bazille, Jail. Ramsey Co

Sex, Female Age, 32.

Civil Condition, Single

Children, none

Age Youngest Child, —

Occupation, Cook: Father, Car Janitor (?)

Degree Education, Common School

Profession, Religion, Congregational

Habits, not intemperate

Nativity, Sweden: parents also born there.

Physicians Committing, D. H. Johnson and Arthur Sweeney

Correspondents, Peter Carlson
854 Van Buren St. St Paul

No. of Year, 192.

Insane Relatives, one Cousin on mother's side insane.

Cause Exciting, Unknown

Cause Predisposing, possibly heredity

Form, Melancholia Acute

Accompanying Bodily Disorder, none mentioned

Suicidal or not, has suggested self-destruction

Date of this Attack, January 1901

Duration, about 5 months

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 31st

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. L. A. Linton *Date of* May 29/1901.

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, not on religious subjects
Own Mental State, appreciates

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Religious delusions

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, 5 months

ONSET, Gradual or Sudden, Sudden

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Living — Father Drinks
Paternal Relatives, unknown
Mother, Living
Maternal Relatives, unknown
Brothers and Sisters, one brother + one sister living one sister died of scrofula

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
nothing

HABITS, Drinking and Smoking, Good

HEADACHES, VERTIGO, OR CONVULSIONS, headache

OCCUPATION, Healthy or not, Cook

Detail Date, Duration, and Character of Previous Attack, if any,
none

Sleep, Appetite, and Bowels,
poor poor regular

Personal and Medical History of Hannah Carlson

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 7in PRESENT WEIGHT, 130lb USUAL WEIGHT, NUTRITION, good

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, Coated: prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, left larger normal Yes

SIGHT, Good

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

HEARING, Good

COORDINATION, Arms, Good Legs, good Grasp, other test, Romberg on one foot: turning quickly + standing eyes shut poor

TREMORS, Hands, Tongue, Facial Muscles, General, none

PATELLAR REFLEX, Present Other Reflexes, absent

ARTICULATION, Slurred, Hesitating, Slow, Good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none strong

Apex Beat, Regularity, intermittent and slow

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Sym 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, Genitals normal: hymen intact: very anaemic: uterus dextro-retroverted, adherent on right: cervicitis, leucorrhoea.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleeps fairly well

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 is quiet + talks quite sensibly Memory seems good: says she feels depressed: there appears to be no objective cause for this! Has delusions of a religious nature, but has not talked sufficiently freely to reveal them — says she has "Crying Spells". —

Personal and Medical History of Hannah Carlson

1901

This patient was brought here by Deputy Sheriff Johnson, attended by Betsey Carlson, in good physical condition, and with following history of case. There is no history of consanguinity. One cousin, on mother's side, insane. This is 1st attack; first symptoms manifested in January 1901, by delusions of a religious nature. Disease appears increasing; variable and with rational intervals, but these not regular. Derangement now shown in that she "hears voices", Commanding her to lead religious life; calling her a sinner and telling her to go out and do good; prays a great deal. Is not disposed to injure others: has not attempted suicide, but has suggested self-destruction: no filthy or destructive habits. No history of previous peculiarities, intemperance, severe disease &c or head-injury. She has not been restrained or confined. Cause of the disease unknown: treatment, rest. On personal examination, patient is melancholy, restless, sleepless, "hears voices", (hears delusions of a religious nature).

May 27 On admission, was put on T.W. (G.N.R.R.) Complexion fair: hair light: eyes blue: condition of skin normal: is clean: Teeth; upper 6: lower: 6: Quiet: talks rational).

Summary of 14 day record, Dict by Dr. A. C. Heyerdale

May 27-1901 Admitted on Inf. W, bathed and put to bed, very melancholy during 14 days Tem. Pl. & Res. practically normal, appetite good, bowels regular, Second Week Continues very melancholy, is very quiet and rather listless, assists slightly with ward work, neat in habits and appearance, attempted to run away on June 3, patient up on ward May 31 Wt. 119½ #.

June to Sept. June 27 visited by sister, July 19 commenced work in the laundry, July 27 attempted to run away from laundry three times, Aug. 5 visited by father, Aug. 30 Wt. 130 #. Sept to Dec. General health slightly improved, is still melancholy, Oct. 25 went home this morning.

Dec to Feb 1903 No change. Wt about 123 #. May 14-1902 visited by sister. Gen. health good: eats & sleeps well: attends Chapel assists with the work: clean in habits: tidy in appearance: menstruates regularly. Is pleasant and agreeable: answers questions quite intelligently aside from her delusions. At times talks to herself in a delusional and incoherent way.

Personal and Medical History of

Personal and Medical History of Sarah A. Vaughn (Vaughan)

Whole No. 5831. Became resident of Minnesota 1873

Residence, Austin, Minn. " " County of Mower 1873

Date Admission, 28th May 1901.

Admitted by Dr L. A. Linton hour, 7.30 PM

How Sent, A. S. Washburn, Jo P. Mower County

Sex, Female Age, 72.

Civil Condition, married

Children, Five

Age Youngest Child, Thirty-four

Occupation, Housekeeper: husband, laborer.

Degree Education, Common School

Profession, Religion, Methodist

Habits, No history of intemperance

Nativity, New York State: father's Ny. Mothers New Jersey

Physicians Committing, E. Washburn Rodgers & A. W. Allen

Correspondents, J. P. Fairbanks

address of family Physician Dr Washburn Rodgers } Austin, Minn

No. of Year, 194

Insane Relatives, none

Cause Exciting, not given

Cause Predisposing, probably age

Form, Senile Dementia

Accompanying Bodily Disorder, varicose veins in both legs

Suicidal or not, Suicidal

Date of this Attack, Five weeks ago

Duration, Five weeks

No. of Attack, 3rd (one, 2 years ago: one, 6 yrs ago)

No. of Admission, 1 5th

Age First Attack, about 64

Time of Leaving, 16th June 1901.

Time in Hospital, 19 days

Result, Recovered: Discharged Nov 30/1901. Dmp

EXAMINATION ON ADMISSION BY DR. L. A. Linton Date of May 29/1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

MEMORY, Past Events, Poor for examination - Valuable information -

Recent Events, Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State, Does not realize

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, 1

ONSET, Gradual or Sudden, Gradual: progressive

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

Father, apoplexy

Paternal Relatives,

Mother, Tuberculosis

Maternal Relatives,

Brothers and Sisters, Children 4 — 3 Daughters - 1 Son.

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Nothing

HABITS, Drinking and Smoking, Habits Good

HEADACHES, VERTIGO, OR CONVULSIONS, Sick headache: early in life Subject to violent attacks of headache

OCCUPATION, Healthy or not, Housework

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

Sleep, Appetite, and Bowels, would go to sleep suddenly then waken up about 2 o'clock then would follow a violent attack appetite poor - delusions about eating - bowels constipated —

Personal and Medical History of Sarah A. Vaughn

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3½ PRESENT WEIGHT, 94½ lbs USUAL WEIGHT, NUTRITION, poor

WOUNDS, Abnormalities and condition of Skin, normal

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

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

SIGHT, poor

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Cataract in both eyes.

HEARING, Fair Finger touch, eyes shut, good

COORDINATION, Arms, good Legs, good Grasp, Standing on 1 foot, poor

TREMORS, Hands, None Tongue, Facial Muscles, Fine General, None Standing, eyes shut, good

PATELLAR REFLEX, present Other Reflexes, wrist & elbow.

ARTICULATION, Slurred, Hesitating, Slow, hesitates & stutters

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, aortic Stenosis and mitral regurgitation Fairly strong somewhat enlarged:

Apex Beat, Regularity, regular apex beat covered by left

ARTERIES, Sclerotic

LUNGS, Chest, Symmetry, Expansion, Dym Poor

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, Labia Atrophied: urethral Carnucle: genitals otherwise normal: uterus enlarged, hard, probably beginning tumor: retroverted: os gaping: cervix apparently cancerous.

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Slept fairly well, first nights.

BOWELS, Present Condition,

Early in the attack, patient was insane in the morning: every afternoon, there would be a lucid interval: this alternation occurred until about 4 days ago, since when there has been no time during which she was rational. She is at times violent & seems to suffer; at others, she is quiet & moody. 30 May 29

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). She had a so-called "fainting spell," during which she fell: complained of being cold, at the time. Patient said to have been a very hypopathetic person & easily worried by sorrow & cares of the friends. Has been morbid over religious matters & lack of sympathy & affection on part of her other daughters. This is not a delusion as she says the daughters has not been to the mother what they might to have been. Attempted suicide by taking Kerosene & gasolene —

Personal and Medical History of Sarah A. Vaughn

1901

This patient was brought here by Deputy Sheriff N. Nicholson, attended by C. Vaughn, in fair physical condition, and with following history of case. There is no history of consanguinity nor heredity. This is not 1st attack; others have occurred, one 2 years, and one, 8 years ago: duration about three months: was never sent away, to hospital. First symptoms of this attack manifested five weeks ago: would not eat, and was morbid, on religious subjects. Disease seems increasing: is not rational: now, she is deranged on all subjects. Is disposed to injure others & has attempted suicide, by medicine: no filthy or destructive habits. Before the accession of the disease, she has been morbid on religious subjects. There is no history of intemperance, nor of any severe disease &c, or head-injury: has been restrained at home. Cause of the disease not stated. She has been given nerve sedatives and supporting treatment. On personal examination, mind seems very dull & ideas incoherent. She is committed because she needs care & treatment while under restraint, & is dangerous to others.

May 28 On admission, was put on T.W. (G.H.N. R/pt. Complexion fair: hair gray: eyes blue: condition of skin dry: is clean: varicose veins on both legs: no teeth; behavior quiet; is somewhat resistive: expressed no delusions).

Summary of 14 day record Dict. by Dr. L. Linton.

a May 28, 1901. patient received on ward: bathed and put to bed: neat in habits tidy in appearance: is quiet: answers questions when addressed: at times refuses nourishment; requires cathartics: appetite not very good: stomach very much dilated & prolapsed: has lavage of stomach: May 29 visited by son: sleeps very little at night: May 31 visited by two lady friends: During 14 days Tem. Pl. & Res. normal. June to Sept June 2 up on ward: seems to be worried about home: June 3 refused breakfast; is quite excited and at times resistive: walks restlessly about the ward: June 6 visited by two friends also on June 8 by daughter and friend: talks quite intelligently: went out riding with daughter. June 10-12-15 visited by daughter Wt. 81½#. June 16 went home.

Discharged

Personal and Medical History of

Personal and Medical History of Mary Peterson

Whole No. 5831 Became resident of Minnesota - 18 years
Residence, Afton, Washington County " County 18 "
Date Admission, 4th June 1901.
Admitted by Dr L. A. Linton hour, 7.30 PM
How Sent, Frank. J. Wilson, Jofl. Washington Co
Sex, Female Age, 54
Civil Condition, married
Children, 5 (five) -
Age Youngest Child, Eight years
Occupation, Housewife (husband, laborer)
Degree Education, Common
Profession, Religion, Lutheran
Habits, If intemperate, unknown
Nativity, Sweden: parents also born there
Physicians Committing, E.O.B. Freligh and J.E. Clark
Correspondents, Louis Wigen, Afton, Minn
Peter Peterson, Afton, Minn (husband's brother)

No. of Year, 197
Insane Relatives, unknown
Cause Exciting, sickness
Cause Predisposing, "Chronic"
Form, Mania Subacute
Accompanying Bodily Disorder, (Deafness).
Suicidal or not, not
Date of this Attack, during past 2 years
Duration, — about 2 years
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 52 (about)
Time of Leaving, 16th July 1901.
Time in Hospital, 1 mo 1 w 2 ds
Result, Recovered: discharged Nov 27/1901.

EXAMINATION ON ADMISSION BY DR. L. A. Linton Date of June 4/1901

MENTAL CHARACTERISTICS.

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

Patient deaf + speaks only in Faunic accents from gue, + nothing obtainable.

HISTORICAL.

LENGTH INVASION,
ONSET, Gradual or Sudden, Gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Dead
Paternal Relatives,
Mother, Dead
Maternal Relatives,
Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
not known

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

Sleep, Appetite, and Bowels,
poor good

Personal and Medical History of Mary Peterson

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 3/4 PRESENT WEIGHT, 109 # USUAL WEIGHT, NUTRITION, Poor
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt: thick white coating
PUPILS, Equality, Size, Response to Light, and Accommodation, unequal Left small eye right Right normal unright
SIGHT, poor
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Cataract of left eye.
HEARING, Deaf in right ear: very poor, in left.
COORDINATION, Arms, good Legs, good Grasp, other tests, good.
TREMORS, Hands, Tongue, Facial Muscles, General, none
PATELLAR REFLEX, Exaggerated Other Reflexes, none
ARTICULATION, Slurred, Hesitating, Slow, good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, None weak normal
Apex Beat, Regularity, Normal regular: slow

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,
Atheromatous
LUNGS, Chest, Symmetry, Expansion, Slow Good
Breath Sounds, Normal
Consolidation in right apex.

Color and Appearance,

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

GYNECOLOGICAL EXAMINATION, Urethral Caruncle: Laemorrhoids: perineum lacerated: mucous membrane of vagina + cervix much congested: uterus normal + free: os gaping.
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 sleeps very well: seems quiet: Her attendant, at time of admission, said that Mrs Peterson is quiet + sensible: works about house + seems sane on all subjects, except religious ones. She made herself a perfect nuisance in the Norma Church, + this was given as the reason for her removal from home. Examination revealed nothing, as Patient does not understand English.

Personal and Medical History of Mary Peterson

1901

This patient was brought here by Louis Wigen attended by Mrs Louis Wigen in poor physical condition, and with following history of case. If any consanguinity, not stated: if any heredity unknown: This is 1st attack; first symptoms manifested during past 2 years: the disease appears increasing: not variable: no rational intervals: Derangement now shown on subject of religion; revelation to preach new Gospel: insists on speaking at public Church-meetings, thus interrupting and disturbing the meetings. Is not disposed to injure others, nor suicidal: no filthy or destructive habits. As to previous peculiarities, nothing special. If any history of intemperance, unknown: Had severe illness 5 or 6 years ago She has not been restrained or confined. Supposed cause of the disease is sickness.- Treatment: none. On personal examination, patient is excitable, claimed to be commissioned to preach: Soul left her body, went to heaven and received a special command to preach. On admission, was put on IW. (G. H. N. Dpt. Complexion dark: hair brown: eyes blue: condition of skin normal: Scars on both legs, also scratch on right leg: is clean: left eye blurred: is quite deaf: Teeth: upper four: lower, three: behavior quiet: does not speak English).

June 4

Summary of 14 day record Dict. by Dr. L. Linton

June 4. 1901 Admitted on ward bathed and put to bed: has scars on both lower limbs: hearing poor: blind in left eye: appetite fairly good requires cathartics: is quite neat and clean in habits & appearance: sleeps fairly well: June 8 up on ward: takes out door exercise: Tem. Pl. and Res. during 14 days normal: is very little with the other patients quite agreeable: attends chapel: assists with work on the ward: July 16 visited by husband and taken home.

Discharged

Personal and Medical History of

Personal and Medical History of Laura M. Whited

Whole No. 5841. Became resident of State of Minnesota? always lived here
" " of Olmsted County? Born in Olmsted Co.

No. of Year, 204

Residence, Douglas, Olmsted Co. Minn.

Date Admission, 13th June 1901

Admitted by Dr. C. L. Chapple hour, 3.15 pm

How Sent, J. G. Leonard, Jof P. Olmsted County

Sex, Female Age, 28

Civil Condition, married

Children, — one —

Age Youngest Child, 13

Occupation, Housework; husband, Stage driver

Degree Education, Common School

Profession, Religion, Methodist

Habits, probably good

Nativity, Genoa, Minnesota; father's, Cleveland, Ohio; Mother's, New York

Physicians Committing, E. M. Clay and H. H. Witherstine

Correspondents, Mrs. Dennis Tyler (mother)
Douglas, Minn

Insane Relatives, Father, Grand-mother & aunt

Cause Exciting, Heredity

Cause Predisposing, Heredity

Form, Melancholia Acute

Accompanying Bodily Disorder, pelvic disease

Suicidal or not, not

Date of this Attack, February 1901.

Duration, about 4 months

No. of Attack, 1st —

No. of Admission, 1st —

Age First Attack, 27+

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. L. A. Linton *Date of* June 14/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events,

Recent Events, Could not determine Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Dull

REASONING POWER, Ordinary Subjects,

Special Subjects, Could not determine

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Could not determine

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, Could obtain nothing on examination, as patient would not talk

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

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

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

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

Sleep, Appetite, and Bowels,

Personal and Medical History of Laura M. Whited

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6½ in PRESENT WEIGHT, 98 lbs USUAL WEIGHT, NUTRITION, poor

WOUNDS, Abnormalities and condition of Skin, Lateral Curvature of spine; Condition of skin normal.

TONGUE, Coatings or Promptness of Movement, Coated: fairly prompt

PUPILS, Equality, Size, Response to Light, and Accommodation, Equal Normal Yes Yes

SIGHT, Good

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

HEARING, Good

COORDINATION, Arms, good Legs, good ~~Grasp,~~ other tests good.

TREMORS, Hands, Tongue, Facial Muscles, General, none tremor none none

PATELLAR REFLEX, present Other Reflexes, elbow — wrist

ARTICULATION, Slurred, Hesitating, Slow, hesitating and slow

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none weak normal

Apex Beat, Regularity, Irregular: slow normal

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Gym fair

Breath Sounds, râles & dull area in left sub-clavicular region.

CRANIAL MEASUREMENTS.

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

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

Albumen, Sugar,

Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal, except slight laceration of pernaeum cervicitis; os eroded. Fundus of uterus removed by abdominal hysterectomy

MENSTRUATION,

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, Sleep poorly.

BOWELS, Present Condition, Bowels 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, so far, has been much depressed, and, on occasions, violent & resistive. Will not converse, but, when addressed, her lips sometimes move in a whisper. Bowels are constipated; stomach irritable and much prolapsed —

1901

This patient was brought here by Sheriff E. H. Vine, attended by Mrs Ella Spurrier in poor physical condition, and with following history of case. There is no history of consanguinity, but she has insane relatives; father, grand-mother and aunt. This is 1st attack; first symptoms manifested in February 1901: melancholy at first, and violent, lately: Disease seems increasing; not variable: no rational intervals. Derangement now shown on nothing in particular. Is disposed to injure others, but not suicidal: no filthy or destructive habits: she has been very religious, previously. No history of intemperance: has been subject to pelvic disease: has been confined, forcibly, to the house. Supposed cause of the disease is heredity: has been given treatment for nervous system. On person examination it is found she has had abdominal hystrosectomy. —

June 13 On admission, was put on T.W. (G.H.N. R'pt. Complexion dark: hair light brown: eyes blue: Condition of skin normal: bruises on both limbs: is clean: slight curvature of the spine: Teeth: upper, twelve: lower, fourteen: Is nervous, but very quiet: talks but very little). —

Summary of 14 day record Dict. by Dr. O. C. Heyerdale.

July 13 1901 Admitted on Inf. W. bathed & put to bed, scar on abdomen due to operation, several small bruises on limbs. First Week Tem. Pl. & Res. practically normal, given liquid diet, at times refuses nourishment. Second Week was given medicine and feedings of egg nog by tube twice daily, very restless, given hypnotics, very melancholy, converses but little, is stupid, up and dressed on July 19, When out doors on July 20 attempted to escape. Aug. 10 visited by sister-in-law, 11 by father and her son, 12 by two lady friends, 16 & 18 son and friends, Aug. 28 given massage, Aug 29 Wt. 119#.

Sept. to Oct. Patient improved some works most of the time in the laundry, also assists some with the ward work, Sept. 1 visited by relatives, Sept 7 went camping at Oronoco Sept. 17 returned from camp, Oct. 23 trans. to A 3 West. Nov. 19 visited by mother, Nov. 22 Wt. 123#, general health fair, is quite agreeable, assists with dining room work, receives gynecological treatment three times a week.

Dec to Feb. 1903 No change. Jan. & 3rd - '01 Visited by friends. Feb 2 was visited by father and son / March 29th Visited by her sister.
Apr. 18th by friends. Patient is in rather failing health and complains of not sleeping well: appetite good: bowels regular: takes out door exercise: assists at times with the work: is nervous, at times disagreeable occasionally violent & resistive. Generally it becomes necessary to compel her to leave the table as she refuses to do so when the others leave the dining room. At times uses profane language.
Is quarrelsome with the patients and quite resistive.
Sept. 21st Visited by brother and sister-in-law. Dec 1st Wt 116½#

Personal and Medical History of Clarinda Quinette

Whole No. 5842.
Residence, Sheldon, Minn
Date Admission, 13th June 1901. —
Admitted by Dr E. J Wagoner hour, 9 15/60 PM
How Sent, L. Brisdall, Jail. Houston County
Sex, Female Age, 66.
Civil Condition, widowed
Children, Six
Age Youngest Child, died at age of nine: 21 years ago
Occupation, Housekeeper
Degree Education, Common school education
Profession, Religion, Presbyterian
Habits, Formerly good
Nativity, New York: Father's Nty: Mother's Nty
Physicians Committing, L. K. Ansgard and O. F Fischer
Correspondents, William Quinette (Son) Sheldon, Minn
Family Physician if Dr. D. C. Rhines California Minn

No. of Year, 205
Insane Relatives, mother
Cause Exciting, no particular cause
Cause Predisposing, Hereditary
Form, Melancholia Agitata
Accompanying Bodily Disorder, Very marked Emaciation.
Suicidal or not, Not
Date of this Attack, In December 1900.
Duration, about 6 months
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 65th
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. L. A Linton Date of Jan 14/901

MENTAL CHARACTERISTICS.

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

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

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

REASONING POWER, Ordinary Subjects,
Special Subjects, Somewhat impaired
Own Mental State, Does not appreciate

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

DELUSIONS, Systematized, Transitory, Special Subjects,
None Determined

HALLUCINATIONS, 0

ILLUSIONS, 0

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, Mother and nephew Insane Died of Senility
Paternal Relatives,
Mother, Insane
Maternal Relatives,
Brothers and Sisters, 6 4 2 brothers living
3 sons (Children)

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Nothing

HABITS, Drinking and Smoking, Good
HEADACHES, VERTIGO, OR CONVULSIONS, None
OCCUPATION, Healthy or not, Housewife
Detail Date, Duration, and Character of Previous Attack, if any, —

Sleep, Appetite, and Bowels, very Constipated, fair Poor

Personal and Medical History of Clarinda Quinette

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 9in PRESENT WEIGHT, 83# USUAL WEIGHT, NUTRITION, Poor
WOUNDS, Abnormalities and condition of Skin, very dark: inclined to be pigmented
TONGUE, Coatings or Promptness of Movement, slight coat: prompt
PUPILS, Equality, Size, Response to Light, and Accommodation, equal normal yes
SIGHT, Wears glasses
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal
HEARING, Good
COORDINATION, Arms, good Legs, good Grasp, other test good.
TREMORS, Hands, Tongue, Facial Muscles, General, none
PATELLAR REFLEX, present Other Reflexes, elbow — wrist
ARTICULATION, Slurred, Hesitating, Slow, good
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, aortic stenosis: mitral regurgitation 2d/4 systolic
Apex Beat, Regularity, regular: slow. Heavy (over) left

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: marked pulsation of abdominal aorta
Left side more prominent — poor
LUNGS, Chest, Symmetry, Expansion,
Breath Sounds, normal
Pupils Nov 11th Lt Nov 11th

EXAMINATION URINE, Quantity, — Sp. g. 1003 Reaction, acid Color and Appearance, Pale yellow Cloudy
Albumen, Heat 0 — nitric acid 0 — Tanstic 0 — Sugar, Fehling's Sol. 0 — Bismuth 0 —
Casts and Crystals, a few uric acid crystals: Epithelium a few cells

GYNECOLOGICAL EXAMINATION, Urethral carnucle: genitals normal: cervix atrophied: uterus adherent, hardened & enlarged: purulent leucorrhoea: haemorrhoids —
MENSTRUATION,
OPHTHALMOSCOPIC EXAMINATION,
BLOOD, Corpuscles, Hæmoglobin,
SLEEP, Present Amount and Character, Sleeps fairly well.
BOWELS, Present Condition, Bowels 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 quiet: sleeps fairly well: bowels torpid. Stomach prolapsed, pit at sternum boards at level of umbilicus — left portion of fundus extends down to crest of ilium — Washings of stomach show much mucus and catarrhal exudate.

1901

This patient was brought here by T H Erens, attended by Mrs Lucy Parish, in poor physical condition, and with following history of case. There is no history of consanguinity, but mother insane. This is 1st attack; first symptoms manifested in December 1900: talking to herself, calling for someone and tearing her clothes. Disease seems increasing. Variable; has rational intervals: has rational intervals in the morning: occasionally, in the afternoon, is rational; as a rule, becomes irrational. Derangement now shown on no particular subject: she screams, and undress and dress without occasion: pinches and scratches herself; occasionally & refuse to eat. Is not disposed to injure others, nor suicidal: no filthy or other habits except disposition to tear clothing. No previous peculiarities noted: father sometimes would get intoxicated: no mention of any severe disease &c or head-injury: has not been restrained or confined. No particular cause for the disease: physician called, but refused to take his medicine. On personal examination, there is found very marked Emaciation: expression of face and the Eye shows mental trouble. Commitment of said Clarinda Quinette recommended for reason 5 of

June 13 Section 17. On admission, was put on I.W. (G.H. N. R'pt. Complexion dark: hair gray: eyes brown: condition of skin dry: is ovity: Teeth; lower four & one root: upper, one & 1 root - Behavior quiet: talks quite rational).

Summary of 14 day record Dict. by Dr. O. C. Heyerdale.

July 13 1901 Admitted on Inf. West. bathed & put to bed, during 14 days Tem. Pl. & Res. about normal, given regular diet, First Week liquid diet given occasional hypnotics, very melancholy, talks quite intelligently is very much emaciated and yellow. Second Week same. Aug 31 Wt 94#.

Sept. to Dec. Given electrical and gynecological treatments, patient has delusion that her bowels do not move at all, very melancholy, no change or improvement noted, Nov. 12 Wt. 86#

Dec to Feb 1903 No change. Wt about as usual.

Personal and Medical History of Emily G. Shiverick

Whole No. 5843. Became resident of State – 1896. " " of County – 1896.

Residence, St Paul, Minn

Date Admission, 14th June 1901.

Admitted by Dr. L. A. Linton hour, 7.30 P.M.

How Sent, E.W. Dazelle, Supt. Ramsey County

Sex, Female Age, 65.

Civil Condition, widow

Children, –

Age Youngest Child, 37.

Occupation, Housekeeping for family: Husband (?) Merchant

Degree Education, Common School

Profession, Religion, Unity Universalist

Habits, probably good – not intemperate

Nativity, Michigan: Father's, New York: Mother's, New York

Physicians Committing, John C. Nelson and Arthur Sweeny

Correspondents, none given in papers

No. of Year, 206

Insane Relatives, none

Cause Exciting, senility

Cause Predisposing, probably age

Form, Senile Dementia

Accompanying Bodily Disorder, none mentioned

Suicidal or not, Suicidal propensity active

Date of this Attack, 2 months ago

Duration, – 2 months –

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, – 65.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. L. A. Linton Date of June 15/1901

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, Does not appreciate

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

DELUSIONS, Systematized, Transitory, Special Subjects, Has the delusion that she is possessed of great wealth: thinks she can communicate, at will, with people at a distance

HALLUCINATIONS, 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, 3 months

ONSET, Gradual or Sudden, –

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

Both grandmothers died of paralysis – apoplexy – tuberculosis.

Father, Died of apoplexy

Paternal Relatives, grandmother paralyzed

Mother, Tuberculosis

Maternal Relatives, Grandmother paralyzed

Brothers and Sisters, 5 – 2 brothers dead also 2 sisters 4 – one sister died with ovarian tumor – 2 children – 1 living

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Lipoma removed from left shoulder

HABITS, Drinking and Smoking, –

HEADACHES, VERTIGO, OR CONVULSIONS, Yes catarrhal headaches, seemingly.

OCCUPATION, Healthy or not, Yes School-teacher before marriage then housework –

Detail Date, Duration, and Character of Previous Attack, if any, Has slept poorly until about 10 Days before admission to hospital – appetite good – bowels regular.

Sleep, Appetite, and Bowels,

Personal and Medical History of Emily G. Shiverick

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2 PRESENT WEIGHT, 146½ lbs USUAL WEIGHT, NUTRITION, Good.

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, clean: prompt

PUPILS, Equality, Size, Response to Light, and Accommodation, equal normal Yes Yes

SIGHT, wears glasses

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

HEARING, Good Finger tests, eyes shut, fair: Standing on foot: not well done

COORDINATION, Arms, Good Legs, good Grasp, Turning quickly: " " Standing, eyes shut: " " Swaying motion: Equilibrium poor –

TREMORS, Hands, Tongue, Facial Muscles, General, none

PATELLAR REFLEX, absent Other Reflexes, absent

ARTICULATION, Slurred, Hesitating, Slow, Good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none strong normal

Apex Beat, Regularity, normal regular

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Sym 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, Urethral mucous membrane prolapsed: has incontinence of urine: Genitals normal: posterior lip of cervix entirely adherent to posterior wall of vagina: fundus of uterus not clearly palpable.

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 did not sleep well as she was afraid to go to sleep. Refused to have thermometer when temperature was being taken in morning after admission. Resents the fact that she has been brought here under the pretense that she was accompanying her son-in-law to the hospital for treatment. She thinks both her daughter and son-in-law insane. She believes that she has charge of a wireless telephone system and can communicate at will all over the world. In every other way she seems quite normal. Her memory is good: and her statements are trustworthy, according to the history given by her son-in-law Mr. George –

Personal and Medical History of *Emily G. Shiverick*

190¹

This patient was brought here by J.F. George, in good physical condition & with following history of case. There is no history of consanguinity, nor heredity. This is 1st attack: has never been in hospital: first symptoms of this attack manifested two months ago by hallucinations and delusions: disease seems increasing: variable & with rational intervals: but these, not regular. Derangement now shown in that she believes that her relatives and friends are insane, and carries on telepathic communications with people in various parts of the country. Is disposed to injure others: has not attempted suicide, but the propensity is now active: Is of filthy and destructive habits. For past two years she has developed eccentricities and peculiarities of conduct. There is no history of intemperance in patient & parents: no severe disease &c or head-injury. She has not been restrained or confined. Supposed cause of the disease is senility. Treatment, none.-

On personal examination, she talks freely of her delusions and hallucinations-

June 14 On admission, was put in T.W. (G.F. N. R'ft. Complexion dark: hair, brown & gray; eyes hazel: Condition of skin normal: scar on back: is clean: Teeth on plate: Quite resistive: effluvia delusions).

June 14, 1901 Summary of 14 day records. Dict by Dr. Heyerdale.

Patient was received on Infirmary West: very resistive and violent: bathed and put to bed: scar on back due to some operation: slept very little during the night: became quite disturbed. Tem. was taken. During first week Tem. P. and R. about normal: appetite good: cathartics given for bowels occasionally. Patient slept well each night during the week after the first night. Patient seems very well physically: is restless: has hallucinations of hearing imagines that she is spoken to through the telephone and receives the news in that way. During second week Tem. P. & R. about normal appetite good: occasional cathartic for bowels: up and about the ward during the second week: at times quite resistive; especially when medicine was given: quite disturbed: slept well during the night as a rule, at times restless and would be up and out of bed. Last day of week took out door exercise

June to Sept. Patient extremely delusional, has hallucinations of hearing, tells about being telephoned to from various cities, frequently complains of being sick is hypochondriacal, otherwise is quite agreeable, Sept. 6 visited by friends, Sept. 22 trans. to A. 2 W. Oct. 6. visited by relatives, Oct. 13 by Rev. Doran, occasionally becomes somewhat disturbed. Nov. 26 Wt. 150 #.

Dec to Feb 1902 Visited by lady friends on Jan. 23rd '02, also on Feb. 11th,

May 3rd visited by Rev. Doran from town. May 29th by relatives.

July 13th by relatives and friend. Dec. 21st by friends & Rev. Doran.

Jan. 14th. visited by Rev. Doran.

Personal and Medical History of

Personal and Medical History of Mary Rheinhart or Mary Rameters 7/9/1901

Whole No. 5846. When became resident of State, unknown
Residence, Unknown; " " County, unknown
Date Admission, 18th June 1901.
Admitted by Dr. L. A. Linton hour, 7.30 PM.
How Sent, Edmund W. Bazille J.P. Ramsey County
Sex, Female Age, 51 Years
Civil Condition, Married
Children, Two (?)
Age Youngest Child, not known
Occupation, Housewife; (husband's, unknown)
Degree Education, Common School
Profession, Religion, Catholic -
Habits, unknown
Nativity, Germany: Parents also born there.
Physicians Committing, William Dinwoodie M.D. Griffith
Correspondents, none given in papers
X 7/9/1901 -- See attached slip

No. of Year, 209.
Insane Relatives, unknown
Cause Exciting, Unknown
Cause Predisposing, unknown
Form, Melancholia Chronic
Accompanying Bodily Disorder, (Varicose Veins) -
Suicidal or not, Yes, by hanging; Propensity now active
Date of this Attack, unknown
Duration, unknown -
No. of Attack, not stated
No. of Admission, 1st
Age First Attack, not given
Time of Leaving, July 1st 1902
Time in Hospital, 1 Year 16 Days
Result, Improved: Dept. Dec 17 - 1902 By B of C.

EXAMINATION ON ADMISSION BY DR. L. A. Linton Date of June 20/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Confused: somewhat sluggish
MEMORY, Past Events,
Recent Events, Poor Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Dull: incorrect, apparently
REASONING POWER, Ordinary Subjects,
Special Subjects, Impaired
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Indifferent
DELUSIONS, Systematized, Transitory, Special Subjects,
Could not determine
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, Unknown
ONSET, Gradual or Sudden,
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father,
Paternal Relatives, Nothing obtainable
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Could not determine
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 Mary Rheinhart

Telephone Book: page 229

DISCLOSES HER IDENTITY.

Missing Woman From Chaska Found in Rochester Asylum.

Rochester, Minn., Special, July 20.—Through the medium of a letter written this week by an inmate of the insane hospital here to her daughter a puzzling case of mysterious disappearance has been satisfactorily, if not happily, cleared up.

Sometime during the month of May last Mary, the wife of Henry Ramekers of Chaska, disappeared without warning and although her husband made unremitting search for her no trace could be found.

About the time she left home a woman was taken into custody in St. Paul who was wandering in the streets in such a mental condition as to be unable to give a clear account of herself. A week's detention seemed to only make her worse, and she was, on June 18, committed to the hospital here in the hope that she might recover. She was registered here as Mary Rheinhart, which accounts for her husband's failure to find her here, although he searched the records for her name. A day or two since she had so far recovered the use of her wits that she wrote a letter to her daughter, Lena Ramekers, at Chaska. The address on the letter recalled to the authorities here the futile search that had been made by Henry Ramekers, and he was at once communicated with. The unfortunate woman proved to be his wife, and the family will be reunited as soon as Mrs. Rameker's condition will admit of her removal to her home. She is believed to be on the road to complete recovery.

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St. Paul.
streets in a demented condition and taken to the city hospital of that place. After a week there she showed no signs of improvement and was taken into the probate court. She claimed to be Mrs. Rheinhart but was able to give no account of herself or tell anything that would lead to identification. She was too unbalanced to know her own name.

Accordingly she was committed to the Rochester state hospital, June 18. She came here in a disturbed condition and was at times very destructive. Though questioned frequently she imparted no clue as to her relatives or friends.

Yesterday afternoon "Mrs. Rheinhart" wrote a letter directing it to Miss Lena Ramekers. When the letter was handed to Dr. O. C. Heyerdale, the name arrested his attention. He remembered that there had been inquiries as to the whereabouts of a missing Mary Ramekers.

Could this be any relative?

Closely he questioned the patient and finally she admitted that she had written the letter to her daughter, Lena. At first the woman could not be convinced that if her young daughter's name was Ramekers, hers must be Ramekers too, but she at length stated that her husband's name was Henry Ramekers. With this clue as to the identity of the strange woman committed from St. Paul, Dr. Heyerdale began investigations and soon found that Mary Rheinhart was in reality Mary L. Ramekers, wife of Henry Ramekers of Chaska.

As he became possessed of the facts and put them at the patient, who is now more rational than at any time since her confinement, she gave such information as to establish beyond a doubt her identity. The letter to Lena Ramekers was not mailed. Instead a telegram was sent late last night to Henry Ramekers informing him that his long-sought wife had been found.

Mrs. Ramekers still has delusions and it will be necessary to keep her at the hospital for some time until she is improved much more than at present. But the discovery will be a cause of much joy to the anxious husband. He feared at first that she had been committed to a hospital or asylum, but when a woman named Ramekers could not be found at any of the state institutions, he gave her up for dead. It is hoped that a visit from her husband will do much toward clearing up her clouded intellect.

Bull
mekers. Chaska. Minn
was committed as
rt" Identified "to day"
by M.J.K.

RISTICS.
EIGHT, NUTRITION, Fair
prompt.
Grasp, Other tests, good
Other Reflexes, Elbow
ecent
Good
ating, Slow,
Sad, Etc.
rmal
nds, Size,
pular,
Good
Expansion,
rmal

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,

uantity, Sp. g. Reaction,
Sugar,

NATION, Genitals normal: uterus retroverted. fundus & cervix both
posterior lip of cervix shows polypoid hypertrophy: Cervicitis
& corrhoea.
INATION,
in,
aracter, Sleeps well
Constipated

of the present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the
revious mental grade, and any physical impairment). Patient seems quiet & indifferent,
as are concerned, Examination failed to elicit any information. Answers
y irrelevant, so it was impossible to determine the exact mental condition.
several different answers to the same question. She does not
much of anything.

Personal and Medical History of Mary Rheinhart or Mary Ramekers 7/29/1901

Whole No. 3846. When became resident of State, unknown

Residence, Unknown; " " County, unknown

Date Admission, 18th June 1901.

Admitted by Dr. L. A. Linton hour, 7.30 P.M.

How Sent, Edmund W. Hazelle J.P. Kansey County

Sex, Female Age, 51 years

Civil Condition, Married

Children, Two (?)

Age Youngest Child, not known

Occupation, Housewife; (Husband, unknown)

Degree Education, Common School

Profession, Religion, Catholic -

Habits, unknown

Nativity, Germany: Parents also born there.

Physicians Committing, William Dinwoodie & W. Gilfillan

Correspondents, None given in papers

X 7/29/1901 - - See attached slip

No. of Year, 209.

Insane Relatives, unknown

Cause Exciting, Unknown

Cause Predisposing, unknown

Form, Melancholia Chronic

Accompanying Bodily Disorder, (Varicose Veins)

Suicidal or not, Yes, by hanging; Propensity now active

Date of this Attack, unknown

Duration, unknown -

No. of Attack, not stated

No. of Admission, 1st

Age First Attack, not given

Time of Leaving, July 1st 1902

Time in Hospital, 1 Year 16 Days

Result, Improved: Dept Dec 17 - 1902 By B of C.

EXAMINATION ON ADMISSION BY DR. L. A. Linton Date of June 20/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events,

Recent Events, Poor Special Subjects,

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

REASONING POWER, Ordinary Subjects,

Special Subjects, Impaired

Own Mental State,

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Could not determine

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, Unknown

ONSET, Gradual or Sudden,

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

Father, Nothing obtainable

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Could not determine

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,

Medical History of Mary Rheinhart

RISTICS.

VEIGHT, NUTRITION, Fair

prompt.

Grasp, Other tests. good

present

Other Reflexes, Elbow

, Hesitating, Slow,

Good

Paretic, Sad, Etc.

Normal

h, Sounds, Size,

y, Regular,

Good

Expansion,

normal

CRANIAL MEASUREMENTS.

Circumference Horizontal,

Circumference Verto-Mental,

Naso-Occipital Arc,

Binauricular Arc,

Ant-Post Diameter,

Transverse Diameter,

Binauricular Diameter,

Facial Length,

Length-Breadth Index,

Volume,

Peculiarities in Shape,

uantity, Sp. g. Reaction, Color and Appearance,

Sugar,

s,

NATION, Genitals normal: uterus retroverted. fundus & cervix both

posterior lip of cervix shows polypoid hypertrophy: Cervicitis

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Constipated

of the present Mental and Physical Condition (the nearest type of Insanity, the most probable cause, the previous mental grade, and any physical impairment). Patient seems quiet & indifferent, as are concerned. Examination failed to elicit any information. Answers ly irrelevant, so it was impossible to determine the exact mental condition. several different answers to the same question. She does not much of anything.

Bishop & Storrs Co.
Telephone Orders Solicited
Chicago, Milwaukee & St. Paul Railway
Fresno and Reedley Stage.
New York and Reedley Stage via Wisconsin Central Railway
Fresno and Reedley Stage.
Pier Bishop & Storrs Co.

In Telephone Book: page 229

Ramekers. Chaska. Minn

kers was committed as
nhart" - Identified "a day"
go A.J.K.

FOUND IN A HOSPITAL.

Insane Woman Unconsciously Reveals Her Identity.

A woman who has been missing from her home in Chaska for more than seven weeks has been found in this city. Mary Ramekers, a patient at the Rochester State Hospital, has at last unconsciously given the key to her identity and will soon be united to the husband who has been searching in vain for his missing wife.

Mrs. Ramekers has been lost to the knowledge of her loved ones through the simple fact that she changed her name when examined in the probate court in St. Paul. In a weak and trembling hand she wrote a name that the judge interpreted as Mary Rheinhart. Thus he called her during the examination, and to this name she has clung during all the days of her confinement at the state hospital.

The discovery of the woman's identity came about in a peculiar manner. Early in June, Mrs. Henry Ramekers wandered from her home in Chaska to St. Paul. She was found on the streets in a demented condition and taken to the city hospital of that place. After a week there she showed no signs of improvement and was taken into the probate court. She claimed to be Mrs. Rheinhart but was able to give no account of herself or tell anything that would lead to identification. She was too unbalanced to know her own name.

Accordingly she was committed to the Rochester state hospital, June 18. She came here in a disturbed condition and was at times very destructive. Though questioned frequently she imparted no clue as to her relatives or friends.

Yesterday afternoon "Mrs. Rheinhart" wrote a letter directing it to Miss Lena Ramekers. When the letter was handed to Dr. O. C. Heyerdale, the name arrested his attention. He remembered that there had been inquiries as to the whereabouts of a missing Mary Ramekers.

Could this be any relative?

Closely he questioned the patient and finally she admitted that she had written the letter to her daughter, Lena. At first the woman could not be convinced that if her young daughter's name was Ramekers, hers must be Ramekers too, but she at length stated that her husband's name was Henry Ramekers. With this clue as to the identity of the strange woman committed from St. Paul, Dr. Heyerdale began investigations and soon found that Mary Rheinhart was in reality Mary L. Ramekers, wife of Henry Ramekers of Chaska.

As he became possessed of the facts and put them at the patient, who is now more rational than at any time since her confinement, she gave such information as to establish beyond a doubt her identity. The letter to Lena Ramekers was not mailed. Instead a telegram was sent late last night to Henry Ramekers informing him that his long-sought wife had been found.

Mrs. Ramekers still has delusions and it will be necessary to keep her at the hospital for some time until she is improved much more than at present. But the discovery will be a cause of much joy to the anxious husband. He feared at first that she had been committed to a hospital or asylum, but when a woman named Ramekers could not be found at any of the state institutions, he gave her up for dead. It is hoped that a visit from her husband will do much toward clearing up her clouded intellect.

Personal and Medical History of Mary Rheinhart or Mary Ramekers

Whole No. 5846. When became resident of State, unknown

Residence, Unknown: " " County, unknown

Date Admission, 18th June 1901.

Admitted by Dr. L. A. Linton hour, 7:30 P.M.

How Sent, Edmund W. Bazille J. of P. Ramsey County

Sex, Female Age, 51 Years

Civil Condition, Married

Children, Two (?)

Age Youngest Child, not known

Occupation, Housewife; (husband's, unknown)

Degree Education, Common School

Profession, Religion, Catholic -

Habits, unknown

Nativity, Germany: Parents also born there.

Physicians Committing, William Dinnoodie and J. G. Gilfillan

Correspondents, none given in papers

X 7/29/1901 - - See attached Ship

No. of Year, 209

Insane Relatives, unknown

Cause Exciting, Unknown

Cause Predisposing,

Form, Melancholia

Accompanying Bodily Disor

Suicidal or not, yes, b

Date of this Attack,

Duration,

No. of Attack,

No. of Admissio

Age First Attack,

Time of Leavin

Time in Hos

Result, 1902

EXAMINATION ON ADMISSION BY DR. L. A. L. of June 20/1901

MENTAL CHARAC

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Confused: somewhat sluggish

MEMORY, Past Events,

Recent Events, Poor Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Dull: incorrect, apparently

REASONING POWER, Ordinary Subjects,

Special Subjects, Impaired

Own Mental State,

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Indifferent

DELUSIONS, Systematized, Transitory, Special Subjects,

Could not determine

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.

unknown

ing Insanity, Consanguinity, Epil-

s, Hysteria, Inebriety, Consumption).

Nothing obtainable

Paternal Re s,

Mother,

Maternal Relatives,

Brothers and Sisters,

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

Could not determine

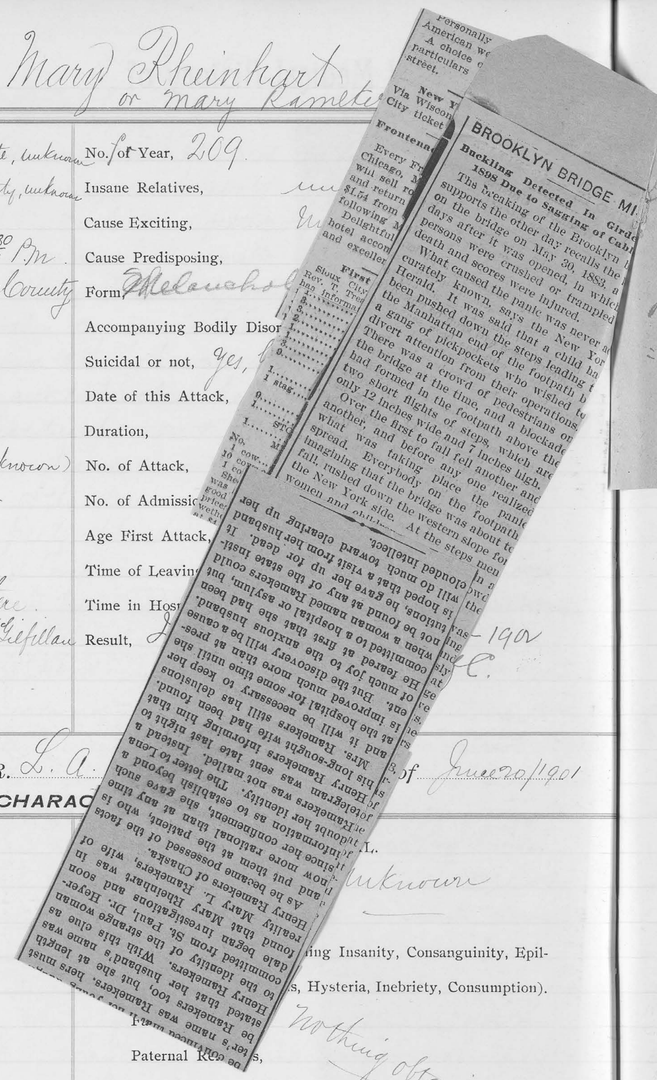
HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not,

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

Sleep, Appetite, and Bowels,



BROOKLYN BRIDGE MI

Buckling Detected In Girde

1898 Due to Sagging of Cab

This weakening of the Brooklyn b supports the other day recalls the on the bridge on May 30, 1883, a days after it was opened, in which persons were crushed or trampled death and scores were injured. What caused the panic was never ac curately known, says the New York Herald. It was said that a child ha been pushed down of the steps leading t the Manhattan end of the footpath b a gang of pickpockets who wished to divert attention from their operations There was a crowd of pedestrians on the bridge at the time, and a blockade had formed in the footpath above the two short flights of steps, which are only 12 inches wide and 7 inches high. Over the first to fall fell another and another and before any one realized what was taking place the panic spread. Everybody on the footpath imagining that the bridge was about to fall, rushed down the western slope pen the New York side. At the steps men women and children.

Personal and Medical History of Mary Rheinhart

July 29 - paid Note on Telephone Book: page 229

Mr. Henry Ramekers. Chaska. Minn

Mary Ramekers was committed as "Mary Rheinhart" - Identified today"

JAK.

...RISTICS.

...VEIGHT, NUTRITION, fair

... prompt.

Grasp, other tests, good

PATELLAR REFLEX, present Other Reflexes, Elbow

ARTICULATION, Slurred, Hesitating, Slow, Good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, None

HEART, Murmurs, Strength, Sounds, Size, Strong normal

Apex Beat, Regularity, regular, but slow - normal

ARTERIES, Normal

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

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: uterus retroverted. fundus & cervix both hypertrophied: posterior lip of cervix shows polypoid hypertrophy: Cervicitis

MENSTRUATION, Leucorrhoea.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, 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). Patient seems quiet & indifferent, so far as the emotions are concerned. Examination failed to elicit any information. Answers to questions were mostly irrelevant, so it was impossible to determine the exact mental condition. Would sometimes give several different answers to the same question. She does not seem to realize much of anything.

Personal and Medical History of Mary Rheinhart or Mary Rameters 7/29/1901

Whole No. 5846. When becam

Residence, Unknown: "

Date Admission, 18th June 19

Admitted by Dr. L. A. Linton

How Sent, Edmund W. Bazille J

Sex, Female Age,

Civil Condition, Married

Children, Two (?)

Age Youngest Child, not Knoc

Occupation, Housewife; (

Degree Education, Common

Profession, Religion, Catholic -

Habits, unknown

Nativity, Germany: Parents also born there

Physicians Committing, William Dinwoodie and J. S. Gilfillan

Correspondents, none given in papers

× 7/29/1901 --- see attached Ship

Age First Attack,

Time of Leaving,

Time in Hospital,

Result, Impr

only 12 inches wide and 7 inches high. Over the first to fall fell another and another, and before any one realized what was taking place the panic spread. Everybody on the footpath imagining that the bridge was about to fall, rushed down the western slope for the New York side. At the steps men women and children

EXAMINATION ON ADMISSION BY DR. L. A. Linton

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events,
Recent Events, Poor Special Subjects,

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

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

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Could not determine

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.

LENGTH INVASION

ONSET, Gradual or S

HEREDITY (Question Epil-
epsy, Paralysis, S tion).
Father,
Paternal Relativ
Mother,
Maternal Relativ
Brothers and Sis

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Could not determine

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,

be convinced that if her young ... ter's name was Rameters, hers must be Rameters too, but she at length stated that her husband's name was Henry Rameters. With this clue as to the identity of the strange woman committed from St. Paul, Dr. Heyerdale began investigations and soon found that Mary Rheinhart was in reality Mary L. Rameters, wife of Henry Rameters of Chaska.

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Mrs. Rameters still has delusions and it will be necessary to keep her at the hospital for some time until she is improved much more than at present. But the discovery will be a cause of much joy to the anxious husband. He feared at first that she had been committed to a hospital or asylum, but when a woman named Rameters could not be found at any of the state institutions, he gave her up for dead. It is hoped that a visit from her husband will do much toward clearing up her clouded intellect.

Personal and Medical History of Mary Rheinhart

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4½ PRESENT WEIGHT, 134# USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, Slight Coating: prompt.

PUPILS, Equality, Size, Response to Light, and Accommodation, equal normal yes yes.

SIGHT, Poor

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

HEARING, good

COORDINATION, Arms, good Legs, good Grasp, other tests, good

TREMORS, Hands, Tongue, Facial Muscles, General, Slight tremor Slight tremor none none

PATELLAR REFLEX, present Other Reflexes, elbow

ARTICULATION, Slurred, Hesitating, Slow, Good

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none Strong normal
Apex Beat, Regularity, normal regular, but slow.

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Igm 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, Genitals normal: uterus retroverted: fundus & cervix both hypertrophied: posterior lip of cervix shows polypoid hypertrophy: cervicitis

MENSTRUATION, Leucorrhoea.

OPHTHALMOSCOPIC EXAMINATION,

BLOOD, Corpuscles, Hæmoglobin,

SLEEP, Present Amount and Character, 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). Patient seems quiet & indifferent, so far as the emotions are concerned. Examination failed to elicit any information. Answers to questions were mostly irrelevant, so it was impossible to determine the exact mental condition. Would sometimes give several different answers to the same question. She does not seem to realize much of anything.

Personal and Medical History of *Mary Rheinhart*

1901

This patient was brought here by Deputy-Sheriff Johnson, attended by Emma Johnson, in poor physical condition. History of case is rather meagre: place of residence, when she became resident of State & County, as to any consanguinity, or heredity, when first Symptoms of attack manifested or in what way; as to any previous peculiarities, history of intemperance, any severe disease &c, or head injury, all is unknown: Number of attack is not stated: Disease seems increasing; not variable; no rational intervals. On what subject, or in what way, Derangement not manifested, is unknown: found wandering on street, by police: Is not disposed to injure others, but has attempted suicide, by hanging & frequently is very active: destroys clothing: has been in City Hospital, St Paul, one week. Cause of the disease is unknown: Treatment at City Hospital; Symptoms increasing. On personal Examination, can give no connected account of herself. N.B. Patient, on June 10 - 1901 was committed to the "Detention State Hospital". Certificate endorsed as warrant Committing her here.

June 18 On admission, was put on T.W. (S. H. R'ft. Complexion dark: Hair brown: Eyes Hazel: Condition of skin Normal: had vermin: is dirty: Varicose veins in both limbs: Teeth: two lower: no upper: Behavior quiet: talked very little: Expressed no delusions). —

June 18 Summary of 14 day record Dict. by Dr. Henderdale.

Patient received on Infirmary Ward: bathed and put to bed. was very dirty quiet in behavior: Tem. P. & R. normal: appetite good: bowels somewhat constipated, given occasional cathartics. During first week patient was very quiet: talks quite intelligently: neat in habits and appearance: Remains quietly in bed during day: is depressed: sleeps well at night. Tem. P. & R about normal second week: appetite good: bowels regular: quiet in behavior: takes her medicine well: second day of week up on ward: takes outdoor exercise at times patient becomes somewhat disturbed and does not sleep well. While out walking on June 30 patient tried to escape. July first was very noisy was given hypnotics to quiet her. June to Sept. 1901 Patient became quite disturbed mentally says someone tried to choke her, talks some to herself, is melancholy and stupid, Aug. 12 visited by friends, menstruates regularly, Aug. 31 Wt. 141 #. Sept. to Dec. receives gynecological treatment three times a week: sept 10. menstruated: Sept. 26 became quite disturbed and destroyed three dresses; and tied an apron tight around her neck attempting suicide: is neat and clean: converses intelligently: assists with ward work: takes out door exercise: attends chapel and amusements: Oct. 6 menstruated: Oct. 25 became disturbed and threw a chair at a nurse: Oct. 29 menstruated also Nov. 20: Oct. 29 trans. to D. 3 West: was more excited than usual: expresses a number of delusions: complains of a pain in her back: Nov. 30 Wt. 144 #. Dec to Mar. 1902. Jan. 6 menstruating: is melancholy: takes out door exercise: Assists with ward work: Feb. 20 menstruating: complains of severe

Personal and Medical History of

pains in back: is agreeable most of the time: Feb. 27 Wt. 143 #.

June 2. Scolds and is disagreeable at times; menstruates regularly: attends amusements: Assists with work: takes exercise Wt. 150 #.

Is at times disturbed, cries and seems depressed: takes out door exercise works in dining room June 1 menstruating June 2 and 3 complained of headache in bed: June 4 visited by husband & taken home.

Personal and Medical History of Rebecca Chase

Whole No. 5853.
Residence, Dodge County, for 20 years, last past.
Date Admission, 24th June 1901 -
Admitted by Dr. E. G. Hanous hour, 7:30 PM
How Sent, J. C. Harvey, Jail. Hennepin County
Sex, Female Age, 82 Years Aug 31 1818
Civil Condition, widower
Children, two
Age Youngest Child, 38.
Occupation, Housewife
Degree Education, Yes: Common School
Profession, Religion, not a church member
Habits, No history of Intemperance.
Nativity, New Hampshire: Parents also born there.
Physicians Committing, Oscar K. Richardson and R. D. Malchar
Correspondents, Adelaide Chase Dearborne (Daughter)
No regular Physician: 1st 3101 - 2nd ave. So. Minneapolis Minn

No. of Year, 216.
Insane Relatives, None
Cause Exciting, Unknown
Cause Predisposing, probably age
Form, Senile Dementia
Accompanying Bodily Disorder, Some weakness -
Suicidal or not, Not, but has threatened others.
Date of this Attack, about 2 years ago
Duration, probably about 2 years
No. of Attack, 1st
No. of Admission, 1st (Sixteen in Jones-Harris Home)
Age First Attack, about 80
Time of Leaving, Jan. 18, 1905.
Time in Hospital, 3 yrs 6 mo. 24 days
Result, Died.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* June 26/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick: Confused
MEMORY, Past Events, poor
Recent Events, poor Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert
REASONING POWER, Ordinary Subjects, poor
Special Subjects,
Own Mental State, Does not think she is insane
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal
DELUSIONS, Systematized, Transitory, Special Subjects, Says that she has been sent to Hospital because some one wishes to get her property" -
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, 2 Years ago
ONSET, Gradual or Sudden, Gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, negative. Died of old age
Paternal Relatives, Negative
Mother, Dead, of old age
Maternal Relatives, negative
Brothers and Sisters, None
Two children - both living -
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
once had Malaria
HABITS, Drinking and Smoking, Good, as she says.
HEADACHES, VERTIGO, OR CONVULSIONS, -
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
Sleep, Appetite, and Bowels, Somewhat Constipated. Good fair

Personal and Medical History of Rebecca Chase

HH/301
No. 5853
M Rebecca Chase
Copy of Order for Hearing Petition of Adelaide Dearborne for appointment of as guardian for Said Rebecca Chase — insane; served and ~~service admitted~~ filed 13th June 1901.
(Papers filed with commitment papers.)
Hearing on 1st July 1902 - at Court House Minneapolis

ACTERISTICS.

SUAL WEIGHT, NUTRITION, fair
at Arcus Senilis present in both eyes.
Grasp, Other tests good and fair
TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor superficially
PATELLAR REFLEX, Administered
Other Reflexes, exist present
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Mitral Regurgitation and aortic stenosis about normal
Apex Beat, Regularity, Regular
ARTERIES, Slight Sclerosis
LUNGS, Chest, Symmetry, Expansion, Yes 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,

Passed Jan 16th Ed. Jan 16th
EXAMINATION URINE, Quantity, — Sp. g. 1016 Reaction, acid Color and Appearance, Yellow clear & showed flaky Dep. -
Albumen, Heat & Nitric acid & Tanets & Sugar, Fehlings Sol & Benedicts &
Casts and Crystals, a few uric acid crystals; waxes amor: Epithelium, a few cells. -
GYNECOLOGICAL EXAMINATION, Genitals normal: Haemorrhoids: uterus free: ante-flexed - Anterior lip of cervix atrophied: posterior lip hard: somewhat hypertrophied:
MENSTRUATION,
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 fair physical condition: Sleeps well at night & has fair appetite: Mentally, she is active: is restless during the day & out of bed frequently: In her talkative and says "She is not insane but has been sent to the Hospital because some one wishes to get her property away from her". She, evidently has many delusions, which she has not expressed as yet. Patient has only very limited education. She talks quite rationally on many subjects. -

Personal and Medical History of Rebecca Cha

Whole No. 5853.
Residence, Dodge County for 20 years, last past.
Date Admission, 24th June 1901.
Admitted by D. E. J. Wanous hour, 7:30 PM
How Sent, J. C. Harvey, Jo. P. Hennepin County
Sex, Female Age, 82 Years and 3 1818
Civil Condition, widower
Children, two
Age Youngest Child, 38.
Occupation, Housewife
Degree Education, Yes: Common School
Profession, Religion, not a church member
Habits, No history of Intemperance.
Nativity, New Hampshire: Parents also born there.
Physicians Committing, Dean K. Richardson & R. D. Malcha
Correspondents, Adelaide Chase Dearborne (Daughter)
No regular Physician: 3101 - 2nd ave. So. Minneapolis Minn

No. for Year, 216.
Insane Relatives, Non
Cause Exciting, Unknown
Cause Predisposing, probably
Form, Senile Dementia
Accompanying Bodily Disorder, Some weak
Suicidal or not, Not, but has threatened to
Date of this Attack, about 2 years ago
Duration, probably, about 2 years
No. of Attack, 1st
No. of Admission, 1st (Broken in Jones-Harrison Home)
Age First Attack, about 80
Time of Leaving, June. 18, 1905.
Time in Hospital, 3 yrs 6 mo. 24 days
Result, Died.

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* June 26/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick: Confused
MEMORY, Past Events, poor
Recent Events, poor Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert
REASONING POWER, Ordinary Subjects, poor
Special Subjects,
Own Mental State, Does not think she is insane
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Normal

DELUSIONS, Systematized, Transitory, Special Subjects, Says that she has been sent to Hospital because some one wishes to get her property" -
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, 2 years ago
ONSET, Gradual or Sudden, Gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
negative
Father, Died of old age
Paternal Relatives, Negative
Mother, Dead, of old age
Maternal Relatives, negative
Brothers and Sisters, None
two children - both living -
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
no had Malaria
HABITS, Drinking and Smoking, Good, as she says.
HEADACHES, VERTIGO, OR CONVULSIONS, -
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
Good fair
Sleep, Appetite, and Bowels, Some what Constipated.

Personal and Medical History of Rebecca Chase

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft - PRESENT WEIGHT, 103 lbs 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, Yes natural large Good good
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, None arcus senilis present in both eyes.
HEARING, good
COORDINATION, Arms, fair Legs, fair Grasp, Ataxic tests good and fair
TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor Slight tremor
PATELLAR REFLEX, diminished Other Reflexes, unit present
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, Initial regurgitative and aortic stenosis slight accentuated
Apex Beat, Regularity, Normal regular
ARTERIES,
Slight sclerosis
LUNGS, Chest, Symmetry, Expansion, Yes 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,

Passed Jan 16th Ex. Jan 16th
EXAMINATION URINE, Quantity, — Sp. g. 1016 Reaction, acid Color and Appearance, Yellow clear & slight flaky Dep. -
Albumen, Heat o Nitric acid o Tanret o Sugar, Fehling's Sol. o Bismuth o
Casts and Crystals, a few uric acid crystals: urates amor: Epithelium, a few cells. -

GYNECOLOGICAL EXAMINATION, Genitals normal: Leucorrhoea: uterus free: ante-flexed - anterior lip of cervix atrophied: posterior lip hard: Vaginal hypertrophied.
MENSTRUATION,
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 fair physical condition: sleeps well at night & has fair appetite: mentally, she is active: is restless during the day & out of the ordinary: delusional and says she is not insane - but has been sent to the Hospital because someone wishes to get her property away from her". She, evidently, has many delusions, which she has not expressed. as yet. Patient has only very limited education. She talks quite rationally, on many subjects. -

Personal and Medical History of Rebecca Chase

1901

This patient was brought here by Phil. P. Megarden, attended by Mr. Howell, in poor physical condition, with following history of case. There is no history of consanguinity nor heredity: This is the first attack: first symptoms manifested about 2 years ago: loss of memory; suspicious of immoral practices by others. Disease seems increasing. With acquaintances, her conversation is never free of references to immoral practices. Derangement now shown on the subject of immoral practices by others; by talking with acquaintances: loss of memory: wanders away from home: inability to find her way from place to place: sudden fits of anger. She has not shown a disposition to injure others, but has threatened: not suicidal: no filthy, or destructive habits: no previous peculiarities manifested: no history of intemperance, nor of any severe disease or head injury. No restraint or confinement has been employed, except mild restraint at home, for 9 months. Cause of the disease unknown. No special treatment. Friends, for past 9 days, have had patient in "Jones-Harrison Home" for aged women, on trial: her condition is such that Authorities of "Home refuse to have her there. In her Examination, she showed, by her answers, extreme forgetfulness: otherwise talked rationally. The patient did nothing marked: was quiet in manner. It fully appears, from the testimony of others, that the Patients' mania, as to immoral practices, has been carried to such an extreme, that suspicions against her friends may induce her, if physically able, to do bodily harm to others. Commitment recommended, because she has threatened daughter: it is reasonably certain, by her threats & otherwise, that she has dangerous tendencies: She wanders about & is exposed to want of food or shelter: She wanders about & is exposed to accidents: the disease is of such a nature as to require, for her recovery, care and treatment, which under legal restraint. her disease is in such a stage as to require, for her recovery, care and treatment under legal restraint. On admission, was put on 1 W. (G.H.N. Hyt: Complexion fair: hair gray: eyes blue: condition of skin Dry: is clean. Teeth: upper plate: lower, seven. Quiet: has morbid ideas).

June 24. 1901 Summary of 14 day record. Dict. by Dr. Heyerdale

Patient received on Infirmary West; bathed and put to bed: quiet in behavior answers questions intelligently: During first week Tem. P. & R. about normal: appetite good given occasional cathartic: slept well during night: during the day quiet in behavior: neat in habits and appearance: her condition is one of slight dementia: memory is very poor; otherwise is very well. She is troublesome due to the fact that she mislays her glasses and book and goes about tearing up the beds in search for them. Is out of bed a good deal of the time during the day. 3d day dressed and up on ward: 4th day took outdoor exercise. Second week Tem. P. and R. normal: appetite good: given occasional cathartics: slept well at night: neat in habits and appearance: during day day time is up and on ward: takes out of door exercise: quiet in habits: talks intelligently: very anxious to be allowed to go home: Seemed somewhat depressed on the sixth day of the week. June to Sept. July 10 visited by daughter, July 26 trans. to A. 1 W. Aug. 31 Wt. 99#. Sept. to Dec. General health good, eats and sleeps well, talks intelligently, condition one of failing memory.

Personal and Medical History of

1901 otherwise normal, Sept. 3 visited by daughter, Nov. 27 tran. to A. 3 West, is very pleasant and agreeable on the ward, shows advanced signs of senility or loss of memory.

Dec. to Feb. 1903. Jan. 16th visited by daughters. No change. Wt about 103#
May 4, 1902 visited by friends - also on June 13th,
Sept. 1, 1902 " " daughters also on Feb. 26 - 1903.

Personal and Medical History of Mary Luxa

Whole No. 5854. Became resident of Minnesota: A.D. 1881. " " of the County A.D. 1881.
Residence, City of Winona, Minn.
Date Admission, 26th June 1901.
Admitted by Dr. O.C. Heyerdale hour, 4 00 p.m.
How Sent, D. E. Vance, J. of P. Winona County
Sex, Female Age, 60
Civil Condition, widow
Children, none: has had two: both
Age Youngest Child, dead, many years.
Occupation, Wash-woman: (husband was a farmer)
Degree Education, Can read, but cannot write
Profession, Religion, Catholic (Roman) –
Habits, habitually intemperate
Nativity, German-Poland: parents also born there
Physicians Committing, G. L. Gates and L. A. Kelly.
Correspondents, none given in papers

No. of Year, 217.
Insane Relatives, not as far as known
Cause Exciting, probably intemperance
Cause Predisposing, " " + age
Form, Senile Dementia
Accompanying Bodily Disorder, (curvature of spine ?)
Suicidal or not, not: but is violent
Date of this Attack, about 2 years ago
Duration, about 2 years.
No. of Attack, Not 1st (has continued, at intervals, for about 10 yrs)
No. of Admission, 1st – has been in "Lock up" + at "Poor Farm"
Age First Attack, About 50
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* June 27/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick, but confused
MEMORY, Past Events, poor
Recent Events, Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
alert
REASONING POWER, Ordinary Subjects, poor
Special Subjects,
Own Mental State, Does not think she is insane
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, No information
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
✓
HABITS, Drinking and Smoking, Is addicted to the excessive use of stimulants whenever she can get anything to drink
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 Mary Luxa

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1½ PRESENT WEIGHT, 171½ lbs USUAL WEIGHT, NUTRITION, good
WOUNDS, Abnormalities and condition of Skin, has a very marked kyphosis (hump-back) – has an umbilical hernia –
TONGUE, Coatings or Promptness of Movement, prompt: white, rather thick coating
PUPILS, Equality, Size, Response to Light, and Accommodation, yes normal fair poor
SIGHT, seems good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, seems good
COORDINATION, Arms, good Legs, good Grasp, standing, eyes shut, good.
TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor fine tremor
PATELLAR REFLEX, absent Other Reflexes, absent
ARTICULATION, Slurred, Hesitating, Slow, quick
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, ✓
HEART, Murmurs, Strength, Sounds, Size, none fairly strong normal
Apex Beat, Regularity, yes normal
ARTERIES, ✓
LUNGS, Chest, Symmetry, Expansion, yes 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,
Color and Appearance,

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

GYNECOLOGICAL EXAMINATION, Genitals normal, except laceration of perinaeum: rectocele prolapse of uterus: 2nd degree
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 very well nourished: she is very irritable and noisy: will not remain in bed, but is upon floor + pounds on door: is very resistive + obstinate, in manner. She has been a county charge of Winona County for several years, +, during this time, would elope + go into town, + by begging, would procure liquor + become intoxicated. Also, was in the habit of stealing any article she could carry away. –

Personal and Medical History of Mary Luxa

1901

This patient was brought here by M. J. Lins, attended by Mary A. Boynton, in fair physical condition, with following history of case. No history of consanguinity, and not of heredity, as far as known. This is not 1st attack: it has continued, at intervals, for about ten years: has not been in hospital. First symptoms of this attack manifested about two years ago: roaming around, begging, stealing articles of no use to her. Disease seems increasing: variable & with rational intervals, but these, at irregular intervals. Derangement now shown by illusions; imagines friends are dead: is refractory and uncontroable, at times: violent fits of weeping and screaming: religious excitement: attempts violence, if interfered with: Is not suicidal: propensity not active. Habits very filthy: not any previous peculiarities, as far as known. Patient habitually intemperate: uses intoxicating liquors to excess, at every opportunity: not any history of severe disease &c or head-injury, as far as known. She has been restrained or confined: very often arrested by Police & confined in "City Lock-up" — lately, has been at "Poor Farm", but cannot be controlled or kept there. Cause of the disease, probably intemperance in the use of intoxicating liquors, for ten years past. Treatment, none. On personal examination, she is restless, excitable, mind wandering; wild expression of countenance, laugh & cry, in quick succession, without cause.

June 26 On admission, was put on T.W. (G.H.N. R'pt. Complexion dark: hair gray: eyes blue: condition of skin rough: a great many small scars on body: appear like "pock-scars". abdominal herniae: is dirty: Teeth: upper two: lower, not any. Curvature of the spine: a number of small scratches on limbs & buttocks: Is quite disturbed: Expresses delusions.)

June 26. 1901 Summary of 14 day record. Dict. by Dr. Heyerdale.

Patient received on Infirmary west: very resistive when bathed: was very dirty: has curvature of the spine: has numerous small scars on body and limbs: given supper: slept well until 3:00 A.M. was noisy thereafter: was given hypodermic at 7:00 P.M. also 8:00 P.M. Refused cathartics: On second day patient up on ward being extremely noisy and resistive hard to keep in bed: refused breakfast and dinner: was given cathartic by 2:00 P.M. Amount of urine during 24 hours was 23 ozs.: slept well during the second night. During first week Tem. P. & R. about normal: took regular diet: bowels regular: slept well each night the remainder of the week. On 3 day of week patient has complete prolapse of uterus. On 4th. day patient began taking out door exercise: quite disturbed and quite resistive: wanders away from the other patients when out of doors. During the second week Tem. P. & R. about normal: takes regular diet: bowels regular: at times patient is very noisy and resistive, hard to manage: uses vile language: takes out door exercise.

June to Sept. July 12 trans. to A.1 W. Aug 4 to C.3 West. patient is old and demented is inclined to be violent with other patients, struck Mrs. Jackson in the face causing quite a severe bruise, Aug. 30 Wt. 166#. Sept to Dec. Patient is somewhat more quiet but obstinate and rather ill behand at times, quite hard to manage. Nov. 27 had tooth extracted, Nov. 21 Wt. 161#.

Dec to Feb 1903. No change. Wt about 157#.

Personal and Medical History of

Personal and Medical History of Josephine Simmons

Whole No. 5855. Became resident of State 45 yrs ago " " of Forest Lake about 30 " "

Residence, Forest Lake, Washington County.

Date Admission, 27th June 1901.

Admitted by Dr. L. A. Linton hour, 7.30 P.M.

How Sent, Frank T. Wilson, Jo. P. Washington Co.

Sex, Female Age, 45.

Civil Condition, married

Children, - 12 -

Age Youngest Child, 16 mos.

Occupation, Housewife (husband, storekeeping & farming)

Degree Education, Common School

Profession, Religion, Catholic -

Habits, probably good

Nativity, Hastings, Minn: parents born in Germany.

Physicians Committing, T. E. Clark and B. J. Merrill

Correspondents, Geo. Simmons, Forest Lake, (Son) Minn

Kate Marsh, 220 E 13th St. St Paul, Minn (sister)

No. for Year, 218

Insane Relatives, John Marsh, recently sent to Rochester, due to drink father, intemperate somewhat.

Cause Exciting, worry & change of life -

Cause Predisposing, not stated

Form, Mania Acute

Accompanying Bodily Disorder, "Change of life"

Suicidal or not, Not: but strikes husband & daughter.

Date of this Attack, about 3d of May 1901.

Duration, about 8 weeks

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, about 45.

Time of Leaving, October 23 - 1901.

Time in Hospital, 3 mos - 26 DS

Result, Recovered

Discharged by Superintendent April 9 - 1902

EXAMINATION ON ADMISSION BY DRS. Heyerdale & Linton *Date of* June 28/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick & confused

MEMORY, Past Events, poor

Recent Events, " " Special Subjects, " "

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

REASONING POWER, Ordinary Subjects, poor

Special Subjects, poor

Own Mental State, thinks she may be "slightly insane"

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
somewhat exalted

DELUSIONS, Systematized, Transitory, Special Subjects,
Thinks she is being persecuted by everyone: her own relatives &c also has delusions regarding her children: "thinks her own baby was brought to her & left at the house". Believes those about her

HALLUCINATIONS, are people from her home & calls them

ILLUSIONS, by name.

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 months

ONSET, Gradual or Sudden, ✓

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

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters,

Could not get from her

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), 12 children ✓

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, constipated (she says "poor" poor)

Personal and Medical History of Josephine Simmons

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in PRESENT WEIGHT, 134½# USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt: slight white coating

PUPILS, Equality, Size, Response to Light, and Accommodation, fair (yes normal fair)

SIGHT, good

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

HEARING, good

COORDINATION, Arms, good Legs, good ~~Grasp,~~ other tests, good

TREMORS, Hands, Tongue, Facial Muscles, General, ✓ (fine tremor fine tremor)

PATELLAR REFLEX, present Other Reflexes, Elbow: wrist: Jaw

ARTICULATION, Slurred, Hesitating, Slow, quick & clear

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, none fairly strong normal

Apex Beat, Regularity, regular normal

ARTERIES, ✓

LUNGS, Chest, Symmetry, Expansion, yes - well developed 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, perinaeum lacerated: haemorrhoids. uterus retroverted: enlarged: cervix enlarged: os patulous, gaping: mucous polypi pro-

MENSTRUATION, -jecting: cervicitis, leucorrhoea.

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 she is active & talks a great deal & in an incoherent manner. Expresses her delusions freely: will not remain in bed: is hypersensitive, as shown when physical examination was made. -

Personal and Medical History of *Josephine Simmons*

1901

This patient was brought here by J. H. Lamers, attended by Kate Marsh and Geo. Simmons, in fair physical condition, and with following history of case. As to any consanguinity not stated: Insane relatives, John Marsh, recently sent to Rochester, due to Drink. This is 1st attack: first symptoms manifested about the 3rd of May 1901 by worry, sleeplessness, delusions: disease seems increasing: not variable: no rational intervals. Derangement now shown by delusions as to personal identity; persecutions: improper conduct on part of husband and daughters. She strikes husband and daughter, but has not attempted suicide; is of filthy & destructive habits: previous peculiarities, none whatever: father addicted to intemperance, but not to excess: no history of any severe disease &c, or head-injury: no restraint or confinement. Supposed cause of the disease is worry: Change of life: has had medical attendance: sedatives at first all night later no results. On personal Examination, Confirmation of all

June 27 delusions; incoherent talking. On admission, was put on T.W. (G. H. N. Kft. Complexion dark: hair black; eyes gray: condition of skin normal: is clean. Teeth: upper set: lower, seven and one root: Examined by E. Norris. Behavior quiet: talk quite rational).

June 27 1901 Summary of 14 day record. Dict. by Dr. Heyerdale.

Patient received on Infirmary West: bathed and put to bed: quiet in behavior: was given cathartic. During first week. Tem. P & R. about normal: appetite poor for couple of days: thereafter given occasional cathartic for bowels: slept rather poorly at night. Patient began to be resistive: refused medicine: is neat in habits: has delusions of sight and hearing: thinks those around her are people from home and calls them by name. Is noisy at times: refused hypnotic: last night of week was given hot bath and hypnotic: slept well during the night. Second week. Tem. P & R about normal appetite fair: patient very much disturbed during the week: very noisy at times: cries considerably: is in seclusion a good deal of the time: sleeps rather poorly: refuses hypnotics. June to Sept. July 20 patient is noisy and resistive has many delusions, receives gynecological treatment, Aug 31 patient improving very much, at times assists with the work, talks more intelligently is less delusional, Wt. 134 1/2 #. Sept. to Dec. Sept. 2 is given electrical treatment daily, Sept. 23 electrical treatment three time a week, Oct. 8 visited by son, depressed afterwards, trans. to A. 3, Oct. 23 patient went home with son practically well, menstruated regularly.

—Discharged—

Personal and Medical History of

Personal and Medical History of Mary Mulcare

Whole No. 5858. Resident of State 33 years of County no —
Residence, Fridley, Anoka County.
Date Admission, 1st July 1901.
Admitted by Dr. L. A. Linton hour, 7.30 P.M.
How Sent, E. W. Bazille, Jeff. Ramsey County
Sex, Female Age, 33
Civil Condition, single
Children, no
Age Youngest Child, —
Occupation, Housework
Degree Education, Common School
Profession, Religion, Catholic: Roman.
Habits, not intemperate
Nativity, Minneapolis, Minn: parents born in Ireland
Physicians Committing, S. O. Francis and Ethelbert F. Geer
Correspondents, none given in papers

No. of Year, 221.
Insane Relatives, None
Cause Exciting, Congenital Defect
Cause Predisposing, previous attacks
Form, Melancholia, Chronic
Accompanying Bodily Disorder, Menstrual flow stopped
Suicidal or not, Not: but will injure others.
Date of this Attack, June 26 – 1901.
Duration, – 4 days –
No. of Attack, Not 1st (others occurred 1899 – 1897) –
No. of Admission, 1st
Age First Attack, about 29.
Time of Leaving, August 28 – 1902
Time in Hospital, 1 yr 1 mo 27 ds
Result, Died: valvular Heart Disease (37 ds)

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* July 1/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Sluggish
MEMORY, Past Events, poor
Recent Events, poor Special Subjects,
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Dull: fairly Correct on some questions.
REASONING POWER, Ordinary Subjects, poor
Special Subjects, poor.
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, one week
ONSET, Gradual or Sudden, Gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption). no history of above
Father,
Paternal Relatives,
Mother,
Maternal Relatives,
Brothers and Sisters, —
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), She says "no"
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 Mary Mulcare

44/313
5858
M Mary A. Mulcare
Copy of Order for Hearing Petition of James H. Mulcare of Anoka County – (her brother) – for appointment of Thomas F. Mulcare of Ramsey Co as guardian for said Mary A. Mulcare insane; served and service admitted —
(Papers filed with commitment papers.)
Hearing set for June 25/02 – at Courthouse, Anoka Minn

...ACTERISTICS.

...USUAL WEIGHT, NUTRITION, good
...arged thyroid gland: Condition of skin, normal
...light white coating.
...nal
...good ~~Grasp,~~ other tests, good
TREMORS, Hands, Tongue, Facial Muscles, General, —
PATELLAR REFLEX, present Other Reflexes, wrist – jerk present
ARTICULATION, Slurred, Hesitating, Slow, slow
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, —
HEART, Murmurs, Strength, Sounds, Size, Strong normal
Apex Beat, Regularity, regular
Haemic murmur at aortic orifice
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, Yes – well developed 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, Genitals normal: hymen intact: uterus retroverted. Enlarged and free: cervicitis: 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 good physical condition: takes her nourishment well: sleeps well at night: is very quiet in manner: does not talk except when questioned when she answers very slowly. She acts as if it was a great effort to concentrate her mind on the question. Even for a few moments and her answers are monosyllabic. She remains quietly in bed and is very tractable, since she has been here. Patient seems to be defective mentally, even feebleminded.

Personal and Medical History of M

Whole No. 5858. Resident of State 33 years of County no —

Residence, Fridley, Anoka County.

Date Admission, 1st July 1901.

Admitted by Dr L. A. Linton hour, 7.30 P.M.

How Sent, E. W. Bazille, Jeff P. Ramsey County

Sex, Female Age, 33

Civil Condition, single

Children, no

Age Youngest Child, ✓

Occupation, Housework

Degree Education, Common School

Profession, Religion, Catholic: Roman.

Habits, not intemperate

Nativity, Minneapolis, Minn: parents born in Ireland

Physicians Committing, S. O. Francis and Ethelbert F. Geer

Correspondents, none given in papers

Form,

Accompanying Bodily

Suicidal or not, Not: no

Date of this Attack, June 26 — 1

Duration, — 4 days —

No. of Attack, Not 1st (others occurred 1899 — 1897) —

No. of Admission, 1st

Age First Attack, about 29.

Time of Leaving, August 28 — 1902

Time in Hospital, 1 yr 1 mo 27 Ds

Result, Died: Valvular Heart Disease (37 Ds)

EXAMINATION ON ADMISSION BY DR. Heyerdale *Date of* July 1/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, poor

Recent Events, poor Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Dull: fairly Correct on some questions.

REASONING POWER, Ordinary Subjects, poor

Special Subjects, poor.

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, one week

ONSET, Gradual or Sudden, Gradual

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption). no history of above

Father,

Paternal Relatives,

Mother,

Maternal Relatives,

Brothers and Sisters, ✓

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), She says "no"

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 Mary Mulcare

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in PRESENT WEIGHT, 131# USUAL WEIGHT, NUTRITION, good

WOUNDS, Abnormalities and condition of Skin, has greatly enlarged thyroid gland: Condition of skin, normal

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

PUPILS, Equality, Size, Response to Light, and Accommodation, yes normal good good

SIGHT, good

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

HEARING, good

COORDINATION, Arms, good Legs, good ~~Grasp,~~ other tests, good

TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor fine tremor —

PATELLAR REFLEX, present Other Reflexes, wrist - jerk present

ARTICULATION, Slurred, Hesitating, Slow, slow

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, ✓

HEART, Murmurs, Strength, Sounds, Size, strong normal

Apex Beat, Regularity, normal regular

haemic murmur at aortic orifice

ARTERIES, normal

LUNGS, Chest, Symmetry, Expansion, yes - well developed 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, Genitals normal: hymen intact: uterus retroverted. Enlarged and free: cervicitis: 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 good physical condition: takes her nourishment well: sleeps well at night: is very quiet in manner: does not talk except when questioned when she answers very slowly. She acts as if it was a great effort to concentrate her mind on the question. Even for a few moments and her answers are monosyllabic. She remains quietly in bed and is very tractable, since she has been here. Patient seems to be defective mentally, even feeblemindedly.

Personal and Medical History of *Mary Mulcare*

1901

This patient was brought here by Dep. Sheriff Johnson, attended by Annie Mullen, in poor physical condition and with following history of case. There is no history of consanguinity nor heredity. This is not 1st attack. Others occurred in 1899 - 1897: duration 2 or 3 days: was not sent to hospital. result of treatment, not. First symptoms of this attack manifested June 26th 01. She became violent, when asked to change her Clothes: disease seems increasing: variable with rational intervals, but these not regular. Derangement now shown in that she wants to be alone. Is disposed to injure others, but not suicidal: no filthy or destructive habits. No previous peculiarities manifested. No history of intemperance. Menstrual flow stopped for about six years. She has not been restrained or confined. Supposed cause of the disease is Congenital defect. She has been treated by Drs Stone of St Paul, and Algren of Minneapolis: no relief. On personal Examination patient is morose and dont answer questions.

July 1 On admission was put on TW. (G. S. N. Cpt. Complexion dark: hair dark-brown: eyes blue; Condition of skin normal: bruises on left arm and both limbs: small open sore on left foot. Is dirty: has a goitre: teeth, upper two & plate: lower, eight. Behavior quiet: talks quite rational).

July 1st. 1901 Summary of 14 day records. Dict. by Dr. Heyerdale.
Patient received on Infirmary West. bathed and put to bed: very dirty: is quiet in behavior: has bruise on left arm and leg: has goitre: is melancholy has very little to say: Tem. P. & R. normal: occasional cathartic given: patient slept well all night during first week. On 31st patient was up on ward dressed: is agreeable & neat in habits and appearance: answers questions quite well. Is very depressed. Sixth day of week patient complained of feeling ill: was put to bed menstruating. During 2 week Tem. P & R about normal: appetite good: given cathartics. First couple of days patient remained in bed thereafter dressed and up on ward: slept well each night during week: very quiet: talks but little: is very depressed.

June to Sept. Aug. 1 patient attempted to run away this afternoon while out on the lawn, very quiet and melancholy, receives gynecological treatment Aug. 31 Wt. 120#. Sept. to Dec. Sept. 23 gynecological treatments discontinued, Oct. 6 visited by brother, Oct. 12 patient has large goiter on neck, treated with thyroid extract internally, Oct. 29 Wt. 118#.

Dec. to Feb. 03 No change. Wt 114# Jan 23rd 1902 Patient visited by brother.

June 23rd Went out camping at Oronoco. While there attempted Suicide by drowning: Returned to the Hospital the following day

July 22nd Patient suddenly attacked with choking at 8 P.M. due to enlarged thyroid: packs to be applied to neck, Strychnine Sulphate hypodermically and Benzoinated Steam inhalations provided. Slept four hours thereafter, somewhat better during the night. July 23rd transferred to Infirmary

Aug. 27th. Patient troubled slightly since date of choking: but to-day again attacked with severe choking: as before salve measures resorted to. with great relief. August 28th another attack of choking.

Personal and Medical History of

Patient died at 10:40. Cause of death due to enlarged thyroid.

Personal and Medical History of Eliza Bolt

Committed on recommendation of Board of Corrections & Charities of State of Minnesota

Whole No. 5861. became resident of Minnesota 1886 Ramsey Co. 1886.

Residence, Ramsey Co.

Date Admission, 1st July 1901.

Admitted by Dr. O.C. Heyerdale hour, 6 PM

How Sent, J.A. Leonard. Jail. Olmsted County

Sex, Female Age, 45

Civil Condition, Single

Children, None

Age Youngest Child, —

Occupation, None

Degree Education, College Education

Profession, Religion, Not a Church-member

Habits, Not Intemperate

Nativity, Switzerland. (Parents also born there) -

Physicians Committing, A.S. Adams and J.S. Cross

Correspondents, (Brother) Gregory Bolt 15 National German-American Bank Bldg St Paul Minn

No. of Year, 224.

Insane Relatives, Paternal Grandmother, Melancholia

Cause Exciting, Unknown

Cause Predisposing, Previous attack (possibly heredity)

Form, Paranoia

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Has threatened Suicide

Date of this Attack, 1888

Duration, Probably long

No. of Attack, not 1st (Others occurred 1888 - 1897)

No. of Admission, 3rd here.

Age First Attack, 32 years

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DRS Heyerdale & Linton *Date of* July —

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Clear & quick

MEMORY, Past Events, Seems good

Recent Events, " " Special Subjects, ✓

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Alert

REASONING POWER, Ordinary Subjects, ✓

Special Subjects, ✓

Own Mental State, Says "She is not insane"

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Exalted

DELUSIONS, Systematized, Transitory, Special Subjects,

Has delusions of persecution (is probably of weak moral Character)

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, Many Years

ONSET, Gradual or Sudden, Gradual

HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption). Grandmother insane: 2 sisters have had acute attacks of insanity.

Father, Died from cancer at 60 years of age

Paternal Relatives, Grandmother has insane

Mother, Died of cancer, at 66 years of age.

Maternal Relatives, - Good history

Brothers and Sisters, - 3 brothers - nervous individuals - one very erratic - Sisters are all very nervous - two have had acute attacks of insanity - one is at present Typhomaniacal

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

HABITS, Drinking and Smoking, Admits of having been intoxicated. very intemperate, at times.

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 Eliza Bolt

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft, 1in PRESENT WEIGHT, 104 3/4 lbs USUAL WEIGHT, NUTRITION, Poor

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, Prompt: white Coating

PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal fairly good fairly good

SIGHT, Good: wears glasses

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

HEARING, Good

COORDINATION, Arms, Good Legs, good ~~Grasp~~, Arm tests, good

TREMORS, Hands, Tongue, Facial Muscles, General, Fair fair

PATELLAR REFLEX, Present Other Reflexes, elbow

ARTICULATION, Slurred, Hesitating, Slow, —

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, None Strong Normal

Apex Beat, Regularity, Normal Yes

ARTERIES,

Normal

LUNGS, Chest, Symmetry, Expansion, Yes 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, Genitals normal; hymen intact; quite rigid and parts very sensitive so that examination was difficult; cervix enlarged; no displacement.

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 & is emaciated. Patient is quick & active, both mentally & physically; talks incessantly when she has a listener; Talks very intelligently on many subjects; has many delusions of persecution. Patient is weak morally; her brother states that she has always been weak mentally; probably insane since girlhood. Always very nervous & excitable; moved from home & wandered away. K.S.H. 1888. for 6 months. Private hospital in my city. for 6 months. then escapes & remained out for 7 years. K.S.H. - 1897 for 5 months. Kankakee Hospital Ill. 1898 for 3 yrs.

Personal and Medical History of Eliza Bolt.

1901

This patient was brought here by Sheriff Vine, attended by Niklaus Bolt (brother), in poor physical condition, and with following history of case. There is no history of consanguinity; Paternal grand-mother, melancholia. This is not 1st attack: others occurred in 1888-1897. She has been in following Hospitals: Rochester State Hospital 1888. Again in 1897: Rock Island, Ills. 1898: Kankakee Ill. 1898: Some improvement. First symptoms of this attack manifested in 1888- (Refer to record at Hospital): Disease seems stationary: not variable: no rational intervals. Derangement now shown by a mania for collecting small articles: has delusions of persecution: Has shown no disposition to injure others: has not attempted, but has threatened suicide; propensity not now active: no filthy or destructive habits. She has been excitable. There is no history of intemperance, nor of any severe disease or a head-injury. She has been restrained as above stated. Cause of the disease is unknown; For treatment, See hospital record.

On personal examination, patient is excitable, Delusional. (N.B. 3rd admission here: was here, before, 1st time, from December 10/89 to May 18/91. See Vol 13 Page 92 No 2232: and the 2nd time " Febry 12/98 to Sep 5/98 see " 38 " 153 " 4973:

July 6 Improved): On admission, was put on T.W. (G.H.N.R/St. Complexion fair: hair brown: eyes brown: Condition of skin normal: bruise on right limb: is clean: Teeth: upper plate: lower eight: Is very talkative: has morbid ideas) — " ———

July 6th-1901 Summary of 14 day records: Dict. by Dr. Heyendale.
Patient received on Infirmary West: bathed and put to bed; talks intelligently. During first week Tem. P. & R. about normal: appetite good: given occasional cathartics for bowels being somewhat constipated. During first week patient slept well at night. July 12 patient dressed and upon ward: transferred to B.3. Patient quiet and agreeable: takes medicine well. During second week. Tem. P. & R. normal: appetite good: takes medicine after each meal: bowels moved daily. slept well at night: quite agreeable on ward: takes out door exercise: is very nervous and talkative: occasionally becomes quite excited and expresses delusions of persecution, especially in regard to her brothers. Conversation is very intelligent. June to Sept. July 12 tran. to B.3. W. patient extremely active and talkative, very intelligent, very disagreeable at times. Aug. 26 Wt. 109#. Sept. to Dec. Patient has many delusions of persecution by her family; no change during quarter, Nov. 27 Wt. 127#.

Dec to Feb 1903 No change. Wt about 109#. Gen'l health good appetite good. occasionally needs cathartics: sleeps well: goes out for exercise: attends Chapel & amusements: usually quite disagreeable and fault finding: interferes with the other patients and is quite officious and complains of all the patients with whom she is associated. Rather dictatorial: is a kleptomaniac: inclined to secrete things belonging to the ward or other patients of no use to her. These she conceals with various fancy articles. It becomes necessary at such times to search her

Personal and Medical History of

bed and room for these things.

Personal and Medical History of Margaret H. Meyers

Whole No. 5862. Resident of State – one year – of County – one year –

Residence, St. Paul

Date Admission, 6th July 1901.

Admitted by Dr. Ord Heyerdale hour, 7:30 P.M.

How Sent, Henry Gallick, Ct. Comm. Ramsey County

Sex, Female Age, 42.

Civil Condition, married

Children, Seven (?) (deceased).

Age Youngest Child, –

Occupation, Nurse

Degree Education, Yes – fair

Profession, Religion, Methodist

Habits, not intemperate

Nativity, Winona, Minn: Father's unknown: Mother's Germany

Physicians Committing, A.M. Lufkin and W. G. Richeson

Correspondents (Mother) Maria A. Heublein, Utica, Winona Co. Minn

(Brother) Philip Heublein – Utica – Minn

7/25/1901 Letter recd. from Mrs. Wm. Heublein (Jean's sister) 48 St. Cedar ave. Mpls.

No. for Year, 225.

Insane Relatives, None

Cause Exciting, Sunstroke

Cause Predisposing, previous attack.

Form, Melancholia Acute

Accompanying Bodily Disorder, Convulsions

Suicidal or not, – not –

Date of this Attack, one week

Duration, – one week –

No. of Attack, 2nd (Had one in 1893).

No. of Admission, 1st –

Age First Attack, about 36.

Time of Leaving, 12th to September 1901

Time in Hospital, 2 mos 5 DD

Result, Recovered: Discharged Nov 7th/1901.

EXAMINATION ON ADMISSION BY DR.S Heyerdale & Linton Date of July 8-1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,

Quick

MEMORY, Past Events, fair

Recent Events, fair Special Subjects, ~

PERCEPTIVITY, Alert or Dull, Correct or Illusive.

Alert

REASONING POWER, Ordinary Subjects, ~

Special Subjects, ~

Own Mental State, Says "She may be insane"

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,

Slightly exalted

DELUSIONS, Systematized, Transitory, Special Subjects,

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, ~

ONSET, Gradual or Sudden, ~

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

Father, Dead – Typhoid fever – 25 years ago

Paternal Relatives, negative

Mother, Living & well

Maternal Relatives, negative

Brothers and Sisters, 1 sister

Children – 7 miscarriages – no living children

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

Two surgical operations: both slight Gynecological – Says she has had both Syphilis & Gonorrhoea: –

HABITS, Drinking and Smoking, –

HEADACHES, VERTIGO, OR CONVULSIONS, Had monthly spasms repeatedly for 2 years

OCCUPATION, Healthy or not, Has done dressmaking & nursing

Catamenia began at 19 years of age –

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

Sleep, Appetite, and Bowels, Good fair regular.

Personal and Medical History of Margaret H. Meyers

Believes Herself Rich.

Mrs. Margaret H. Myers arrived here Saturday on the Red Wing train, being committed to the state hospital from St. Paul. She is an attractive appearing woman with black eyes and dark hair. She has $1,000,000 in her own right, according to her own belief, but she was arrested last Thursday in St. Paul for stealing silverware and bricabrac from the International hotel. She was committed by Court Commissioner Gallick. She holds to the delusion that she has inherited vast wealth and all that she needs to do is to call for it at the post office. She is said to have a mania for buying out large hotels and was conducting negotiations with the proprietor of the International when arrested for theft. She was quite disturbed when brought here but will doubtless improve as the benefits of hospital treatment make itself felt in her clouded intellect.

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 97½ lbs USUAL WEIGHT, NUTRITION, poor

and condition of Skin, normal

omptness of Movement, prompt: slight white coating

Response to Light, and Accommodation, yes yes

t, Arcus Senilis, or other troubles, normal, except for a slight pterygium of right eye.

Good

Good Legs, good Grasp, other tests good.

ue, Facial Muscles, General,

Exaggerated Other Reflexes, Elbow, wrist, present

ARTICULATION, Slurred, Hesitating, Slow, ~

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, ~

HEART, Murmurs, Strength, Sounds, Size, None. Strong Normal

Apex Beat, Regularity, Normal regular

ARTERIES,

Normal

LUNGS, Chest, Symmetry, Expansion, Yes 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, Patient has had Syphilis & gonorrhoea: Genitals normal. Hymen nigh & very sensitive: Vaginitis: Cervicitis: Uterus dextro-retro-flexed: Cervix eroded: Purulent leucorrhoea.

MENSTRUATION, Mucous membrane of vagina very sensitive, bleeding at touch.

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. Quite emaciated & thin. Mentally, patient is irritable & nervous. Very talk active and trend of thought seems to be always sexual lines. Is separated from her husband, whom she accuses of gross abuse. She admits of having consorted with some other man, since she left her husband. Says she mother is extremely wealthy that she can have all the money she wants. She was married at the age of 22 & has had 7 miscarriages has never had a living child.

Personal and Medical History of Margaret H. Meyers

Whole No. 5862. Resident of State – one year – " of County – one year –

Residence, St. Paul

Date Admission, 6th July 1901.

Admitted by Dr. O. C. Heyerdale hour, 7:20 P.M.

How Sent, Henry Gallick, Co. Comm. Lawrey County

Sex, Female Age, 42.

Civil Condition, married

Children, Seven (?) (deceased).

Age Youngest Child,

Occupation, Nurse

Degree Education, Yes — fair

Profession, Religion, Methodist

Habits, not intemperate

Nativity, Winona, Minn: Father's unknown: Mother's Germany

Physicians Committing, A.M. Lufkin and W. G. Richeson

Correspondents (Mother) Maria A. Heublein, Wilson, Winona Co. Minn

(Brother) Philip Heublein – Wilson – Minn

7/28/1901 Letter rec'd from Mrs. Bm. Heublein (Hans sister) 48 St. Cedar ave Minpls.

No. of Year, 225.

Insane Relatives, None

Cause Exciting, Sun

Cause Predisposing, pre

Form, Melancholia

Accompanying Bodily Disorder,

Suicidal or not, —

Date of this Attack,

Duration,

No. of Attack, 2nd

No. of Admission, 1st —

Age First Attack, about 36.

Time of Leaving, 12th September 1901

Time in Hospital, 2 mos 5 DD

Result, Recovered: Discharged Nov 7th/1901.

8 secs., actual sailing.
se times, while they show great
nces between the yachts, hard-
w the true form of the sailing
of the racers. There were some
and errors made that were
The Constitution sailed with
od judgment from start to fin-
On the run home the Columbia
an error in handling sails. On
ndependence a grave error of
ent put the yacht far behind
in the race and she got all the
of the dukes in the wind.

erican Fights for His Flag.
, July 8.—Albert Hopkins, son
president of the Women's col-
Baltimore, has come out vic-
in a duel with a Frenchman,
d'Estournel, a man about town.
urnel found fault with young
is for wearing an American
Hopkins, who is an athlete and
o be pitcher at St. John's col-
Baltimore, slapped the French-
face. This led to a meeting
words in the Bois de Boulogne
Hopkins was slightly

EXAMINATION ON ADMISSION BY DR.S Heyerdale & Linton Date of July 8-1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, fair
Recent Events, fair Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert

REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, Says "She may be insane"

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

DELUSIONS, Systematized, Transitory, Special Subjects,
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,

ONSET, Gradual or Sudden,

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

Father, Dead – Typhoid fever – 20 years ago

Paternal Relatives, negative

Mother, Living + well

Maternal Relatives, negative

Brothers and Sisters, 1 sister

Children – 7 miscarriages – no living children

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

Two surgical operations: both slight Gynecological – Says she has had both Syphilis + Gonorrhoea. —

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS, Frequently for 2 years. Had monthly spasms

OCCUPATION, Healthy or not, Has been dressmaking + nursing

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

Sleep, Appetite, and Bowels, Good fair regular.

Personal and Medical History of Margaret H. Meyers.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft, 1 in PRESENT WEIGHT, 97½ lbs USUAL WEIGHT, NUTRITION, poor

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt: slight white coating

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

SIGHT, good

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal, except for a slight pterygium of right eye

HEARING, Good

COORDINATION, Arms, Good Legs, good Grasp, other tests good.

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

PATELLAR REFLEX, Exaggerated Other Reflexes, Elbow, wrist, present

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, None Strength, Strong Sounds, Normal Size, Normal
Apex Beat, Regularity, Regular

ARTERIES,
Normal

LUNGS, Chest, Symmetry, Yes 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, Patient has had Syphilis + gonorrhoea: Genitals normal. Hymen negative + very sensitive: Vaginitis: Cervicitis: Uterus dextro-retro-flexed: Cervix eroded: Purulent leucorrhoea.

MENSTRUATION, Mucous membrane of vagina very sensitive, bleeding at touch

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 quite emaciated + thin. Mentally, patient is irritable + nervous. Is very talk active and dwells of the night scenes + the alleged sexual lives. Is separated from her husband, whom she accuses of gross abuse. She admits of having consorted with some other man, since she left her husband. Says the mother is extremely wealthy + that she can have all the money she wants. She was married at the age of 22 + has had 7 miscarriages has never had a living child.

Personal and Medical History of Margaret H. Meyers

1901

This patient was brought here by Deputy Sheriff Johnson, attended by Mrs Louisa Schmale; in poor physical condition, and with following history of case. There is no history of consanguinity, nor heredity: this is not 1st attack: one occurred in 1893: duration 13 months - First symptoms of this attack manifested one week: (in what way is not stated) - Disease seems stationary: is variable: no regular intervals: Derangement now shown on subject of business: is buying out a hotel: presumption of wealth: she is not disposed to injure others, nor suicidal: no filthy or destructive habits: no previous peculiarities noted: no history of intemperance: Is subject to convulsions: has been confined in jail: arrested for stealing: referred to Probate. Supposed cause of the disease is sunstroke: no treatment.

July 6 On admission, was put on T.W. (G.H.N.R.Pt. Complexion dark: hair dark brown: eyes hazel: Condition of skin normal: slight scar on right wrist: is clean: Teeth: upper nine: lower, fifteen: Behavior quiet: Talks quite rational). —

N.B. See letter 7/28/1901, from Miss B. M. Heublein, 48. St. Ceder Ave. Minneapolis "my Idea her illness was caused from her married trouble. She was married to Mr. Myers in 1882: then went to Dakota: She lived a happy life until '93, when her husband failed & having several miscarriages, also married against her people's wishes. The Dr. here says that she eats morphine. Last summer she spent money freely: had her examined in July: Dr. said then I should send her to "Detention Hospital": but she seemed to get better, so that I did not fear her, anymore. She went to St. Paul, only a a few days before she came in your charge, when the Woodmen were here. She wrote me, saying (in June 11) saying she went there to canvass with books. x x x She has nursed: I thought that hard on her nerves. x x x - I am her twin-sister: my health is poor &c." —

July 6, 1901 Summary of 14 day record: Dict. by Dr. Heyerdale.

Admitted on Infirmary west was bathed and put to bed: very quiet: talks quite intelligently: was given cathartic. During first week Tem. P & R about normal: appetite good: bowels regular: slept well at night. Patient quite agreeable: neat in habits: out of bed considerably: during last day of week patient dressed and up on ward: inclined to be somewhat disagreeable during the day. Second week T. P. & R. about normal: appetite good was given cathartics once during the week, bowels otherwise regular: slept well each night: quiet in behavior; quite talkative; takes out door exercise. June to Sept. July 22 neat in habits and appearance, melancholy, works in the laundry, inclined to interfer with the treatment of other patients, trans. to B.3 W. menstruates regularly, Aug 31 Wt. 105½#. Sept. to Dec. Sept. 3 trans. to A.3. West, no change, Sept. 12 went home this A.M.

— Discharged —

Personal and Medical History of

Personal and Medical History of Annie Marie Haugen

Whole No. 5866.
Residence, Cannon City Rice Co. Minn.
Date Admission, 10th July 1901.
Admitted by Dr. O. C. Heyerdale hour, 8 15 P.M.
How Sent, W. A. Eggleston, Acting J. of P. Rice County
Sex, Female Age, 22 years
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Housework: father – farmer
Degree Education, Common School
Profession, Religion, Lutheran
Habits, Probably good; not intemperate
Nativity, Goodhue Co. Minn; parents born in Norway
Physicians Committing, A. A. Dodge and M. L. Mayland
Correspondents, H. Annah Haugen (Sister) Faribault, Minn

No. of Year, 229.
Insane Relatives, none
Cause Exciting, Change of life & weakened condition of system
Cause Predisposing, "Chronic"
Form, Melancholia Chronic
Accompanying Bodily Disorder, Tuberculosis
Suicidal or not, Not attempted but threatened
Date of this Attack, about 3 years ago
Duration, – about 3 years –
No. of Attack, 1st (at intermissions)
No. of Admission, 1st —
Age First Attack, about 19
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* July 12/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Clear
MEMORY, Past Events, Seems good
Recent Events, " " Special Subjects, —
PERCEPTIVITY, Alert or Dull, Correct or Illusive. Alert: Correct
REASONING POWER, Ordinary Subjects,
Special Subjects,
Own Mental State, Says "She's not insane": Says "She's very quick – tempered"
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 3 years
ONSET, Gradual or Sudden, gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption). Says: her mother is not right, mentally – two sisters died of consumption –
Father, Living – well
Paternal Relatives, —
Mother, Living – well
Maternal Relatives, —
Brothers and Sisters, 5 sisters – 3 well – 2 dead
Children – none
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), None
HABITS, Drinking and Smoking, Temperate – In summer time, during heated season. –
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any, ✓
Sleep, Appetite, and Bowels, poorly constipated

Personal and Medical History of Annie Marie Haugen

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken PRESENT WEIGHT, Not taken USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal – anaemic
TONGUE, Coatings or Promptness of Movement, prompt – clean
PUPILS, Equality, Size, Response to Light, and Accommodation, Good (Yes, normal, good)
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal: Conjunctivae are very anaemic
HEARING, Good
COORDINATION, Arms, Good Legs, good Grasp, other tests good
TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor, fine tremor
PATELLAR REFLEX, Exaggerated Other Reflexes, elbow – wrist
ARTICULATION, Slurred, Hesitating, Slow, ✓
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size, none, fairly strong, normal
Apex Beat, Regularity, regular (normal)
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, Yes, fair
Breath Sounds, bronchial breathing in apices of both lungs –

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: uterus & cervix small: hymen intact, but relaxed – She began menstruating at age of 20 & has been irregular
MENSTRUATION, — Since
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 is weak & very anaemic. Answers questions quite freely, as a rule, except regarding her own condition. About which she is very reticent: patient seems somewhat depressed & melancholy. Says "she was perfectly well until 3 years ago, when she began to menstruate: since that time she has been sickly." Says "her menstruation is irregular and copious." She is a girl who has had but little opportunity for education. –

Personal and Medical History of Annie Marie Haugen

1901

This patient was brought here by Sheriff J.B. Thompson, attended by sister Anna Haugen, in fair physical condition, with following history of case. There is no history of consanguinity nor heredity; this is 1st attack, at intermissions; duration nearly three years: not sent to hospital: First Symptoms of this attack manifested about three years ago: nervous and irritable and threatening to hurt others: is worse in warm weather: variable and there are rational intervals, but these are variable. Derangement now shown in that She is afraid to meet people, and wants to stay in bed, all the time. Is threatening to injure others: has not attempted suicide, but has threatened: no filthy or destructive habits. She showed peculiarities previously: very religious when disease started. There is no history of intemperance, nor of any severe disease &c(?) or head-injury: Has not been restrained or confined. Supposed cause of the disease is Change of life and weakened condition of the system: no medical attendance. On personal Examination, Pulse 92. Temp. 101 3/5 She very anaemic and weak: tuberculosis of apices & probably tubercular meningitis.

July 10 On admission, was put on I.W. (Girls Ward). Complexion fair: hair light: eyes blue: condition of skin normal: is clean. Teeth: lower twelve: upper, fifteen: Behavior quiet: talks very little).

7/29/01. See Letter from Hannah Haugen, in reply to one of July 13th regarding sister's illness. "Home-Conditions far from what they should be: many reasons to think that Mary's sickness came on as the result of cruel treatments. Mama's custom to keep her children away from Company of others: rather shut up: very careless about our health: Mary, not able to work out, was kept home, most of time & has had a very trying & hard time: was the scold'd and picked at her, when not being able to do much work of any kind: Was made to go down into cold Cellar and work: overheated by washing &c; sudden cooling off seemed to affect the hair & the health otherwise. I have been away from home, most of time, for last 10 years, cannot therefor tell everything. Mary never was bright: was quite herself & rather well, until about 3 years ago: then, she began to change. She did not seem to be interested in much of anything: her temper seemed to cause a good deal of trouble. Still she did not show hardly any signs of insanity until last fall & since then it came on more & more. Several times She spoke of ending her life, although she never tried to, as far as I know."

July 10-1901 Summary of 14 day record: Dict. by Dr. Heyerdale.

Patient received on Infirmary West. bathed and put to bed: is very quiet: was given cathartic. Tem. P. & R. normal: appetite poor: was given several enemas each day also malt and cod liver oil: occasional cathartic: bowels somewhat constipated: during first week patient slept well at night: very melancholy: very anemic. July 12 patient began to menstruate: July 14 dressed and up on ward. During morning of 15th. and 16th. patient remained in bed. During second week Tem. P. & R. normal: was given several enemas during each day, also malt & cod liver oil. Bowels regular: slept well each night: takes out door exercise daily: appetite seems somewhat better: patient depressed talks very little.

June to Sept. Takes massage and electrical treatment, is melancholy and very disagreeable at times, complains, assists some with ward work, Oct. 10 visited by sister. Aug. 31 Wt. 110#. Sept. to Dec. Oct. 10 visited by sister, general health fair, is melancholy, disagreeable at times, takes

Personal and Medical History of

out door exercise, assists with ward work. Nov. 11 7/4 Wt.

Dec. to Feb. 1903 No change. Wt about 109 #.

Personal and Medical History of Julia Earl

Whole No. 5871. Became resident of Minnesota Feby 1901. of County. Feby 1901
Residence, Austin, Minn — " By marriage with a resident of this County.
Date Admission, 12th July 1901.
Admitted by Dr. O. C. Heyerdale hour, 10.00 Am
How Sent, S. S. Washburn, Jas P. Mower County
Sex, Female Age, 28.
Civil Condition, married
Children, None
Age Youngest Child, ✓
Occupation, Housewife: formerly Schoolteacher: husband, painter
Degree Education, High School
Profession, Religion, Congregational
Habits, probably good
Nativity, McLeod Co. Minnesota: parents: N.Y.
Physicians Committing, E. Washburn - Rodgers and Homer F. Peirson
family physician — none
Correspondents, S. H. B. Earl (husband) Austin Minn

No. of Year, 234.
Insane Relatives, none
Cause Exciting, Typhoid fever & business affairs
Cause Predisposing, previous attacks
Form, Mania Acute
Accompanying Bodily Disorder, none mentioned
Suicidal or not, not
Date of this Attack, 4 weeks ago
Duration, - 4 weeks -
No. of Attack, 4th (others in 1896. 1898. & 1899).
No. of Admission, 1st here (not at James town. N.Y.)
Age First Attack, about 23.
Time of Leaving, August 10 - 1901.
Time in Hospital, 29 days.
Result, Improved —
Discharged by Board of Control
- Feby 26 - 1902 -

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* July —

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick: Confused
MEMORY, Past Events, Seems good
Recent Events, " " Special Subjects, —
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert
REASONING POWER, Ordinary Subjects, ✓
Special Subjects, ✓
Own Mental State, says "She is well".
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed
DELUSIONS, Systematized, Transitory, Special Subjects,
Expresses many delusions regarding property &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, Sudden
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Living - well
Paternal Relatives, —
Mother, Dead from childbirth. 20 years ago
Maternal Relatives, —
Brothers and Sisters, 3 brothers living - well 4 sisters - 3 living - well
children - none -
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Typhoid at age of 22
HABITS, Drinking and Smoking, good - temperate
HEADACHES, VERTIGO, OR CONVULSIONS, —
OCCUPATION, Healthy or not, Teaching
Detail Date, Duration, and Character of Previous Attack, if any, ✓
Sleep, Appetite, and Bowels, constipated.

Personal and Medical History of Julia Earl

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 8½ PRESENT WEIGHT, 148# USUAL WEIGHT, NUTRITION, good
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt — white coating
PUPILS, Equality, Size, Response to Light, and Accommodation, yes normal fair good
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, good Legs, good Grasp, other tests good -
TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor fine tremor
PATELLAR REFLEX, present Other Reflexes, ✓
ARTICULATION, Slurred, Hesitating, Slow, ✓
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, ✓
HEART, Murmurs, Strength, Sounds, Size, none normal normal
Apex Beat, Regularity, normal normal
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, yes - very well developed 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: cervix elongated.

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 excellent physical condition: takes nourishment well, but is rather restless, at night. Patient talks to herself a good deal; answers questions & talks freely: wanders from the subject frequently and becomes incoherent. says "She has taught school for several years." —

Personal and Medical History of Julia Earl

1901

This patient was brought here by Sheriff John. C. Johnson, attended by husband H. B. Earl and Minnetta Washburn, in fair physical condition, with the following history of case.— There is no history of consanguinity nor heredity. This is not first attack; others occurred in 1896, and 1898 and 1899; duration, 6 months 1st — 4 months 2nd + 3rd. has been in hospital at Jamestown, N. Dak: result of treatment, apparently as well as before: First symptoms of this attack manifested 4 weeks ago, by headache + rambling talk: Disease seems increasing: not variable: Derangement now shown on no particular subject. Patient is not disposed to injure others, nor suicidal: destroyed clothing + a valise. No previous peculiarities noted: no history of intemperance: She had typhoid fever before 1st attack: has not been restrained or confined, but continually watched. Supposed cause of the disease is typhoid fever and business affairs. No treatment for this attack. On personal examination, patient answers correctly but babbles on afterwards. Lays her trouble to business + to her heart: as examination proceeds, talk becomes more incoherent. Commitment recommended because she requires medical treatment while under legal restraint. ——— " ———

July 12 On admission, was put on T.W. (G. H. N. Kpt: Complexion dark: hair light brown: eyes gray: condition of skin normal: no marks: large scar on right leg: no eruptions, ulcers or bruises noted: is clean: has 14 lower and 14 upper teeth: behavior quiet: has delusions)-

July 17. 1901 Summary of 14 day records: Dict. by Dr. Heyerdale.

Admitted on Infirmary West bathed and put to bed is quiet in behavior. During first week Tem. P + R. about normal: appetite good: bowels constipated requiring occasional cathartic: slept quite well during week: Patient quite agreeable in manner: answers questions readily: expresses delusions of persecution: Talks about some property which she says she is going to prove up the claim upon: says friends cause her a great deal of trouble. Quantity of urine for 24 hours. 40 ozs. July 15 patient somewhat disturbed complained of pain in abdomen and back: menstruated: July 18 patient dressed and up on ward: very noisy: takes outdoor exercise. Second week Tem. P. + R. about normal: appetite good bowels regular: slept quite well during week with the aid of hypnotics. At night patient extremely noisy at times: takes regular outdoor exercise: talks incoherently: has delusions of hearing: uses vile language: assists some with the work.

June to Sept. Patient up on ward extremely noisy most of the time, is incoherent in her speech, has hallucinations of hearing, sleeps poorly, requires hypnotics, general health good, assists a little with the work on the ward, trans. to C. 3 West. Aug. 6-7-8 visited by husband, Aug. 9. menstruating Aug. 9 somewhat improved, taken home by husband.

— Discharged —

Personal and Medical History of

Personal and Medical History of Emma Littlefield

Whole No. 5872 Resident of Minnesota 15 years " " County about 1886
Residence, Winona, Minn
Date Admission, 12th July 1901.
Admitted by Dr. C. L. Chapple hour, 4.30 P.M.
How Sent, D. E. Vance. Jail Winona County.
Sex, Female Age, 63 years
Civil Condition, Single
Children, None
Age Youngest Child,
Occupation, House-keeping: Father: Don't Know
Degree Education, Common school
Profession, Religion, Methodist Episcopal
Habits, If intemperate, do not Know
Nativity, North Stonington Conn: Parents also born there
Physicians Committing, Thos. A. Peirce M.D. Paul B. Blair
Correspondents, No relatives Known

No. of Year, 235.
Insane Relatives, not any, as far as known
Cause Exciting, Decay of mental faculties
Cause Predisposing, probably age
Form, Senile Dementia
Accompanying Bodily Disorder, great weakness
Suicidal or not, not
Date of this Attack, about 3 years ago
Duration, about 3 years
No. of Attack, 1st
No. of Admission, 1st
Age First Attack, 64
Time of Leaving, March 29-1902
Time in Hospital, 8 mos 17 ds
Result, Died: Ephi w Senile dementia

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of July

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Is demented & confused
MEMORY, Past Events, poor
Recent Events, " " Special Subjects, " "
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
✓
REASONING POWER, Ordinary Subjects, ✓
Special Subjects, ✓
Own Mental State, Demented
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,
Paternal Relatives, No history Ref
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 Emma Littlefield

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken PRESENT WEIGHT, Not taken USUAL WEIGHT, NUTRITION, Poor
WOUNDS, Abnormalities and condition of Skin, normal: Copper colored.
TONGUE, Coatings or Promptness of Movement, —
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes unusual
SIGHT, Impaired
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Arcus Senilis
HEARING, Impaired
COORDINATION, Arms, Patient lies Legs, in bed, all of Grasp, the time
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, None Fairly strong Normal
Apex Beat, Regularity, Normal Regular
ARTERIES, Sclerotic
LUNGS, Chest, Symmetry, Expansion, Yes 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,

Passed Oct 21st Ext Oct 21st
EXAMINATION URINE, Quantity, Sp. g. 1016 Reaction, acid Color and Appearance, Reddish yellow cloudy
Albumen, Heat: a small amount Nitric acid: a large amount Tannets a large amount Sugar, Fehlings Sol: o Bismuth o
Casts and Crystals, Casts, granular - a few. Pus - several cop. Epithelium, a few cells. Urates, amor: a large amount.
GYNECOLOGICAL EXAMINATION, Lacerated perineum 1st degree urethral carnucle Uterus & cervix small and atrophied.
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. Is quiet and confined to her bed, all of the time. Very feeble in habits requires constant attention. Is an Indian & has a very dark copper colored skin. Is very old and demented but answers some questions fairly well: answers are sometimes rambling and irrelevant.

Personal and Medical History of *Emma Littlefield*

1901

This patient was brought here by M. J. Luis, attended by Ezeb. Veir, Rhoda Veir & Wm Lambkin, in poor physical condition, & with following history of case. Do not know as to consanguinity; not any insane relatives as far as known: this is first attack: first symptoms of this attack manifested in that it has been coming on about 3 years; gradual failure of mental and physical powers. Disease seems increasing: not variable: no rational intervals. Derangement now shown by loss of memory; melancholia: aberration: nervous twitching of muscles; tearing her clothing and disrobing entirely. Is not disposed to injure others, nor suicidal. Is of filthy habits and destructive of clothing &c. No previous peculiarities noted. Do not know any history of intemperance, nor of any severe disease &c or head-injury. She has not been restrained or confined — Supposed cause of the disease is decay of mental faculties: no special treatment. On personal examination, there are noted apathy of countenance, general nervous condition, poor circulation, varicose ulcers on limbs, general debility. —— · —

July 12 On admission, was put on T.W. (G.H.N. R'pt. Complexion dark: (half-breed): hair gray: eyes brown: condition of skin, normal: marks, none: scars on lower part of legs (varicose). eruptions on her back: ulcers on lower part of back & leg: no bruises, hernias or vermin is very dirty: has 5 lower and 7 upper teeth. Behavior quiet: would not converse). —

July 12, 1901 Summary of 14 day records: Dict by Dr. Heyerdale.

Received on Infirmary West: bathed and put to bed: very dirty: is old and feeble in knee joints: seems quite stiff: has varicose ulcers on legs: has two sores on back number of small ones on limbs. During first week Tem. seemed above normal P. & R. in accordance: appetite good took regular diet: given occasional cathartic: bowels moved quite regular daily: slept well at night: very dirty in her habits: ulcers and bed sores dressed daily: Patient will answer questions but volunteers no remarks. Second week Tem. P. & R. normal appetite quite good: takes regular diet: bowels somewhat constipated was given cathartics occasionally: slept well at night: bed sores and ulcers dressed daily & back bathed with alcohol: appetite fair: patient out of bed on the 20.

Patient is quiet - filthy in habits, old, feeble and helpless, demented, causes no particular trouble. Aug 31 Wt. 91#. Sept. to Dec. Patient sits about on the ward part of the time, failing some physically. Nov. 25 Wt 83#. Dec. to Mar. 1902 Patient kept on ward in bed; untidy; rarely says anything; will not answer questions usually but when she does answers then intelligently, sleeps well, usually fed by nurses, is unable to stand alone has stiff knees; Dec. 4 trans. to B 1 remains untidy; Dec. 26 trans. to A 1; has very bad bed sores; receives treatment twice daily during Dec. and early part of Jan. 1902. Wt not taken. Patient quite helpless dressed and fed by nurses is noticed to be gradually failing, circulation very poor; appetite poor; requires cathartics: Mar. 29 patient taken ill at 12:00 o'clock; pulse very weak: extremities cold; breathing very

Personal and Medical History of

1902. difficult: put to bed and stimulants given: died Mar. 29 at 3:30 P.M.

— Died —

Personal and Medical History of Wilhelmina Golish

Whole No. 5873. Resident of Minnesota nearly 40 yrs.
Residence, Winona, Minn. " " County about 1860.
Date Admission, 12th July 1901.
Admitted by D. C. L. Chapple hour, 4.30 PM
How Sent, D. E. Vance, Jeff. Winona County
Sex, Female Age, 84 years
Civil Condition, Widow
Children, Five
Age Youngest Child, about fifty years.
Occupation, Housewife: husband, farmer
Degree Education, Common School (German)
Profession, Religion, Lutheran
Habits, No history of intemperance
Nativity, Germany: parents also born there
Physicians Committing, J. B. McGaughey and C. P. Robbins
Correspondents, August Golish (Son) Ridgeway P.O. Winona Co. Minn

No. of Year, 236.
Insane Relatives, No: not to our knowledge
Cause Exciting, family troubles & loss of property.
Cause Predisposing, probably age.
Form, Senile Dementia
Accompanying Bodily Disorder, Great weakness
Suicidal or not, Not
Date of this Attack, in 1876.
Duration, about 25 years
No. of Attack, 1st —
No. of Admission, 1st
Age First Attack, about 59.
Time of Leaving, March 27th 1902.
Time in Hospital, 8 mos 15 ds
Result, Unimproved: Disgd. Sep 11 - 1902 By Bof C

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* July —

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, fairly Clear
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, 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,
Paternal Relatives, Nothing mentioned
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 Wilhelmina Golish

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft PRESENT WEIGHT, Not taken 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, Yes Small Slight very slight
SIGHT, rather poor: uses spectacles.
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, ✓
HEARING, seems good
COORDINATION, Arms, fair Legs, fair Grasp, other tests fair
TREMORS, Hands, Tongue, Facial Muscles, General, present
PATELLAR REFLEX, patellar present Other Reflexes, wrist
ARTICULATION, Slurred, Hesitating, Slow, ✓
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, ✓
HEART, Murmurs, Strength, Sounds, Size, none fairly strong normal
Apex Beat, Regularity, normal normal

ARTERIES, Sclerotic
LUNGS, Chest, Symmetry, Expansion, Yes 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, Lacerated perineum: cystocele: rectocele: uterus normal. Cervix small.
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 old, feeble & demented somewhat: so far as observed on ward, she is agreeable & has caused no trouble, answers questions readily & is pleased & contented with her surroundings. Takes nourishment well & sleeps quite well. She complains of some pain in chest & abdomen, but conditions do not point to any definite trouble. Patient is very fleshy & seems quite weak & exhausted: probably due to excessive heat of past few days — H.

1901

This patient was brought here by M. J. Lin's, attended by Rhoda Weir, in fair physical condition, with following history of case. There is no history of consanguinity; no insane relatives, not to our knowledge. This is 1st attack; first symptoms manifested in 1876: ran away from home; wandered around; seemed to be deranged & irresponsible. Disease seems increasing; variable & with rational intervals; but these irregular. Derangement now shown in that she imagines attempts are being made to rape and rob: becomes noisy & violent; pounds upon door, and screams. Is not disposed to injure others, nor suicidal: propensity not active. No filthy or destructive habits: on this point (previous peculiarities) we have no information. No history of intemperance: not any severe disease &c or head-injury to our knowledge. She has not been restrained or confined. Supposed cause of the disease is family troubles and loss of property. No special treatment —

On personal examination, the following noted: facial expression almost blank: answers to questions indicate loss of reasoning power. —— " —— " ——

July 12 On admission, was put on T.W. (G. H. N. R'pt. Complexion dark; hair gray; eyes blue; condition of skin normal: marks on left shoulder and back (small red marks), no scars, ulcers, bruises or herniae noted: is clean: has no lower teeth & only 2 upper: behavior quiet. Does not speak English, but complained of pain in chest & abdomen).

July 12 Summary of 14 day records. Dict. by Dr. Heyerdale.

Received on Infirmary west, bathed & put to bed: quiet in behavior: lower limbs considerably swollen: During first week Tem. P. & R. about normal: regular diet: occasional cathartic: bowels moved daily: slept well at night: neat in habits & appearance: complained some of pain in abdomen: converses mainly in German: at times inclined to be slightly resistive and somewhat disturbed: on 15th patient dressed and up on ward: 16 takes outdoor out door exercise. During second week Tem. P. & R. about normal: regular diet: was given cathartic otherwise bowels regular: slept well at night: neat in habits and appearance: occasionally complains of pain in abdomen: on 20th. put to bed had slight emesis: somewhat disturbed and melancholy at times: very anxious to go home.

June to Sept. Patient old and feeble; converses quite intelligently in German; expresses delusions of persecution and poisoning: occasionally takes out door exercise: receives gynecological treatment: is melancholy worries because she cannot go home: Sept to Dec Oct. 3 trans. to A 1 neat and clean in appearance and habits: occasionally takes out door exercise: has become much quieter and seems very much more contented and happy: answers questions intelligently: requires cathartics: is quite agreeable: Nov. 30 Wt. 138#. Dec. to Mar. 1902 Remains in her room most of the time from choice does not seem to care to associate with the other patients, repeatedly asks to be taken home and finally her son requested that she be sent to Winona Wt. Feb. 27: 139#: was sent home Mar. 27-1902

Personal and Medical History of Ellen Kjelset

Whole No. 5876 Resident of State 19 years County 19 "
Residence, St Paul
Date Admission, 16th July 1901.
Admitted by D. O. C. Heyerdale hour, 7 35 P.M.
How Sent, Henry Gallick, Ct Commr Ramsey Co.
Sex, Female Age, 62
Civil Condition, married
Children, Ten
Age Youngest Child, Twenty –
Occupation, Housewife; husband's, Carpenter
Degree Education, Common school
Profession, Religion, Lutheran
Habits, Not intemperate
Nativity, Norway: parents also born there.
Physicians Committing, A. W. Whitney and W. G. Richeson
Correspondents, (for) O. G. Wold
612 Warren St.
St Paul Minn

for Ole Kjelset – 1014 Jessie St. phgr rec'd 7/27/1901

No. of Year, 239
Insane Relatives, None
Cause Exciting, unknown
Cause Predisposing, probably age
Form, Senile Dementia
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Not, but will injure others –
Date of this Attack, One year ago
Duration, one year
No. of Attack, 1st –
No. of Admission, 1st –
Age First Attack, – 61 –
Time of Leaving, August 11 – 1901
Time in Hospital, – 26 DS –
Result, Died: uraemia

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of July. –

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Confused.
MEMORY, Past Events, Poor
Recent Events, Poor Special Subjects, ✓
PERCEPTIVITY, Alert or Dull, Correct or Illusive. Quite 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,
Paternal Relatives, Nothing mentioned
Mother,
Maternal Relatives,
Brothers and Sisters,
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), ✓
HABITS, Drinking and Smoking, ✓
HEADACHES, VERTIGO, OR CONVULSIONS, ✓
OCCUPATION, Healthy or not, ✓
Detail Date, Duration, and Character of Previous Attack, if any, ✓
Sleep, Appetite, and Bowels, ✓

Personal and Medical History of Ellen Kjelset

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ PRESENT WEIGHT, 125½ # USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt: white coating
PUPILS, Equality, Size, Response to Light, and Accommodation, poor (yes small poor)
SIGHT, Seems fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Seems fair
COORDINATION, Arms, fair Legs, poor Grasp, Finger to nose, eyes shut, fair Standing on one foot – could not turning quickly – poor Standing, eyes shut, poor –
TREMORS, Hands, Tongue, Facial Muscles, General, (fine of tongue)
PATELLAR REFLEX, diminished Other Reflexes, wrist, left: Elbow right
ARTICULATION, Slurred, Hesitating, Slow, ✓
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, ✓
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity, ✓
ARTERIES, Sclerotic
LUNGS, Chest, Symmetry, Expansion, (yes 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, Lacerated perineum: uterus small: Cervix small & patulous: Leucorrhoea 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 poor physical condition: is old, feeble & demented. Condition is poor & she is unsteady and faltering in her gait. She answers questions freely but at times, is irrelevant in her answers: her voice is somewhat faltering. –

Personal and Medical History of Ellen Kjelset

1901

This patient was brought here by Deputy-Sheriff Johnson, attended by Dr O.G. Wold, in fair physical condition, with following history of case. There is no history of consanguinity, nor heredity. This is 1st attack; first symptoms manifested one year ago; wandering away from home, and neglect of person. Disease seems increasing; variable and with rational interval, but these not regular. Derangement now shown in that she mixes up past events with the present in her talking. Has shown disposition to injure others, but is not suicidal: is of filthy & distinctive habits: previously, she showed loss of memory; forgetfulness. There is no history of intemperance, nor of any severe disease &c, or head-injury. She has had to be watched & has been restrained or confined. Cause of the disease unknown. Has had some medical treatment: no improvement. On personal examination, she talks incoherently, and has a dull, stupid appearance of the face.

July 16 On admission, was put on Infirmary. (G.H.N. Rft. Complexion dark: hair gray: eyes blue: Condition of skin normal: no marks noted: scars from varicose ulcers on lower part of legs: no eruptions or ulcers noted: a few bruises on left arm: no hernia or vermin: is clean. Has a very large abdomen: has 4 upper and 5 lower teeth & all are in bad condition. Behavior quiet. Answers questions fairly well.)

N.B. See letter 8/1901 from O. G. Wold, in reply to one written his sister Miss Tillie Kjelset: "It has been generally believed that she lost her memory & reason through worry, hardship & old age - yet there is only 6 yr & her mother was of sound mind at 94 years & did not die of old age, then. About 10 years ago, she had either a stroke of paralysis, or she lost (almost) the use of her left side, from rheumatism. She lost almost all the feeling of her left side & her head was greatly affected & face, on the same side; has been suffering from rheumatism probably 30 years & more. About 7 years ago, she got a running sore on one of her legs: scar is there to show where it was. Sore kept running with matter, about 2 years, when it was finally healed by different treatments. Since she got that sore, it seemed to bring back more than use of her limbs. But from that time again she has gradually lost her memory, and finally, about one year ago, commenced to lose her reason."

July 16. 1901 Summary of 14 day record. Dict. by Dr. Heyerdale.
Patient admitted on Infirmary west: bathed and put to bed: quiet in behavior: During first week Temp. P. & R. normal: appetite good: given occasional cathartic bowels moved daily: during first four days patient very quiet: speaks only Norwegian: slept well at night: very untidy in habits: on 20th. took outdoor exercise: 19 dressed & up on ward: 21st. patient very much disturbed and resistive did not sleep until after 2:00 A.M: 22d. Patient kept in bed very much disturbed: slept quite well during night. During second week Temp. P. & R about normal: appetite good: bowels regular: quite disturbed & resistive: very untidy: slept quite well at night by aid of hypnotic.

July 29. Patient up on ward: has special diet: Appetite quite good: Aug. 9th. transfered to B.1: no change: very untidy. Aug 10. patient sick in bed has some rise in Temp. transfered back to Infirmary West.

Personal and Medical History of Ellen Kjelset

Aug 10. patient comatose: unable to take nourishment: hot pack given also enema which was not retained: Urine showed large amount of albumin Patients condition one of Uraemia. Aug. 11th. Patient remained in same condition: resp. labored: Tem 105 at 3:00 P.M. Pulse 140 Res. 64: had slight convulsive movement of lower limbs at 8:35 P.M. when she died.

Dead.

Personal and Medical History of Nellie H. Smith

Whole No. 5879. Became resident of Minnesota by birth of County born here is a legal resident

Residence, Chatfield, Minn

Date Admission, 22nd July 1901.

Admitted by Dr. C. L. Chapple hour, 3.30 P.M.

How Sent, J. A. Leonard, Jo P. Olmsted County

Sex, Female Age, 35

Civil Condition, Married

Children, Two

Age Youngest Child, 7

Occupation, Housewife: father, retired farmer

Degree Education, Normal Graduate

Profession, Religion, Presbyterian

Habits, Probably good: not intemperate

Nativity, Olmsted Co. Minn: Parents born in Maine

Physicians Committing, A. W. Stinchfield and F. J. Halloran

Correspondents, George J. Smith (husband) Deer Park Wash

Miss Emma Hamlin (sister) Fergus Falls

No. of Year, 242.

Insane Relatives, none

Cause Exciting, No known cause

Cause Predisposing, previous attack

Form, Mania Chronic

Accompanying Bodily Disorder, none mentioned

Suicidal or not, Not

Date of this Attack, Became worse last Saturday

Duration, Probably short.

No. of Attack, 2nd (had one, 2 years ago)

No. of Admission, 1st here (was at Medical Lake, Washington)

Age First Attack, 33.

Time of Leaving, 15th October 1901

Time in Hospital, 2 mos. 23 ds.

Result, Recovered (out of State) Disd Nov 22/1901 (?)

% State Hospital

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of July

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, fair

Recent Events, ✓ Special Subjects, ✓

PERCEPTIVITY, Alert or Dull, Correct or Illusive. alert

REASONING POWER, Ordinary Subjects, poor

Special Subjects, poor

Own Mental State, ✓

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Exalted — very talkative

DELUSIONS, Systematized, Transitory, Special Subjects, numerous delusions & expresses them freely

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, Dead —

Maternal Relatives, ✓

Brothers and Sisters, ✓

Two children living — well —

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 Nellie H. Smith

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5½ in PRESENT WEIGHT, 120½ # USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal

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

PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal good good

SIGHT, good

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

HEARING, good

COORDINATION, Arms, good Legs, good ~~Grasp~~, other tests good —

TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor

PATELLAR REFLEX, present Other Reflexes, elbow

ARTICULATION, Slurred, Hesitating, Slow, ✓

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, ✓

HEART, Murmurs, Strength, Sounds, Size, none strong normal

Apex Beat, Regularity, normal normal

ARTERIES, normal: pulse small & weak.

LUNGS, Chest, Symmetry, Expansion, Yes 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: retroverted. Cervix indurated and elongated —

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 exalted in manner: very destructive & very restless: talks a great deal: talks when alone & when others are in her room: when alone, she addressed various people, calls them by name & carries on a conversation. Replies to inquiries but does not give reliable and correct answers to questions. —

Personal and Medical History of Nellie. H. Smith.

This patient was brought here by Sheriff E. H. Vine, attended by Emma Hamlin, in apparently fair physical Condition, with following history of case. There is no history of Consanguinity nor heredity. This is not first attack; another occurred 2 years ago; was never entirely well since. Was at hospital at Medical Lake, Washington: got some relief. First symptoms of this attack manifested probably recently: became worse last Saturday. Disease appears paroxysmal: variable with rational intervals, but these not regular intervals. Derangement now shown in all subjects. Is not dispossed to injure other, nor suicidal: propensity not active: Destroyed clothing at first. No previous peculiarities noted: no history of intemperance. She had severe scarlet fever, 20 years ago: has been confined at Asylum for twenty-five weeks. No known cause of the disease: treatment not known. On personal examination, is an excited Condition

July 22 On admission, was put on Infirmary. (E. H. V. Kpt. Complexion quite dark: hair brown: eyes gray: Condition of Skin rough: has small pimples on body & arms. Is clean. Teeth: upper, Eleven: lower, Twelve: Is very talkative: does not express delusions.

July 22-1901 Summary of 14 day record. Dict. by Dr. Heyerdale.

Patient admitted on Infirmary West: bathed and put to bed: was extremely noisy. During first week. Tem. P. & R. about normal: appetite very poor: bowels quite regular: was given cathartic upon admission: tidy in habits: very much disturbed: talks a great deal and is very sarcastic and disagreeable to those about her: is out of bed a great deal: destructive of clothing and bedding: extremely noisy at times: was given prolonged hot baths and hypnotics to induce sleep. During second week Tem. P. & R about normal: appetite fair: was given cathartics bowels otherwise regular: very noisy talkative and restless: destructive of clothing and bedding: sleepless at night: was given occasional hypnotic. on 31st. patient dressed and up on ward: Aug. 2d. took outdoor exercise: very restless at times.

August. 10-1901 Patient operated upon by Dr. C. H. Mayo Laparotomy for ventral fixation and also curettment: patient reacted well from operation and made an uneventful recovery from same: Temp. at no time going higher than 100°. During her convalescence patient continued very much disturbed: extremely sarcastic to all with whom she came in contact; complaining about the nurses and physicians, in fact, everything that was done for her. Aug. 21st. up and sitting on ward. Gynecological treatment given tri-weekly. Sept 10. patient confined to bed menstruating: has been taking electrical treatments daily: complains of a paraletic feeling in left leg. Sept 14 patient dressed and up on ward improving very much is quiet and agreeable to those about her: improving in general physical health. Sept. 19 taking massage which is given by Florence Jessup twice a week. Sept. 23 visited by sister: has parol of grounds and is out of doors a great deal: improving very rapidly both mentally and physically: very quiet & agreeable to those about her: neat in habits

Personal and Medical History of

and appearance: still given massage twice a week by Deborah Chisholm: Oct. 2 patient continues to improve: is neat in habits & appearance: pleasant and agreeable on ward: mind is perfectly restored: transferred to A 2. Oct. 7 Patient menstruating complained of cramps and pain in back: Oct. 15 went home to her people in Chatfield.

Personal and Medical History of Ida. S. Moody

Whole No. 5881. Resident of State 19 years, " of County 19 "
Residence, St Paul, Minn
Date Admission, 23rd July 1901.
Admitted by Dr. O. C. Heyerdale hour, 7 40 P.M.
How Sent, Henry Gallick, Ct. Commr., Ramsey County
Sex, Female Age, 35 years
Civil Condition, Married
Children, None
Age Youngest Child, —
Occupation, Milliner: husband, Civil Engineer
Degree Education, Common School
Profession, Religion, Lutheran
Habits, (have been intemperate) —
Nativity, Sweden: parents also born there
Physicians Committing, W. G. Richeson and A. W. Whitney
Correspondents, (sister) Miss Ruth Peterson
676 Rivoli Street
St Paul

No. of Year, 244.
Insane Relatives, None
Cause Exciting, Unknown
Cause Predisposing, previous attack
Form, General Paresis.
Accompanying Bodily Disorder, great weakness —
Suicidal or not, attempted it by using razor —
Date of this Attack, In April 1901.
Duration, about 3 months —
No. of Attack, 2nd (had one, in August 1899)
No. of Admission, 2nd
Age First Attack, about 32 years.
Time of Leaving, 12th May 1902
Time in Hospital, This time 9 mos 19 ds
Result, Improved: Discharged Nov 8/02.
(Cared for by relative)

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* July 23/1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Sluggish
MEMORY, Past Events, poor
Recent Events, poor Special Subjects, —
PERCEPTIVITY, Alert or Dull, Correct or Illusive. Dull
REASONING POWER, Ordinary Subjects, probably poor
Special Subjects, She refuses to talk much.
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, Says living
Paternal Relatives, —
× Mother, Says living
Maternal Relatives, —
Brothers and Sisters, —
children none —
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), —
HABITS, Drinking and Smoking, —
HEADACHES, VERTIGO, OR CONVULSIONS, —
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any, —
Sleep, Appetite, and Bowels, —

Same as in previous examination (which please see) She would not answer questions
× Statements not accurate

Personal and Medical History of Ida. S. Moody

SENT TO ROCHESTER—Ida Moody, living on Rivoli street, was committed to the Rochester insane asylum yesterday by the probate court.

PHYSICAL CHARACTERISTICS.

[illegible] not taken PRESENT WEIGHT, not taken USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, Coated, white, moist: prompt
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal good good
SIGHT, Seems fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Seems good
COORDINATION, Arms, poor Legs, poor Grasp, Finger to nose, eyes shut, fair; Standing on one foot, cannot stand; Turning quickly, " "; Standing, eyes shut, " "
TREMORS, Hands, Tongue, Facial Muscles, General, Slight of hands: Slight of tongue —
PATELLAR REFLEX, present Other Reflexes, —
ARTICULATION, Slurred, Hesitating, Slow, —
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, —
HEART, Murmurs, Strength, Sounds, Size, None fair normal
Apex Beat, Regularity, normal normal
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, Yes 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 genitals red & inflamed and irritable: uterus normal, retroverted: cervix normal: os small: slight 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 weak physical condition: Unable to walk: is dull & apathetic: has little strength: condition is probably one of General Paresis. Refuses to talk, at times: never says much. answers questions occasionally. —

Personal and Medical History of Ida. S. Moody

Whole No. 5881. Resident of State 19 years
" of County 19 "

Residence, St Paul, Minn

Date Admission, 23rd July 1901.

Admitted by D. C. Hesserdale hour, 7 40 PM

How Sent, Henry Gallick, Ct. Commr., Ramsey County

Sex, Female Age, 35 years

Civil Condition, Married

Children, None

Age Youngest Child,

Occupation, Milliner: husband, Civil Engineer

Degree Education, Common School

Profession, Religion, Lutheran

Habits, (Have been intemperate) –

Nativity, Sweden: parents also born there

Physicians Committing, W. G. Richeson & A. W. Watney

Correspondents, (Sister) Miss Ruth Peterson
676 Rivoli Street
St Paul

No. of Year, 244.

Insane Relatives, No

Cause Exciting, Unknown

Cause Predisposing, Previous attack

Form, General Paresis.

Accompanying Bodily Disorder, great weakness –

Suicidal or not, attempted by using razor –

Date of this Attack, in April 1901.

Duration, about 3 months –

No. of Attack, 2nd. (Had one, in August 1899)

No. of Admission, 2nd

Age First Attack, about 32 years

Time of Leaving, 12th May 1902

Time in Hospital, This time 9 mos 19 ds

Result, Improved: Discharged Nov 8/02.
(Cared for by relative)

HERPICIDE
Relieves Dandruff

EXAMINATION ON ADMISSION BY DR. D. C. Hesserdale Date of July 23/1901.

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Poor

Recent Events, poor Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Dull

REASONING POWER, Ordinary Subjects, probably poor

Special Subjects, She refuses to talk much.

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, Says living

Paternal Relatives,

Mother, Says living

Maternal Relatives,

Brothers and Sisters,
Children none

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

HABITS, Drinking and Smoking,

HEADACHES, VERTIGO, OR CONVULSIONS,

OCCUPATION, Healthy or not, Housework

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

Sleep, Appetite, and Bowels,

× Same as in previous ex. – connection (which please see) Statement not accurate Statements not Answered Questions

Personal and Medical History of Ida. S. Moody

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, white, moist: prompt

PUPILS, Equality, Size, Response to Light, and Accommodation, Yes Normal Good Good

SIGHT, Seems fair

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

HEARING, Seems good

COORDINATION, Arms, Poor Legs, poor Grasp, Turning quickly, " "
Slight tremor of hands: Slight tremor
Standing, eyes shut,
TREMORS, Hands, Tongue, Facial Muscles, General,

Finger to nose, eyes shut, fair
Standing on left foot, cannot stand
Standing, eyes shut, " "

PATELLAR REFLEX, present Other Reflexes,

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Apex Beat, Regularity, Yes Fair Normal Normal Normal

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Yes 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 genitals red & inflamed and irritable: uterus normal, retroverted: Cervix normal: os small: slight 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 weak physical condition: Unable to walk: is dull & apathetic: has little strength: condition is probably one of General Paresis. Refuses to talk, at times: never says much, answers questions occasionally. –

Personal and Medical History of Ida. S. Moody

1901

This patient was brought here by Deputy Sheriff Johnson attended by Mr. H. K. Lang and Sister, Miss Ruth Peterson, in poor condition with following history of case. There is no history of consanguinity nor heredity. This is not first attack; one occurred in August 1899, duration 8 months, when she was at this (Rochester) hospital & discharged, cured. First symptoms of this attack manifested in april 1901, by melancholia: Disease seems increasing; not variable: no rational intervals. Derangement now shown in that she refuses to eat and talk, and fearful of those around her. Is not disposed to injure others, but has attempted suicide, by using a razor; propensity not now active. Is also disposed to filthy and destructive habits. No previous peculiarities noted: She has not been addicted to intemperance & the use of narcotics since former Commitment. No history of any severe disease &c in head - injury. Has been confined at Rochester 8 months. Cause of the disease unknown. She has been treated by Dr. Sohlberg, St Paul. On personal examination she refuses to talk: has a sallow Complexion. N.B. 2nd admission: was there before from Aug 8 - 1899 to April 25 - 1900: discharged Nov 7 - 1900, improved. Patient then said to be intemperate. Diagnosis: General Paresis. See Vol 40 page 369 no 5375.

July 23 On admission, was put on T.W. (G.H.N.Rpt. Complexion dark: hair dark brown: eyes gray: condition of skin, hot and dry: no marks scars or bruises noted.: is dirty. has 12 upper and 14 lower teeth: behavior quiet. Talk very little: will scarcely answer a question).

July 23d. 1901. Summary of 14 day record. Dict. by Dr. Heyerdale:
Patient received on Infirmary west: bathed and put to bed: During first week. Tem. P. & R. normal: appitite poor given liquid diet: also cathartic upon admission: bowels moved daily: slept well at night: given hypnotic on evening of 24th: is quiet, resistive: will answer questions: very untidy in habits. During second week Tem. P. & R. about normal: takes liquid diet and occasional cathartic for bowels which were quite regular: slept well at night: is extremely quiet: does not converse: is resistive: Patients condition seems very much like general Paresis. June to Sept. Aug. 15 patient up on ward will not converse or help herself in any way: takes some out door exercise, does not show any change in condition: Aug. 30 Wt. 109½#.
Sept. to Dec. Receives gynecological treatment three times a week: Sept. 2 trans. to B. 1 West: untidy in habits and careless in appearance: fed from a tray: converses very little: rarely answers questions: Appetite poor: sleeps well: quite constipated: during Oct. became very much brighter began to take an interest in the ward doings: Oct. 31 visited by friends: habits became clean and tidy in appearance: talks quite intelligently: assists with ward work. Nov. 27 Wt. 131½#. Dec. to Mar. 1902 Dec. 15 visited by father. Dec 17 trans. to A. 2 W. Assists some with the ward work: improving mentally and physically: Jan. 20 menstruating: Feb. 27 Wt. 135#. Mar 8.

Personal and Medical History of

April 11. 1902 menstruating: very well mentally and physically: May 12 visited by father and taken home.

Personal and Medical History of Inga. A. Fretteim

Whole No. 5882. Became resident of Minnesota 1882 " " of County Goodhue 1882

Residence, Kenyon, Minnesota

Date Admission, 23rd July 1901.

Admitted by Dr. O. C. Heyerdale hour, 7.40 pm

How Sent, Axel Haller J of P. Goodhue County

Sex, Female Age, 44

Civil Condition, Married

Children, Eight (8)

Age Youngest Child, six years

Occupation, Housewife; husband a farmer

Degree Education, Common School

Profession, Religion, Lutheran

Habits, no history of intemperance –

Nativity, Norway, Europe; parents also born there

Physicians Committing, L. L. Maryland and Geo. C. Willner

Correspondents, (Brother) Andrew Moe, West Concord, Minn

Rev. Laundebwigh, Kenyon, Minn

No. of Year, 245.

Insane Relatives, one brother insane; nothing further known

Cause Exciting, Blow upon head

Cause Predisposing, previous attacks (& possibly heredity)

Form, Mania chronic

Accompanying Bodily Disorder, none mentioned

Suicidal or not, not, but will injure others.

Date of this Attack, July 21st 1901

Duration, – about 2 Days –

No. of Attack, not 1st – (6th attack & probably more)

No. of Admission, – 5th –

Age First Attack, about 23 years

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* July 30/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick and Quite Clear

MEMORY, Past Events, seems fair

Recent Events, " " Special Subjects, " "

PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert – quite correct

REASONING POWER, Ordinary Subjects, ✓

Special Subjects,

Own Mental State, Says "She is perfectly well"

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

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

Paternal Relatives,

Mother, Dead – (childbirth) –

Maternal Relatives, –

Brothers and Sisters, – 8 children (6 living?)

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
She says "No" –

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, ✓

This address was found in purse
July 23/1901
Mr. E. O. Fretheim
c/o Rev. Mn. O. Silseth
Larimore
N. Dak

Personal and Medical History of Inga. A. Fretteim

RISTICS.

WEIGHT, NUTRITION, good

...t white coating

Grasp, other tests good

PATELLAR REFLEX, present

Other Reflexes, Elbow, wrist, Jaw jerk.

ARTICULATION, Slurred, Hesitating, Slow, ✓

FACIAL EXPRESSION, Paretic, Sad, Etc. ✓

SENSIBILITY, ✓

HEART, Murmurs, Strength, Sounds, Size, none strong normal

Apex Beat, Regularity, normal regular

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Yes 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, Extensive laceration of perinaeum: rectocele: cystocele: uterus normal in size: cervix large & patulous; 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). patient admitted in good physical condition. appetite good: sleeps well, at night: she is exalted & hysterical in manner & behavior: talks a great deal & laughs immoderately upon the slightest pretext. She is very active physically; patient answers questions quite intelligently & is very anxious to be sent to her home, as she says she is perfectly well –

Personal and Medical History of Inga. A. Fretteim

Whole No. 5882. Became resident of
" " " of
Residence, Kenyon, Minnesota
Date Admission, 23rd July 1901.
Admitted by Dr. O.C. Heyerdale
How Sent, Axel Haller Jof 1. Goodh
Sex, Female Age, 44
Civil Condition, Married
Children, Eight (8)
Age Youngest Child, Six Years
Occupation, Housewife; Husban
Degree Education, Compmmbch
Profession, Religion, Lutheran
Habits, no history of intemperance -
Nativity, Norway, Europe; parents also born there
Physicians Committing, L.L. Mayland and Geo. C. Wilkins
Correspondents, (Brother) Andrew Moe, West Concord, Minn
Rev. Laundebvergh, Kenyon, Minn

Age First Attack, about 23 years
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O.C. Heyerdale *Date of* July 30/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick and Quite Clear
MEMORY, Past Events, Seems fair
Recent Events, " " Special Subjects, " "
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert - Quite Correct
REASONING POWER, Ordinary Subjects, ~
Special Subjects,
Own Mental State, Says "she is perfectly well".
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted - hysterical.

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
Paternal Relatives,
Mother, Dead - (childbirth)-
Maternal Relatives,
Brothers and Sisters, - 8 children (6 living)
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
She says "no" -
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 Inga. A. Fretteim

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6in PRESENT WEIGHT, 141½ lbs USUAL WEIGHT, NUTRITION, good
WOUNDS, Abnormalities and condition of Skin, Normal
TONGUE, Coatings or Promptness of Movement, Prompt: very slight white coating
PUPILS, Equality, Size, Response to Light, and Accommodation, fair
SIGHT, Good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Normal
HEARING, Good
COORDINATION, Arms, Good Legs, Good Grasp, other tests good
TREMORS, Hands, Tongue, Facial Muscles, General,
PATELLAR REFLEX, present Other Reflexes, Elbow, wrist, Jaw jerk.
ARTICULATION, Slurred, Hesitating, Slow, ~
FACIAL EXPRESSION, Paretic, Sad, Etc. ~
SENSIBILITY, ~
HEART, Murmurs, Strength, Sounds, Size, Apex Beat, Regularity, regular
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, Extensive laceration of perineum: rectocele: Cystocele: uterus normal in size: Cervix large & patulous; 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). Patient admitted in good physical condition appetite good: Sleeps well, at night: She is exalted & hysterical in manner & behavior: talks a great deal & laughs unprovokedly upon the slightest pretext. She is very active physically; patient answers questions quite intelligently & is very anxious to be sent to her home, as she says she is perfectly well.

Personal and Medical History of Inga. A. Frettem

1901

This patient was brought here by Dep.-Sheriff E. R. Renke, attended by Mrs Mamie Rose, in poor condition, & with following history of case. There is no history of consanguinity; - she has one brother Insane; nothing further known: This is not first attack; others occurred in 1886. - 1894 - and 1896: durations about four to six months each: was at hospital at Rochester, Minn; result of treatment, improvement. First symptoms of this attack were manifested July 21 - 1901, by singing in a noisy way and using abusive language. Disease seems stationary: variable, yes: no regular intervals. Derangement now shown on no subject in particular: talkative and hysterical. Is disposed to injure others, but not suicidal: no filthy or destructive habits. Had a quick uneven temper. No history of intemperance: has had injury to head: no restraint or confinement has been employed, but has had to be watched. Supposed cause of the disease is blow upon head. Not any treatment for this attack. On personal examination, she is hysterical, talkative, disposed to cry; rapid pulse.* N.B. This is 6th attack (probably more): 5th admission: was here before First time from Nov 14/86 to Apl 8/87 - see Vol 7 page 173 No —
— " " Second time " Jan 16/94 to Apl 24/94 - See " 24 " 365 —
— " " Third time " June 20/95 to Nov 12/95 - See " 28 " 277 —
— " " Fourth time " Oct 5/96 to Jany 28/99 - See " 30 " 357 —
(Form of Insanity was diagnosed as "Chronic mania") ——— ———

July 23 On admission, was put on Infirmary (G. H. N. R/H. Complexion fair: hair light: eyes blue: Condition of skin normal: no marks or scars noted: a small bruise on leg & arm: no hermae: no vermin: is clean: has two upper and 13 lower teeth & all are in bad condition. Behavior quiet: In talking is rather silly: laughs a great deal). —

July 23. 1901 Summary of 14 day records. Dict. by Dr. Heyerdale.

Patient admitted on Infirmary West: bathed and put to bed: quiet in behavior: During first week Tem. P. & R. about normal: appetite good; occasional cathartic given, bowels moved daily: slept well at night: neat in habits and agreeable in behavior. Aug. 1st. patient became quite disturbed; given hypnotic: dressed and up on ward Aug. 3d: takes outdoor exercise thereafter.

During second week Tem. P. & R about normal: appetite good: bowels regular: slept well at night: quiet in behavior: talks intelligently: neat in habits & quite agreeable: quite disturbed at times: inclined to be quite silly: at times quite disturbed: takes outdoor exercise. June to Sept. July 29 commenced working in the laundry: is still delusional but usually quiet: attends chapel, takes out door exercise: Aug 10 menstruated: Aug 14 had 5 teeth extracted: Aug 30 trans. to D. 3 Sept. 1 Wt. 138#. Sept. to Dec. Latter part of Oct. had sore throat received treatment for same: patient is at times noisy, disagreeable and quite hysterical on the ward sometimes laughs and other times cries and sometimes has to be put in seclusion: generally quiet: works in dining room: Nov. 30 Wt. 146½ #.

Personal and Medical History of

Dec. to Feb. 1903. Patient has been quite noisy and excitable, requiring seclusion. Later she became more agreeable: assists with the work talks a great deal in a religious way. When disturbed, is quite silly and childish: when at her best is pleasant & agreeable and quite helpful on the ward: answers questions intelligently. Dec. 1st Wt 149⅓ #. Dec. 23 to Dec 27th had an attack of tonsilitus: was put to bed, treated, and medicine given. Dec. 27th. Visited by friends.

Personal and Medical History of Anna Anderson #2

Whole No. 5887. Became resident of State? State-born of County — 5 years

Residence, St Paul Minn

Date Admission, 30th July 1901.

Admitted by Dr. E. Z. Wanous hour, 7 30 P.M.

How Sent, Henry Gallick, Ct Commr Ramsey Co

Sex, Female Age, 42 years

Civil Condition, widow

Children, none

Age Youngest Child, —

Occupation, Cook: fathers, farmer

Degree Education, Common school

Profession, Religion, Lutheran

Habits, History of intemperance

Nativity, Minnesota: parents born in Norway

Physicians Committing, Edgar T. Schmidt and O. Martel

Correspondents, none given in papers

No. of Year, 250.

Insane Relatives, yes: mother

Cause Exciting, Dont know

Cause Predisposing, heredity

Form, Mania Acute

Accompanying Bodily Disorder, Blindness of both eyes.

Suicidal or not, not

Date of this Attack, 6 months ago

Duration, 6 months

No. of Attack, 1st

No. of Admission, 1st

Age First Attack, 41 past

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale — Date of July —

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, good

Recent Events, good Special Subjects, good

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

REASONING POWER, Ordinary Subjects, —

Special Subjects, —

Own Mental State, Says "she is not insane & always knows what she is doing" —

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Seems quite 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). her mother was insane: father was paralyzed —

Father, Dead: had been paralyzed for 10 years

Paternal Relatives, —

Mother, Dead: was insane & died at Rochester State Hospital

Maternal Relatives,

Brothers and Sisters, 1 brother: 2 sisters

Children — none

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Brain-fever at 10 years of age: mumps the month previous to the brain-fever —

HABITS, Drinking and Smoking, good

HEADACHES, VERTIGO, OR CONVULSIONS, ✓

OCCUPATION, Healthy or not, Housework

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

Sleep, Appetite, and Bowels, poor good regular

Personal and Medical History of Anna Anderson #2

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in PRESENT WEIGHT, 119# USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal

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

PUPILS, Equality, Size, Response to Light, and Accommodation, none None

SIGHT, Blind in both eyes

EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, Blind in both eyes

HEARING, good

COORDINATION, Arms, good Legs, fair Grasp, Finger to nose, eyes shut, good; Standing on one foot, poor; Standing, eyes shut, good

TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor fine tremor

PATELLAR REFLEX, present Other Reflexes, Elbow, wrist, Jaw jerk

ARTICULATION, Slurred, Hesitating, Slow, ✓

FACIAL EXPRESSION, Paretic, Sad, Etc. ✓

SENSIBILITY, ✓

HEART, Murmurs, Strength, Sounds, Size, none fairly strong normal

Apex Beat, Regularity, normal regular

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, yes 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 genitals normal: uterus about normal: Cervix large & soft.

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 good physical condition: is quiet & agreeable: she answers questions intelligently & rationally: she is totally blind in both eyes: which blindness, she says, was caused by an attack of brain fever. —

Personal and Medical History of Anna Anderson

1901

This patient was brought here by Dep-Sheriff Johnson, attended by Mrs Silverstein, in poor physical condition, with following history of case. No consanguinity: mother insane: this is 1st attack: first symptoms manifested 6 months ago, on the subjects of matrimony and religion: the disease appears increasing; variable and with rational intervals, but these, not regular. Derangement now shown as stated, as above: is disposed to injure others, but is not suicidal. No filthy or destructive habits. Dont know as to any previous peculiarities, exept religious impressions. There is history of intemperance: Last had brain-fever. She has not been restrained or confined. Dont know supposed cause of the disease: treatment, none. On personal examination there is noted blindness of both eyes, supposed to be the result of brain-fever.

July 30 On admission, was put on T.W. (S.H.N.Pat. Complexion dark: hair light-brown: eyes gray: condition of skin normal: no marks, scars or bruises noted: is clean: Patient blind in both eyes — has 10 lower teeth and an upper plate: behavior quiet: talks intelligently, but says, at times, She feels very cross).

July 30th 1901 Summary of 1st day records: Dict. by Dr. Meyerdale.
Patient admitted 2nd Infirmary West, bathed & put to bed: is blind in both eyes. During first week Tem. P. & R. normal: talks quite intelligently is neat in habits & appearance: quiet in behavior: Aug 1st became quite disturbed: was given hypnotic to induce sleep: dressed & up on ward Aug. 3. takes outdoor exercise. During second week Tem. P. & R. normal: appetite good: bowels regular: slept well at night: quiet in behavior: talks intelligently: takes regular outdoor exercise: during latter part of week is somewhat troublesome: is resistive and more disturbed: inclined to disarrange bed: wanders about the ward: causes no serious trouble however.

June to Sept. Expresses delusions and some incoherence; Aug. 30 trans. to B.1: Sept. 2 Wt. 113½#. Sept. to Dec. Patient is at times quite resistive and very disagreeable and sometimes destructive: neat in habits and appearance: quite depressed at times: sometimes converses: reads from a book of raised letters that was sent to her by a friend: menstruates regularly: Nov. 22 Wt. 120#.

Dec to Feb 1903 Patient is usually quiet: at times talks quite sensibly. Is neat and clean: appetite good: bowels regular: sleeps well. Nov. 27th Wt 114#. Jan. 5th complained of being sick at stomach. Cathartic given: put to bed. Expectorates quite a good deal: is blind so does not exercise. Never converses as a rule but talks to herself a good deal. Usually answers questions.

Personal and Medical History of

Personal and Medical History of Judith K. Sawyer

Whole No. 5891.
Residence, Medford, Minn.
Date Admission, 2nd August 1901
Admitted by D. O. C. Heyerdale hour, 4:30 P.M.
How Sent, W. A. Eggleston, Jo P. Steele County
Sex, Female Age, 83.
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, None
Degree Education, Academy
Profession, Religion, Congregational
Habits, Not stated — Father was addicted to liquor
Nativity, Warner, New Hampshire: Parents born in New Hampshire
Physicians Committing, J. M. Emerson and Thos. L. Hatch
Correspondents, (Nephews) Wm. J. A. Sawyer or W. F. Sawyer Owatonna, Minn

No. of Year, 3.
Insane Relatives, one brother died in Insane Hospital
Cause Exciting, Don't Know
Cause Predisposing, Chronic & possibly hereditary
Form, Senile Dementia
Accompanying Bodily Disorder, asthmatic condition + injury to spine
Suicidal or not, Not. Not will injure others.
Date of this Attack, 30 years ago
Duration, 30 years
No. of Attack, 1st (has continued for 30 years)
No. of Admission, 1st
Age First Attack, 53 years
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale *Date of* Aug. —

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick, but Confused
MEMORY, Past Events, Poor
Recent Events, Poor Special Subjects, Poor
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
—
REASONING POWER, Ordinary Subjects, Poor
Special Subjects, Poor
Own Mental State,
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
—
DELUSIONS, Systematized, Transitory, Special Subjects,
—
HALLUCINATIONS,
ILLUSIONS, — Patient is demented

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, 30 years
ONSET, Gradual or Sudden, gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father was always alone, an hermit. Brother died in an insane Asylum at Cincinnati
Father, Died at a very old age
Paternal Relatives,
Mother, Died — very old
Maternal Relatives,
Brothers and Sisters, 2 brothers — 2 sisters
Children — none
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Commitment states that she fell & injured her back, 30 years ago, & since, it has troubled her much & has
HABITS, Drinking and Smoking, Temperate
HEADACHES, VERTIGO, OR CONVULSIONS, —
OCCUPATION, Healthy or not,
School teacher for years. Has done nothing for some years.
Detail Date, Duration, and Character of Previous Attack, if any,
for good
Sleep, Appetite, and Bowels, Irregular

Personal and Medical History of Judith K. Sawyer

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4in PRESENT WEIGHT, 114 lbs USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt
PUPILS, Equality, Size, Response to Light, and Accommodation, yes small Left fair
SIGHT, fair, for one of her age
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, Poor Legs, poor Grasp, Fingers to nose, eyes shut, Fair Standing, or arm first, poor Turning quickly poor. Standing, eyes shut, poor.
TREMORS, Coarse Hands, Fine Tongue, Facial Muscles, General, —
PATELLAR REFLEX, Diminished Other Reflexes, Elbow, wrist
ARTICULATION, Slurred, Hesitating, Slow, —
FACIAL EXPRESSION, Paretic, Sad, Etc. —
SENSIBILITY, —
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
Could not hear heart sounds distinctly owing to Cough & disturbed respiration
ARTERIES,
Somewhat 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,
Somewhat large antero-posteriorly due, probably, to emphysematous condition of lungs. There are numerous coarse rales & marked bronchial breathing, all over whole chest. Patient is asthmatic.
EXAMINATION URINE, Quantity, Sp. g. Reaction, Color and Appearance,
Albumen, Sugar,
Casts and Crystals,

GYNECOLOGICAL EXAMINATION, External genitals normal: Hymen intact: Uterus and cervix small.
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: is asthmatic & has difficulty in breathing: is quite helpless & weak: she is old & feeble & mental condition is one of senile dementia.

Personal and Medical History of Judith K. Sawyer

1901

This patient was brought here by Mr. J.A. Sawyer, attended by Mrs L.M. Blumenshein, in poor condition, with following history of case. There is no history of consanguinity: one brother died in Insane Hospital. This is 1st attack: has continued for 30 years. First Symptoms of this attack manifested 30 years ago: became suspicious and talked incoherently. Disease seems increasing: variable with rational intervals, but these not regular. Derangement now shown in that she has "Spells" of being wild & incoherent. Is disposed to injure others, but not suicidal: is disposed to filthy and destructive habits. She previously showed some peculiarities of temper, disposition &c. For several years, her father was addicted to use of liquor. Thirty years ago, had injury to spine. She has been confined to her room, more or less, for the last 3 or 4 months. Don't know cause of the disease: treatment, none. On a Personal examination, She shows an asthmatic condition: chlorisis: incoherency, at times.

Augr On admission, was put on T.W. (G.H.N.R'pt. Complexion dark: hair gray: eyes blue: condition of skin dry & flabby: no marks: small scar on left cheek: no eruptions, ulcers, hernia or vermin noted: several small bruises on legs, hand and arms: is very dirty: has marked kyphosis: both feet badly swollen: has both and upper and lower plate. Is very irritable: begs almost constantly for eatables.

August 2d. 1901 Summary of 14 day record: Dict. by Dr. Heyerdahl

Patient admitted on Infirmary West bathed and put to bed: was very dirty: is quiet: During first week Tem. P. & R. about normal: appetite good: bowels regular: given regular diet: given occasional cathartic: slept well at night: very quiet in behavior: talks considerably: has some difficulty in breathing when lying down: coughs some: is out of bed frequently during the night. During second week. Tem. P. & R. about normal appetite good: bowels regular: takes medicine regularly 3 times per day: slept well at night. dressed and up on ward on the tenth on the 13th. took outdoor exercise: is quiet in behavior: very untidy in appearance: is demented: very agreeable. Sept. to Dec. Sept. 3 trans. to A 1 converses quite readily, in fact is very talkative but is delusional. does not seem to realize where she is: wanders about the ward in a restless way: is inclined to lie about on the beds in the day time: is feeble: habits untidy: appearance careless, takes no exercise: requires cathartics: appetite good: Nov. 30 Wt 123#. Aug. 21 visited by friends: condition is one of senile dementia

Dec to Feb 1903 Patient is quite childish: voluntarily converses and answers questions tho generally irrelevantly. Has no realization of the passage of time. Her general health is rather poor. Appetite very good. She usually complains that she has had nothing to eat. even immediately following a hearty meal: always seems to be hungry. Bowels usually regular: sleeps well. Nov 27th Wt 121#

Personal and Medical History of

Personal and Medical History of Louise Duhamel

Whole No. 5893. Became resident of State at birth. " " of County, at birth.
Residence, St Paul: Minn
Date Admission, 7th August 1901.
Admitted by Dr. O. C. Heyerdale hour, 7.30 P.M.
How Sent, Edmund W. Bazille, Jof P. Ramsey Co.
Sex, Female Age, 23.
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Shop-girl
Degree Education, Common School
Profession, Religion, R. Catholic
Habits, Do not know as to intemperance.
Nativity, St Paul. Minn: Parents born in Canada.
Physicians Committing, Arthur B. Aucker M.D. Halon Ineve
Correspondents, None given on papers
Mrs Alfred Duhamel. 583 Warren St St Paul.
(per St. H. 8/8/1901)

No. of Year, 5.
Insane Relatives, Do not know
Cause Exciting, Unknown
Cause Predisposing, not stated
Form, Delusional Insanity. Paranoia
Accompanying Bodily Disorder, Is anaemic.
Suicidal or not, Not
Date of this Attack, about a year ago
Duration, about a year.
No. of Attack, 1st
No. of Admission, 1st (time): at C&C Hospl. since July 15/1901
Age First Attack, 22 (about).
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O C Heyerdale Date of Aug 8/1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick & quite clear, except on subjects of persecutions, witches influence &c
MEMORY, Past Events, quite good
Recent Events, " Special Subjects, ——
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert
REASONING POWER, Ordinary Subjects, fair
Special Subjects, ——
Own Mental State, Says "She is perfectly well: that she is not insane."
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
somewhat depressed
DELUSIONS, Systematized, Transitory, Special Subjects, Says "certain people have an influence over her". "That she is bewitched" —
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, Evidently gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Dead: (Heart trouble) —
Paternal Relatives, negative history
Mother, Living — well
Maternal Relatives, negative history
Brothers and Sisters, 5 sisters: all well.
Children — none —
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Has gonorrhoeal vaginitis at the present time.
HABITS, Drinking and Smoking, Bad: drank beer & wine
HEADACHES, VERTIGO, OR CONVULSIONS, —
OCCUPATION, Healthy or not, Shop-girl
Detail Date, Duration, and Character of Previous Attack, if any, —
Poor Fair
Sleep, Appetite, and Bowels, Constipated, usually.

Personal and Medical History of Louise Duhamel

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4in PRESENT WEIGHT, 105½ lbs USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt
PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal Good Good
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Good
COORDINATION, Arms, Good Legs, good Grasp, other test, Good
TREMORS, Hands, Tongue, Facial Muscles, General, none true
PATELLAR REFLEX, present Other Reflexes, elbow
ARTICULATION, Slurred, Hesitating, Slow, —
FACIAL EXPRESSION, Paretic, Sad, Etc. —
SENSIBILITY, —
HEART, Murmurs, Strength, Sounds, Size, Normal Normal Normal
Apex Beat, Regularity, Normal Normal
ARTERIES, Normal
LUNGS, Chest, Symmetry, Expansion, Yes 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, Has gonorrhoeal vaginitis, at the present time. Sept 17/1901 — Has gonorrhoea — Syphelis. —
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: is anaemic & somewhat emaciated: talks freely & answers questions promptly. Expresses delusions of persecution & also says "there are witches & others influencing her" —

Personal and Medical History of *Louise Duhamel*

Personal and Medical History of

1901

This patient was brought here by Deputy E. Johnson, attended by Mrs Daniel Mullen, in poor Condition, with following history of case. There is no history of consanguinity: as to any insane relatives, do not know. This is 1st attack: first Symptoms manifested, about a year (ago), by delusions of persecution: ran away to Chicago, last February: Disease seems increasing; not variable; no rational intervals: Derangement is now shown in that she thinks she is being persecuted by persons, who appear to her as Witches: suspicious: sleepless. Patient is not disposed to injure others, nor suicidal: no filthy or destructive habits. Mother says that she has been peculiar for more than a year. As to any history of intemperance, do not know: no history of any Sexual disease &c, or head-injury. Patient has been in City & County Hospital since July 4/1901. Cause of the disease unknown: treatment has been rest and tonics. On a personal examination, she is anaemic: talks about people who assume various shapes to bother her, and influence all her actions. ——

Aug 7 On admission, was put on T.W. [T.H.N. Pkt. Complexion dark: hair, light brown: eyes blue: condition of skin normal: no marks, scars or bruises noted: is rather dirty: has vermin: has 13 upper and 13 lower teeth: behavior quiet: thinks people are trying to influence her and win her affections). —

August 7th 1901 Summary of 1st day records. Dict. by Dr. Meyerdale Admitted on Infirmary West: bathed and put to bed: very dirty: quiet in behavior: slept well at night: During first week Tem. P. & R. about normal: appetite good: bowels constipated: medicine given three times daily: patient has gonorrhoea: bichloride douches given every morning: sleeps well at night: at times somewhat disturbed, resistive: generally quiet in behavior: dressed and up on ward on 12th. somewhat disturbed during night: has delusions thinks she is hypnotized and under the control of others and that she is being pinched. Second week Tem. P. & R. about normal: appetite good: bowels regular: takes medicine three times daily: sleeps well at night: takes outdoor exercise: vaginal douches given every morning, boric acid: discharge profuse. June to Sept. Patient up and about the ward each day: quiet in behavior: sometimes very profane in her language: is unoccupied: receive gynecological treatment three times a week has gonohorrea: has many delusions of persecution which she expresses freely. Aug. 31 Wt. 113½ #. Sept. to Dec. Sept. 14 patient attacked nurse struck her several times: given douche of bichloride of Mercury: bladder irrigated daily with a solution of boric acid: Oct. 28 menstruated Nov. 1 trans. to B.3 West: fairly agreeable: assists some with ward work: Nov. 27 Wt. 124½ #.

Dec to Feb 1903 No change. Wt about 117#. Gen'l health good: appetite good: bowels regular as a rule: sleeps well: takes outdoor exercise: neat in habits rather careless in appearance: answers questions intelligently aside from delusions. Rarely volunteers conversation: rather reticent: takes little interest in surroundings. Does no work. Dec 1st. Wt. 103½ #.

Personal and Medical History of Caroline Hofmeister

Whole No. 5896.
Residence, Rice County
Date Admission, 15th August 1901.
Admitted by Dr. O.C. Heyerdale — hour, 8.00 PM
How Sent, James Hunter Jof P. Rice County
Sex, Female Age, 53.
Civil Condition, married
Children, 2 Dead: 6 living.
Age Youngest Child, 9 years —
Occupation, Housewife: husband, Shoemaker
Degree Education, — Common School —
Profession, Religion, Lutheran
Habits, not intemperate —
Nativity, Germany; parents also born there.
Physicians Committing, Clerc. N. Jackson and John Dargavel
Correspondents, Mr. Carl Hofmeister
(Husband) Morristown. Minn

No. of Year, 8.
Insane Relatives, None
Cause Exciting, Worry over arrest of son: law suit, last spring - (1st time - frightened)
Cause Predisposing, — previous attack —
Form, Mania acute
Accompanying Bodily Disorder, tremulous: high pulse
Suicidal or not, Suicidal propensity active
Date of this Attack, Last spring (March) -
Duration, 5 months
No. of Attack, 2nd: one 19 years ago -
No. of Admission, 1st —
Age First Attack, — 34 —
Time of Leaving, December 30 - 1901
Time in Hospital, 4 mos - 15 Ds
Result, Improved: Discharged July 9-1902 (By Hof C)

EXAMINATION ON ADMISSION BY DR. O.C. Heyerdale *Date of* Aug 16-1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quick: confused
MEMORY, Past Events, poor
Recent Events, " " Special Subjects, " "
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert: quite Correct on many Subjects
REASONING POWER, Ordinary Subjects, —
Special Subjects, ——
Own Mental State, Says: "She is not insane" -
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Exalted
DELUSIONS, Systematized, Transitory, Special Subjects,
~
She has numerous delusions: thinks she is some prominent person —
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
Paternal Relatives, ——
Mother, Dead —
Maternal Relatives, ——
Brothers and Sisters, 3 brothers — 1 sister
Children — 6 living
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Says "no"
HABITS, Drinking and Smoking, Says "good"
HEADACHES, VERTIGO, OR CONVULSIONS,
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any,
——
Sleep, Appetite, and Bowels, Regular. Poor Poor

Personal and Medical History of Caroline Hofmeister

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1in PRESENT WEIGHT, 115 lbs USUAL WEIGHT, NUTRITION, fair
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, prompt: thick gray coating
PUPILS, Equality, Size, Response to Light, and Accommodation, Eq normal Size normal Light fair Good.
SIGHT, good
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, good Legs, good Grasp, Right test good
TREMORS, Hands, fine Tongue, fine Facial Muscles, General, —
PATELLAR REFLEX, exaggerated Other Reflexes, Elbow — wrist
ARTICULATION, Slurred, Hesitating, Slow, ~
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, ~
HEART, Murmurs, Strength, Sounds, Size, none normal normal
Apex Beat, Regularity, normal normal
ARTERIES, normal
LUNGS, Chest, Symmetry, Expansion, Rs 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, Perinaeum lacerated: Cystocele: rectocele: uterus hard retroverted: cervix lacerated: hard
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 much disturbed mentally, and, at times, is entirely incoherent in her speech: some questions heard answer quite well. When disturbed, she makes a queer noise, like an angry parrot.

Personal and Medical History of *Caroline Hofmeister*

1901

This patient was brought here by Sheriff J. B. Shank, attended by Mrs Amanda Shank, in fair condition, with following history of case. There is no history of consanguinity, nor of heredity. This is not 1st attack; another occurred 19 years ago: duration 6 months - (This, since last spring): was not sent to any hospital: recovery under treatment. - First symptoms of this attack manifested last March: worry over arrest of son; was sleepless; cries, sings, talks excessively: law-suit last spring: disease seems increasing slowly: variable & with rational intervals, but these, not regular. Derangement is now shown in everything: religious, sings & prays: "Thinks herself Mrs McKinley & others" - Is not disposed to injure others: has not attempted suicide: now, propensity a little active: talks of poison, paris Green &c: no filthy or destructive habits: no previous peculiarities noted: no history of intemperance, nor of any severe disease &c or head-injury. Has not been restrained or confined. Supposed cause of the disease 1st time, fright: this time, (as in No. 9): worry over arrest of son &c: law-suit, last spring. Treatment has been sedatives, with some effect, temporary. On Personal Examination, pulse 111; hand excited: talks excitedly: sings meaningless snatches, tremulous tongue; forehead tensely corrugated: melancholia expression in repose.

Aug 15 On admission, was put on T.W. (G.H.N. R'pt. Complexion dark: hair brown: eyes hazel: Condition of skin normal: no marks, scars, eruptions or ulcers noted: small bruises on both legs & small scratch on right arm: no herniae: no vermin, but is dirty: has 7 lower, and 5 upper teeth, all in bad condition. Behavior quiet: has delusions. —

August 15th. 1901 Summary of 14 day records: Dict. by Dr. Heyerdale.

Patient admitted on Infirmary West: bathed and put to bed: was very dirty: weak: very noisy all night. During first week Tem. P. & R. about normal: appetite good: bowels regular: on 16th was given hypnotic: very noisy and much disturbed first two nights: talked a great deal and uttered a parrot like yell: during rest of week slept very well at night: on 19th. dressed and up on ward: took outdoor exercise. During second week Tem. P. & R. normal: appetite good: bowels regular: slept well at night: takes regular outdoor exercise: converses quite intelligently: patient is active at times and very much disturbed.

Aug 30 patient up on ward: assists with work: neat in habits and appearance; appetite good: bowels regular: takes outdoor exercise: expresses delusions; Aug 30 Wt. 108½#. Sept. to Dec. Patient improving rapidly: assists regularly with work: Nov. 29 Wt. 110½#. Dec. to Mar. 1902 Dec. 3 visited by son: Dec. 30 by husband: general health very good: very much improved mentally and physically: went home with husband Dec. 30. 1901.

Personal and Medical History of

Personal and Medical History of Jessie Dills

Whole No. 5897.
Residence, Albert Lea, Minn
Date Admission, 16th August 1901.
Admitted by Dr. O. C. Heyerdale hour, 8:00 P.M.
How Sent, Ageman Blackmer, Jolf. Freeborn County
Sex, Female Age, 45.
Civil Condition, Married
Children, — 4 —
Age Youngest Child, 17 —
Occupation, Housewife: Husband; laborer
Degree Education, Common School
Profession, Religion, not a church member.
Habits, not intemperate
Nativity, Minnesota: Father, Maine; Mother, America
Physicians Committing, O.C. Wilcox and Dr. J. P. VanBerg
Correspondents, Chas. H. Dills (Husband) Albert Lea Minn

No. for Year, 9
Insane Relatives, None
Cause Exciting, Epilepsy
Cause Predisposing, " " + previous attack.
Form, Melancholia Epileptic Epileptic Dementia
Accompanying Bodily Disorder, Epilepsy
Suicidal or not, Suicidal + propensity active.
Date of this Attack, August 12th 1901.
Duration, — 4 days —
No. of Attack, 2nd: one occurred about 2 yrs ago.
No. of Admission, 1st
Age First Attack, 43 (about).
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION BY DR. O.C. Heyerdale *Date of* Aug 17-1901

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Clear + quick
MEMORY, Past Events, Quite good
Recent Events, " " Special Subjects, " "
PERCEPTIVITY, Alert or Dull, Correct or Illusive.
Alert: Correct
REASONING POWER, Ordinary Subjects, —
Special Subjects, —
Own Mental State, Believes "Her insane".
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed,
Depressed
DELUSIONS, Systematized, Transitory, Special Subjects,
~
Melancholia, with Delusions "Thinks people are against her + that they do not treat her right"
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, For years
ONSET, Gradual or Sudden, gradual
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father was subject to convulsions: an uncle who was hysterical.
Father, Living well
Paternal Relatives, —
Mother, Dead — (many years) —
Maternal Relatives,
Brothers and Sisters, 2 brothers: 1 sister
Children 4 — 3 boys — 1 girl — well
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
Patient is subject to Epilepsy.
HABITS, Drinking and Smoking, —
HEADACHES, VERTIGO, OR CONVULSIONS, Has Epilepsy — frequently has vertigo
OCCUPATION, Healthy or not, Housework
Detail Date, Duration, and Character of Previous Attack, if any, —
Sleep, Appetite, and Bowels, Poor Poor Constipated.

Personal and Medical History of Jessie Dills

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken PRESENT WEIGHT, Not taken USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, Has an unhealed wound on left leg resulting from self-inflicted injury.
TONGUE, Coatings or Promptness of Movement, prompt: thick white coating.
PUPILS, Equality, Size, Response to Light, and Accommodation, Normal. Small. Yes. Yes
SIGHT, Fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, Fair
COORDINATION, Arms, Good Legs, good Grasp, right hand good
TREMORS, Hands, Tongue, Facial Muscles, General, Fine Fine —
PATELLAR REFLEX, present Other Reflexes, Elbow - wrist
ARTICULATION, Slurred, Hesitating, Slow, ~
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, ~
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity, ~
ARTERIES, Sclerotic.
LUNGS, Chest, Symmetry, Expansion, Yes Fair
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 slightly lacerated: external genitalia otherwise normal: uterus large, hard and retroverted: 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 admitted in poor physical condition. Her friend states that she has not eaten anything for 4 days. She does not walk on account of an injury to her leg, resulting from a self-inflicted wound of one years standing. Patient talks + answers questions sensibly + rationally. Memory seems very good. She is much depressed. —

Personal and Medical History of Jessie Dills

1901

This patient was brought here by C. M. Wilkinson, attended by Mr. Wilkinson and Mrs Prescott, in poor condition & with following history of case. There is no history of consanguinity: no insane relatives. This is not first attack; me occurred about 2 years ago. Duration 1/2 hour to a week: was not sent to hospital: First symptoms of this attack manifested August 12th 1901: threatened to poison others and attack her husband violently, tearing his clothes and scratching him. Disease seems increasing - variable & with rational intervals, but these not at regular intervals: but she has, for ten years or more, been more or less deluded. Derangement now shown by mental disease; ugly and hard to control; "thinks she is hated and despised". Has shown a disposition to injure others: has attempted suicide: has used an axe: propensity was active: disposed to destroy clothing: not any peculiarities noted, before 20 years ago.- No history of intemperance: She is subject to epilepsy: is hysterical: Has been restrained & confined at home. Supposed cause of the disease is Epilepsy: Treatment, none: On personal examination, there is noted a staring, crazy look: is haggard and worn:

Aug 16 On admission, was put on T.W. (G.H.N. 1st). Complexion fair: hair, light & partly gray: eyes blue: condition of skin, hot and dry: no marks: scars on left leg, below the knee: no eruptions: ulcers on left leg: (cut with an axe): no bruises, hernia & vermin; is dirty: has 11 upper and 10 lower teeth. Behavior rather maniacal: remarks are incoherent). —·—

August 16th. 1901 Summary of 14 day records: Dict. by Dr. Heyerdale

Patient admitted on Infirmary West: bathed and put to bed: several bruises on arms and left leg and foot very badly swollen: had two old separations on foot and ankle: self inflicted many months ago during a fit of insanity: slept quite well. During first week Tem. P. & R. normal: appetite good: bowels regular: given cathartic upon admission: Oct. 20 menstruating: ankle and foot dressed daily with antiseptic dressings. During second week Tem. P. & R normal: appetite good: bowels regular: occasional cathartic given: slept well at night: dressings changed on leg daily: Patient is an epileptic and had a convulsion Aug. 25-26 several times during the day 28 and 29. Patient dressed and up on ward Aug. 23: Walks with crutches: is somewhat depressed: neat and agreeable in habits. Aug. 31 Wt. 114 3/4 #.

Sept. to Dec. Oct. 8 trans. to Inf. W. Nov. 26 has been well for a long time; but is now very much disturbed and inclined to be violent, noisy and disagreeable: attacked nurses: wounded foot has been treated regularly every day: menstruates regularly: Nov. 27 trans. to L-2 West. Nov. 28 very noisy attacked nurse.

Dec to Mar 29th '02 No change. Is an epileptic. Mar 29th slightly better went home. August 7/1902 returned again - received on ward.

Personal and Medical History of

Personal and Medical History of Mary Foley

Whole No. 5899. Became resident of State: at birth. County at birth.

Residence, St Paul, Minn

Date Admission, 19th August 1901.

Admitted by Dr E. J. Wanous hour, 7:30 P.M.

How Sent, Edmund W. Bazille, Jeff. County

Sex, Female Age, 47

Civil Condition, Married

Children, two

Age Youngest Child, 12 years

Occupation, School-Teacher: husband, farmer

Degree Education, High School

Profession, Religion, Catholic

Habits, not intemperate

Nativity, Equestrian, Minn: parents born in Ireland.

Physicians Committing, J.B. Brimhall and Arthur Sweeney

Correspondents, Mrs Annie O'Leary (Sister) 50 East Cheyenne St Paul Minn

No. of Year, 11.

Insane Relatives, Two aunts were insane

Cause Exciting, Unknown

Cause Predisposing, Heredity

Form, Melancholia Acuta

Accompanying Bodily Disorder, None mentioned

Suicidal or not, — Not —

Date of this Attack, a week ago

Duration, — a week —

No. of Attack, 2nd: (7 years ago, was mentally deranged)

No. of Admission, 1st

Age First Attack, 40

Time of Leaving, November 9 — 1901

Time in Hospital, 2 mos - 21 ds.

Result, Improved: Dispt. May 10 — 1902 by B of C

EXAMINATION ON ADMISSION BY DR. O.E. Heyerdale Date of Aug —

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Fair

Recent Events, " " Special Subjects, —

PERCEPTIVITY, Alert or Dull, Correct or Illusive. Dull

REASONING POWER, Ordinary Subjects, Poor

Special Subjects, poor

Own Mental State, Says "this not insane" —

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, —

DELUSIONS, Systematized, Transitory, Special Subjects, Has delusions of persecution. "Thinks people are endeavoring to poison 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, one week

ONSET, Gradual or Sudden, Sudden

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

Father, Living — Asthmatic at times, drank excessively: 2 aunts were insane

Paternal Relatives, —

Mother, Dead

Maternal Relatives, —

Brothers and Sisters, 2 sisters: 2 brothers, living - well. 2 children — well —

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

HABITS, Drinking and Smoking, occasional glass of beer

HEADACHES, VERTIGO, OR CONVULSIONS, —

OCCUPATION, Healthy or not, housework & teaching School

Detail Date, Duration, and Character of Previous Attack, if any, a previous attack, 7 years ago: duration 2 years fair poor Quiet Satis

Sleep, Appetite, and Bowels, —

Personal and Medical History of Mary Foley

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4in PRESENT WEIGHT, 133 lbs USUAL WEIGHT, NUTRITION, fair

WOUNDS, Abnormalities and condition of Skin, normal

TONGUE, Coatings or Promptness of Movement, prompt: thick white coating

PUPILS, Equality, Size, Response to Light, and Accommodation, eq unequal none good

SIGHT, good

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

HEARING, good

COORDINATION, Arms, good Legs, fair Grasp, other tests good

TREMORS, Hands, Tongue, Facial Muscles, General, tremor tremor —

PATELLAR REFLEX, present Other Reflexes, Elbow & wrist

ARTICULATION, Slurred, Hesitating, Slow, —

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY, —

HEART, Murmurs, Strength, Sounds, Size, normal normal normal

Apex Beat, Regularity, normal

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Yes 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: cervix lacerated & enlarged

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: has been taking but little food: is depressed & tearful: believes people are endeavoring to kill her & she is startled at any noise. Is restless & wanders about at night. up & out of bed, a great deal. She is a teacher & is a woman of good education —

Personal and Medical History of Mary Foley

1901

This patient was brought here by Deputy Johnson, attended by Annie O'Leary, in fair physical condition, with following history of case. There is no history of consanguinity, but two aunts were insane. This is not first attack; 7 years ago, was mentally disturbed; duration two years. First symptoms of this attack manifested a week ago, by delusions of persecution. Disease seems increasing: variable & with rational intervals, but these, not regular. Derangement now shown in that she believes that people are trying to kill her, and she runs about the house, and is very noisy and incoherent. Is not disposed to injure others, nor suicidal: no filthy or destructive habits. No previous peculiarities noted: no history of intemperance, nor of any severe disease &c, or head-injury. Has not been restrained or confined. Cause of the disease is unknown. Has been given sedative treatment, without result.

On personal examination, patient talks freely of her troubles, and believes that there is a conspiracy to injure her and her children. Is restless and noisy, at times.

Aug 19 On admission, was put on T.W. (G.H.N. R'pt. Complexion dark: hair gray: eyes hazel: condition of skin rough: no marks: scars on left leg: eruptions on back & chest: no ulcers, bruises, hernias or vermin noted: is clean: has 14 upper and 14 lower teeth and 3 roots: Behavior quiet: Is incoherent: prays a great deal).—

August 19th. 1901. Summary of 14 day record: Dict. by Dr. Heyerdale.

Patient admitted on Infirmary West: bathed and put to bed: very quiet in behavior: During first week Tem. P. & R. normal: appetite good: bowels regular by aid of an occasional cathartic: medicine given three times daily: slept quite well each night: was given hypnotic on the 25th. Patient is very melancholic and has hallucinations of hearing: imagines that she is being poisoned and her people are about to do her harm. at times is quite resistive and very restless: dressed and up on ward on 22d. wanders about intently listening to all sounds: expresses her delusions freely also says that none but catholics will be saved: at times is very resistive: Aug. 25th. attacked nurses and endeavored to get outdoors. During second week Tem. P. & R. Normal: appetite good: bowels regular: occasional cathartic given: medicine given three times daily: occasional hypnotic given: slept fairly well at night: patient has stomach trouble, breath very offensive: coughs a great deal: Aug. 30th. in bed menstruating: Sept. 1st takes outdoor exercise. Aug 31 visited by friend: takes regular electrical and gynecological treatments, has illusions of hearing and delusions of persecution: Wt. 126#.

Sept. to Dec. Oct. 26 & 27 visited by daughter, brother and sisters of the catholic order: patient very melancholy: quiet: takes no interest in her surroundings: takes out door exercise: will answer questions quite intelligently; takes gynecological and electrical treatments regularly: Nov. 9 taken home.

Discharged.

Personal and Medical History of

Personal and Medical History of Jessie Jacobs

Whole No. 5900. Resided in Ramsey Co: 15 years
Residence, St Paul, Minn
Date Admission, 19th August 1901
Admitted by Dr E. J. Wanous hour, 7 30 PM
How Sent, E. W. Bazille, Jos P. Ramsey County
Sex, Female Age, 52
Civil Condition, married
Children, —
Age Youngest Child, —
Occupation, Housewife: husband, Laundry-man
Degree Education, Common school
Profession, Religion, Lutheran —
Habits, not intemperate — Father's (Ireland)
Nativity, Ohio: where parents born, do not know: Mother's (American)
Physicians Committing, O. Wellington Archibald and Arthur Sweeney
Correspondents, Mr Nathan Jacobs
(head Laundryman) Windsor Hotel, St Paul

No. of Year, 12
Insane Relatives, no (?)
Cause Exciting, unknown
Cause Predisposing, not stated
Form, Mania Subacute
Accompanying Bodily Disorder, great weakness (?)
Suicidal or not, — not —
Date of this Attack, 3 weeks ago
Duration, 3 weeks
No. of Attack, 1st —
No. of Admission, 1st —
Age First Attack, — 52 —
Time of Leaving, November 9 — 1901
Time in Hospital, 2 mos: 21 ds
Result, Recovered: Disgd. May 13 - 1902. (by Supt)

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdall Date of Aug 21 - 1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish, Quick
MEMORY, Past Events, fair
Recent Events, poor Special Subjects, —
PERCEPTIVITY, Alert or Dull, Correct or Illusive. Alert: illusive
REASONING POWER, Ordinary Subjects, —
Special Subjects, —
Own Mental State, says "She is not insane" —
EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Normal
DELUSIONS, Systematized, Transitory, Special Subjects, has delusions regarding a steamboat & also "of persecution": has some delusion regarding a dog.
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, 3 weeks
ONSET, Gradual or Sudden, Sudden
HEREDITY (Question concerning Insanity, Consanguinity, Epilepsy, Paralysis, Syphilis, Hysteria, Inebriety, Consumption).
Father, Dead
Paternal Relatives, —
Mother, Dead (from effects of burn on head)
Maternal Relatives, —
Brothers and Sisters, one brother
Children — none.
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), says "She had a sunstroke, at age of 32: had cataract removed from right Eye.
HABITS, Drinking and Smoking, —
HEADACHES, VERTIGO, OR CONVULSIONS, —
OCCUPATION, Healthy or not, Housework & Dress — making —
Detail Date, Duration, and Character of Previous Attack, if any, —
Sleep, Appetite, and Bowels, poor poor regular.

Personal and Medical History of Jessie Jacobs

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1 3/4 PRESENT WEIGHT, 85 lb USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal.
TONGUE, Coatings or Promptness of Movement, prompt: brownish-coating: dry
PUPILS, Equality, Size, Response to Light, and Accommodation, no right large (see below) left normal fair.
SIGHT, fair, with right, fair with spectacles: fair with left —
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, {right eye has been operated for cataract & also an iridectomy — pupil is large & irregular in shape —
HEARING, good
COORDINATION, Arms, good Legs, fair Grasp, finger to nose, eyes shut good: standing on one foot, fair: standing, eyes shut, quite good.
TREMORS, Hands, Tongue, Facial Muscles, General, fine: very fine
PATELLAR REFLEX, present Other Reflexes, Elbow: wrist
ARTICULATION, Slurred, Hesitating, Slow, —
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY, —
HEART, Murmurs, Strength, Sounds, Size, none normal normal
Apex Beat, Regularity, normal regular
ARTERIES, Normal
LUNGS, Chest, Symmetry, Expansion, yes 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, Ext. Gen. normal: cervix large & soft: uterus somewhat retroverted.
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. Is quiet & answers questions promptly: has fair memory for past events. Expresses her delusions freely: her delusions are of the persecutory type.

Personal and Medical History of *Jessie Jacobs*

1901

This patient was brought here by Andrew Devitt, attended by Mrs H. Jaeger, in fair physical condition, with following history of case. There is no history of consanguinity, nor of heredity. This is 1st attack; first symptoms manifested 3 weeks ago, by delusions & incoherent talk: Disease seems stationary: not variable: no rational intervals: Derangement now shown in that she believes she is on a steamboat, and that her dog is being mutilated. Is noisy and abusive. Is not disposed to injure others, nor suicidal: no filthy or destructive habits. No peculiarities previously noted: no history of intemperance, nor of any severe disease &c, or head-injury; has not been restrained or confined: Cause of disease is unknown: has been given large doses of K. I. On personal examination, she is noisy and talkative; delusional & incoherent. —

Aug 19 On admission, was put on T.W. (G.H.N. R'pt. Complexion dark: hair, dark brown: eyes brown; condition of skin normal: no marks &c noted: is clean: has an upper plate and 12 lower teeth. Behavior quiet: remarks rather incoherent) —

August 19th. 1901 Summary of 14 day record: Dict. by Dr. Heyerdale.

Admitted on Infirmary West: bathed and put to bed: quiet in behavior. During first week: Tem. P. & R. about normal: appetite good: slept well at night: neat in habits & appearance: quiet: converses intelligently: complains some of being weak: is quite emaciated and in rather poor physical health: takes laxatives three times daily. During second week Tem. P. & R. normal appetite good: given egg nogs each day: bowels regular: quiet: slept well at night: takes outdoor exercise: gaining in strength and weight: seems somewhat improved mentally: is less hypochondriacal: out of bed at the beginning of the second week. Aug. 31 patient up on ward: neat in habits and appearance: answers questions intelligently: takes an interest in her surroundings: quiet in behavior: receives gynecological treatment 3 times a week: Wt. 90½#. Sept. to Dec. Sept. 22 trans. to A. 2 West: considerably improved physically: attends chapel: takes regular out door exercise: neat in habits and appearance: assists with ward work: pleasant and agreeable: Nov. 9 went home.

Discharged.

Personal and Medical History of

Personal and Medical History of Ella Olson

Whole No. 5905. Became resident of State – 14 yrs ago " " County – 5 yrs.

Residence, St Paul. Minn

Date Admission, 20th August 1901.

Admitted by Dr. E. J. Ravous hour, 7.30 PM

How Sent, E.W. Bazille, Jeff. Ramsey County

Sex, Female Age, 40 Years

Civil Condition, married

Children, 3

Age Youngest Child, 5 Years

Occupation, Housewife: husband, farmer

Degree Education, Common school

Profession, Religion, Lutheran

Habits, Not intemperate –

Nativity, Sweden: parents also born there.

Physicians Committing, Arthur B. Aucka and E. N. Whitcomb.

Correspondents, Mr. Chas. Evstron (Bro) 575 Bradley St St Paul

No. of Year, 17.

Insane Relatives, None

Cause Exciting, Probably, domestic infelicity

Cause Predisposing, previous attacks

Form, Mania Chronic

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Suicidal: jumped into river.

Date of this Attack, Last Christmas

Duration, 8 months

No. of Attack, 3rd (one, 11 yrs ago: one, 4 yrs ago) – 1st here (has also been at St Peter, Minn & Tuscaloosa, Alabama, also in detention Hosp. St Paul.

No. of Admission,

Age First Attack, – about 29 –

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Aug 23 – 1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Fair

Recent Events, Fair Special Subjects, —

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

REASONING POWER, Ordinary Subjects, fair.

Special Subjects, —

Own Mental State, —

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Has some 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, —

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, 5 brothers: 7 sisters
3 children: 2 boys – 1 girl – well

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
no

HABITS, Drinking and Smoking, Good

HEADACHES, VERTIGO, OR CONVULSIONS, —

OCCUPATION, Healthy or not, Housework

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

Sleep, Appetite, and Bowels, Poor Good Regular

Personal and Medical History of Ella Olson

COMMITTED TO ROCHESTER—Ella Olson, who has been in the detention hospital for a month, was committed to Rochester by Judge Bazille in the probate court yesterday.

PHYSICAL CHARACTERISTICS.

PRESENT WEIGHT, 124 lbs 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, Yes mod Good Good

SIGHT, Good

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

HEARING, good

COORDINATION, Arms, Good Legs, Good Grasp, Abn tests, good.

TREMORS, Hands, Tongue, Facial Muscles, General, fine fine none —

PATELLAR REFLEX, present Other Reflexes, Elbow – wrist

ARTICULATION, Slurred, Hesitating, Slow, —

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Normal Strong normal

Apex Beat, Regularity, Normal regular

ARTERIES,
Normal

LUNGS, Chest, Symmetry, Expansion, Yes 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. Haemorrhoids: Cervix lacerated: uterus hypertrophied, fixed: cervicitis. Endometritis, leucorrhoea: menstruates regularly.

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 & a gracile woman: asserts grief the work: talks intelligently & answers questions fully & rationally. Has been a patient in an Insane hospital in Sweden, at Fergus Falls & Tuscaloosa Hospital, Alabama prior to her Commitment here. Patient says she has domestic relations have been very unhappy & full of trouble, which, no doubt, is a cause of nervousness of her insanity. She is very nervous & probably long has been afflicted with. She has some delusions of persecution: says "people have not treated me well": that they are trying to keep her from her children.

Personal and Medical History of Ella Olson

Whole No. 5905. Became resident of State – 14 yrs ago
" " " County – 5 yrs.

Residence, St Paul. Minn

Date Admission, 20th August 1901.

Admitted by Dr. E. T. Ramsey hour, 7:30 PM

How Sent, E.W. Bazille, Jail. Ramsey County.

Sex, Female Age, 40 Years

Civil Condition, married

Children, 3

Age Youngest Child, 5 Years.

Occupation, Housewife: husband's farmer

Degree Education, Common school

Profession, Religion, Lutheran

Habits, Not intemperate –

Nativity, Sweden: parents also born there.

Physicians Committing, Arthur B. Aucker and E. N. Whitcomb.

Correspondents, Mr. Chas. Evstron
(Bro) 575 Bradley St St Paul

No. of Year, 17.

COMMITTED TO ROCHESTER—Ella Olson, who has been in the detention hospital for a month, was committed to Rochester by Judge Bazille in the probate court yesterday.

Insane Relatives,

Cause Exciting, Probably, domestic infelicity

Cause Predisposing, previous attacks

Form, Mania Chronic

Accompanying Bodily Disorder, None mentioned

Suicidal or not, Suicidal: jumped into river.

Date of this Attack, Last Christmas

Duration, 8 months

No. of Attack, 3rd (one, 11 yrs ago: one, 4 yrs ago) –

No. of Admission, 1st time (has also been at Stillwater, Minn + Tuscaloosa, Alabama, also in Detention Hosp. St Paul.

Age First Attack, – about 29 –

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Aug 23 – 1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, Fair
Recent Events, fair Special Subjects, —

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

REASONING POWER, Ordinary Subjects, fair.
Special Subjects, —
Own Mental State, —

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

DELUSIONS, Systematized, Transitory, Special Subjects,
Has some 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, —

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, 5 brothers: 7 sisters
3 children: 2 boys – 1 girl – well

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),
no

HABITS, Drinking and Smoking, Good

HEADACHES, VERTIGO, OR CONVULSIONS, —

OCCUPATION, Healthy or not, Housework

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

Sleep, Appetite, and Bowels, Poor Good Regular

Personal and Medical History of Ella Olson

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1in PRESENT WEIGHT, 124 lbs 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, Yes mod Good Good

SIGHT, Good

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

HEARING, good

COORDINATION, Arms, good Legs, good Grasp, does test: good.

TREMORS, Hands, Fine Tongue, Fine Facial Muscles, General, Nerves —

PATELLAR REFLEX, present Other Reflexes, Elbow – wrist

ARTICULATION, Slurred, Hesitating, Slow, —

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, Normal Strong Normal
Apex Beat, Regularity, Normal regular

ARTERIES,
Normal

LUNGS, Chest, Symmetry, Expansion, Yes 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. Haemorrhoids: Cervix lacerated: uterus hypertrophied, Lord; cervicitis, endometritis, leucorrhoea: menstruates regularly.

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 committed in Jail, Good Physical Condition & is quiet & a quarrelsome ward: asserts good the work: talks intelligently & answers questions fairly rationally. Has been a patient in an Insane hospital in Sweden, at Fergus Falls & Tuscaloosa Hospital, Alabama prior to her Commitment here. Patient says she has Mother relations have been very unhappy & full of trouble, which, no doubt, is a cause of recurrences of her insanity. She is said to be very nervous & probably has off along with. She has some delusions of persecution. Says "people have not treated herwell": that they are trying to keep her from her children –

Personal and Medical History of Ella Olson

1901

This patient was brought here by Deputy Johnson, attended by Mrs Goloway, in good physical condition, with following history of case. There is no history of consanguinity, nor of heredity. This is not first attack: others occurred 11 years ago; also 4 years ago: duration of first attack 4 months; of 2nd, 2 years: was sent to hospital at St Peter, Minn, and Tuscaloosa, Ala: was discharged. First symptoms of this attack manifested last Christmas, by insomnia & great restlessness. Disease seems increasing: not variable: no rational intervals. Derangement now shown by insomnia, extreme nervousness; irritable and easily vexed; formerly, an industrious woman, has become an idle one. Has made threats to injure others: has attempted suicide: jumped into the river: do not know if propensity now active: no filthy or destructive habits. No previous peculiarities noted: no history of intemperance, nor of any severe disease &c or head-injury: has not been restrained or confined. Cause of disease probably domestic infelicity. Treatment none. On personal examination, patient very nervous & garrulous. Was in the "Detention Hospital" last June, for 2 weeks. —— ——

Aug 10 On admission, was put on I W. (G. H. N. R'pt. Complexion fair; hair light: eyes blue: condition of skin normal: no marks noted: one scar on back of left leg, below the knee: no eruptions, bruises &c: is dirty: has no teeth: behavior quiet: answers questions intelligently.)

August 20th 1901 Summary of 14 day record: Dict. by Dr. Heyerdale

Admitted on Infirmary West: bathed and put to bed: quiet in behavior. During first week Tem. P. & R. normal: appetite good: has regular diet: takes laxatives three times daily: slept well during the night: neat in habits and appearance: talks quite intelligently on most subjects: has delusions of persecution. began menstruating on 22d.: Patient dressed and up on ward on 24th.: thereafter takes outdoor exercise. During second week Tem. P. & R. about normal appetite good: takes medicine three times daily: bowels regular: neat in habits and appearance: talks quite intelligently: assists with ward work. On. 28 complained of severe pain in right ear: had two small abscesses both lanced by Dr. Heyerdale: slept well at night: Aug 31 Wt. 121½#.

Sept. to Dec. neat in habits and appearance: assists with ward work: takes outdoor exercise, attends chapel: quiet in behavior but meddlesome: Sept 20 menstruating: Nov. 10 fought nurses: Nov. 14 very disagreeable, extremely nervous, very meddlesome and annoying: trans. to B. 3 West Nov. 30: menstruates regularly Nov. 30 Wt. 124#.

Dec to Feb. 1903 No change. Wt about 130#.

Personal and Medical History of

Personal and Medical History of Melissa. F. Cook
or Malissa

Whole No. 5908.
Residence, Faribault Co.
Date Admission, 27th August 1901.
Admitted by Dr. E. J. Watrous hour, 4:00 PM
How Sent, John W. Vance, Sh. Faribault County
Sex, Female Age, 45
Civil Condition, married
Children, Three
Age Youngest Child, — 16 —
Occupation, Housewife: husband's, Teamster
Degree Education, — Common School —
Profession, Religion, Not a church member
Habits, not intemperate
Nativity, Wisconsin: Parents born in New York
Physicians Committing, F. M. Hunt & J. E. Cooper
Correspondents, Joseph E Butler, Granada, Minn
Friends (Husband left Ker) — Martin Co —
10/10/01 Austin Cook (husband) Nashville Tenn wrote also re

No. of Year, 20.
Insane Relatives, Yes: Aunt was insane: Also a grandparent
Cause Exciting, Do not know
Cause Predisposing, Heredity —
Form, Melancholia Chronic
Accompanying Bodily Disorder, None mentioned
Suicidal or not, Suicidal: took poison.
Date of this Attack, 2 years ago
Duration, Continuous for past 2 years.
No. of Attack, not 1st (others occurred 2 years ago)
No. of Admission, 1st
Age First Attack, 43
Time of Leaving,
Time in Hospital,
Result, Died

EXAMINATION ON ADMISSION BY DR. O. L. Heyerdale Date of Aug 31 - 1901.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY, Clear or Confused, Quick or Sluggish,
Quite clear, as ordinary subjects.
MEMORY, Past Events, fairly good
Recent Events, fairly good Special Subjects, —
PERCEPTIVITY, Alert or Dull, Correct or Illusive.

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

DELUSIONS, Systematized, Transitory, Special Subjects,

HALLUCINATIONS,
ILLUSIONS,
Aunt and grand parent insane
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).
Aunt and a grand parent were insane — Mother and father well, 3 Cousins —
Father, Dead — Typhoid.
Paternal Relatives,
Mother, Dead
Maternal Relatives,
Brothers and Sisters, 3 bro. 1 sister — all well
Children — 3 boys — well
PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations),

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,
Poor poor
Sleep, Appetite, and Bowels, Constipated.

Personal and Medical History of Melissa. F. Cook

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 5 in PRESENT WEIGHT, 85 lbs USUAL WEIGHT, NUTRITION, poor
WOUNDS, Abnormalities and condition of Skin, normal
TONGUE, Coatings or Promptness of Movement, yes — none
PUPILS, Equality, Size, Response to Light, and Accommodation, fair
Left turned. Fair
SIGHT, fair
EYES, Nystagmus, Squint, Arcus Senilis, or other troubles, normal
HEARING, good
COORDINATION, Arms, fair Legs, rather poor Grasp, Swings quickly — poor: Staggers some, feet, poor — Swings & nose, eyes shut, fair — Staggers some foot, poor — Having eyes shut — poor —
TREMORS, Hands, Tongue, Facial Muscles, General, None fine
PATELLAR REFLEX, present Other Reflexes, Slight of left elbow. Slight of right wrist —
ARTICULATION, Slurred, Hesitating, Slow,
FACIAL EXPRESSION, Paretic, Sad, Etc.
SENSIBILITY,
HEART, Murmurs, Strength, Sounds, Size,
Apex Beat, Regularity,
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,

Passed Dec 26th Exp. Dec 26th

EXAMINATION URINE, Quantity, — Sp. g. 1020 Reaction, Acid Color and Appearance, Cloudy & heavy reddish yellow Yellowish ropy. Sed. Deposit 0
Albumen, Not a trace amount Nitric acid a large amount Sulphosal a large amount Sugar, Fehling's 0
Casts and Crystals, a large amount of granular debris & bacteria. Phosphates triple — urates. amor: Blood, several Corpuscles & cremated cells: pus a large amount. Oxalate of lime a few cells
GYNECOLOGICAL EXAMINATION, Slight laceration of perineum: External Genitalia otherwise normal: bilateral laceration of cervix: uterus anteflexed: tumors hard & painful on
MENSTRUATION, pressure: herpes vaginalis: endometritis: cervicitis: slight leuco
OPHTHALMOSCOPIC EXAMINATION, Vocal discharge.
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: is very quiet & depressed: answers questions reluctantly & slowly: says she has been whipped by her husband, & expresses fear that her people were trying to do her bodily harm. Says: poison was put in her food. —

Personal and Medical History of *Melissa F. Cook*

1901

This patient was brought here by G. N. Freer, attended by Victoria Freer, in poor physical condition, with following history of case. Mother and father were 3rd Cousins: Aunt was insane; also a grand parent. This is not 1st attack; others occurred 2 years ago: duration continuous for past 2 years: was not sent to hospital. First symptoms of this attack manifested 2 years ago: thought she was being persecuted, and that she is being ———— Disease seems increasing: variable: rational intervals (?) but not at regular intervals. Derangement now shown in that she thinks she is being abused by her husband and others: cries and gets hysterical when questioned: is incoherent. Has shown no disposition to injure others: has attempted suicide, took poison: propensity not active now: no filthy or destructive habits: no previous peculiarities noted: no history of intemperance, nor of any severe disease or a head-injury: no confinement or restraint has been employed. Do not know cause of the disease: treatment none. On personal examination is incoherent in conversation, unable to express herself intelligently on any subject: hysterical at times.

Aug 29 On admission, was put on T.W. (G.H.N.Rft. Complexion dark: hair black, part gray: eyes brown: condition of skin, hot and dry: no marks, scars a bruises re noted: is dirty: has 9 upper & 11 lower teeth: Quiet: talks very little: answers questions very well, but slowly.

August 27th. 1901 Summary of 14 day record: Dict. by Dr. Hyerdale:
Admitted on Infirmary West: bathed and put to bed: During first week Tem. P. & R. about normal: appetite good: bowels very constipated requiring occasional cathartics: slept quite well during each night: is very melancholy will hardly answer questions: volunteers no remarks whatever. During second week Tem. P. & R. about normal appetite good: bowels regular by aid of cathartics: slept well during each night: will not converse: Dressed and up on ward Sept. 5.

Aug 30 Wt. 84#. Sept. 19 visited by relatives: Sept. 29 up and about the ward part of the time: very unsteady on her feet: takes some out door exercise: very noncommunicatin: Oct. 30 & 31 visited by son and husband: Nov. 29 extremely melancholy: complains a great deal of her treatment although she has a great deal of attention both day and night: given massage regularly

Dec to Feb 1903 No change. Dec. 25-01 Visited by husband
Mar. 29th visited by husband and son. June 25th & 26th was visited by husband, also on Oct. 8th. Wt. about 84 #.

Personal and Medical History of

Personal and Medical History of Annie Mc Grath #2

Whole No. 5909. Resident of State 20 years, County 20 years

Residence, St Paul, Minn.

Date Admission, 28th August 1901.

Admitted by Dr L. A. Linton hour, 7.30 PM

How Sent, Edmund W. Bazille, Jeff. Ramsey County

Sex, Female Age, 47.

Civil Condition, Married

Children, Three

Age Youngest Child, 15 Years

Occupation, Housewife: husband, Foreman St Paul Foundry

Degree Education, — Common School —

Profession, Religion, Roman Catholic —

Habits, not intemperate —

Nativity, Vermont: parents born in Ireland.

Physicians Committing, Louis A. Nelson and N. J. Nippert

Correspondents, Mr P Mc Grath

previous ad. 628 Selby Ave St Paul Minn

No. of Year, 21.

Insane Relatives, Yes: her mother

Cause Exciting, Don't Know

Cause Predisposing, Heredity

Form, General Paresis

Accompanying Bodily Disorder, None mentioned

Suicidal or not, not

Date of this Attack, 3 years ago

Duration, Continuous

No. of Attack, 1st (?)

No. of Admission, 2nd

Age First Attack, 44 years (about)

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION BY DR. O. C. Heyerdale Date of Sept 2/1901

MENTAL CHARACTERISTICS.

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

MEMORY, Past Events, fair

Recent Events, fair Special Subjects,

PERCEPTIVITY, Alert or Dull, Correct or Illusive. Alert

REASONING POWER, Ordinary Subjects,

Special Subjects,

Own Mental State, says "he is not insane" —

EMOTIONAL STATE, Normal, Indifferent, Exalted, Depressed, Quite normal

DELUSIONS, Systematized, Transitory, Special Subjects, has many ideas about her husband, which may or may not be delusions.

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 — Dropsy (mother was insane; a brother probably insane for a short time according to statement)

Paternal Relatives,

Mother, Dead — was insane —

Maternal Relatives,

Brothers and Sisters, 1 3 all well

3 Children — well —

PROMINENT DISEASES (especially Typhoid Fever, Sunstroke, Head Injuries, and Surgical Operations), Typhoid at age of 34 years

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 poor constipated

Personal and Medical History of Annie Mc Grath #2

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6in PRESENT WEIGHT, 119 lbs USUAL WEIGHT, NUTRITION, poor

WOUNDS, Abnormalities and condition of Skin, normal

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

PUPILS, Equality, Size, Response to Light, and Accommodation, Yes normal fair

SIGHT, only fair — wears spectacles

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

HEARING, good Finger to nose, eyes shut, good with right arm

COORDINATION, Arms, left arm paralyzed Legs, good Grasp, other hand good —

TREMORS, Hands, Tongue, Facial Muscles, General, fine tremor fine

PATELLAR REFLEX, Exaggerated Other Reflexes, elbow, wrist, jaw-jerk present

ARTICULATION, Slurred, Hesitating, Slow,

FACIAL EXPRESSION, Paretic, Sad, Etc.

SENSIBILITY,

HEART, Murmurs, Strength, Sounds, Size, None strong normal

Apex Beat, Regularity, regular normal

ARTERIES, Normal

LUNGS, Chest, Symmetry, Expansion, Yes fair

Breath 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, Urethral Caruncles: purulent gonorrhoeal discharge from urethra. Lacerated perineum and cervix: uterus in normal position, free, enlarged & congested. Endometritis, Cervicitis, Leucorrhoea. Venereal vaginitis.

MENSTRUATION, Menopause reached at 40.

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. Paralysis of left arm very marked: Speech thick & somewhat difficult (this may be due somewhat to ill fitting false teeth). She seems feeble & is quite emaciated. Her gynecological condition suspicious of specific infection. Mentally patient seems more dull mentally than when she left the hospital —

Personal and Medical History of Annie McGrath #2

1901

This patient was brought here by Deputy Sheriff Johnson, attended by Mrs. Dan Mullen, in poor physical condition, with following history of case. There is no history of consanguinity, but her mother was insane. This attack, 3 years ago; duration continuous; was at Rochester Hospital, Minn: result of treatment, was improved. There is now noted exacerbation, coming on gradually: disease seems increasing: variable and with rational intervals, but these not regular. Derangement now manifested by antipathy to church and husband: destructive tendency: Is disposed to injure others: but not suicidal: is destructive of furniture & clothing. As to any previous peculiarities not known. No history of intemperance, nor of any severe disease &c or head-injury: has not been restrained or confined. Dont know cause of the disease: has had previous treatment at Rochester. On personal examination, there is noted Dementia, with progressive Paresis. N.B. This is 2nd admission; was here before from Sep 29 – 98 to Nov 18 – 1900, and discharged May 1 – 1901, improved – see Vol 38 page 393 No 5144 – Form: Paranoia. — — — —

Aug 28 On admission, was put on I.W. = (G.H.N. R'pt: Complexion dark: hair brown: eyes blue: Condition of skin normal: no marks, scars or bruises noted: Lypoma on lower part of abdomen: vermin & none: rather dirty: has an upper & lower plate: has some difficulty in speaking & her left arm is partially paralyzed. Quiet: talked against her husband & claimed to have been treated roughly by him)

August 28th. 1901 Summary of 14 day record: Dict. by Dr. Heyerdale. Admitted on Infirmary West: bathed and put to bed. During first week Tem. P. & R. about normal: appetite poor: bowels constipated given occasional cathartics: took medicine three times daily potassium iodide: slept well at night: talks freely: has delusions of persecution: is somewhat depressed and quiet. During second week Tem. P. & R. normal: appetite good: given cathartic, potassium iodide increasing dose during second week. Dressed and up on ward Sept. 4: slept well each night: takes regular out door exercise. Patient has partial paralysis of left arm also has difficulty in talking as she has partial paralysis of the tongue. Aug. 31 Wt. 110½#. Oct. 23 trans. to B. 3 West. up on ward daily: neat in habits and appearance: takes out door exercise: attends chapel: has difficulty in speaking: left arm and hand are very much paralized: vaginal douche given daily one to 4000: bladder irrigated daily: has gonorrhoea Nov. 30 Wt. 116#.

Dec. to Feb. '02 No change. Converses with great difficulty. She has had a partial paralysis of the left side: generally makes her wants known by motions: understands everything that is transpiring about her. attends Chapel and amusements: goes out for exercise: has no use whatever of left arm: is at times quite depressed. Takes electric treatments. Eats with difficulty. Bowels inclined to be constipated: complains a great deal of pain in side and back. Dec. 1st. Wt. 103⅓#.