Description/explanation/instructions for using the List of Names and the Database

List of names. The list of 2,666 people includes everyone who was admitted to the Delaware State Hospital between 1894 and 1920 *and* who is known to have died before 1973 or is very likely to have died before 1969 (indicated by a death date of 1/11/1111 in the Database). HIPAA applies for 50 years after a person’s date of death, thus the cut-off of 19712The list is in alphabetical order by last name. The first column has an asterisk if the person is one of the case studies described in the book Remembering Farnhurst. The case studies provide more genealogical information about the patients, as well as relevant newspaper articles and other materials. Because the list of names is a Microsoft Word file, you can use the “find” function to look for specific names.

For genealogical researchers looking for their ancestors or other relatives, look them up by last name in the “List of Names,” noting all of the Patient Code Number(s) associated with that name, and then look up those code numbers in the “Demographic info and clinical notes” section of the database. Remember that many individuals had multiple admissions, and that people may have been admitted under various spellings or versions of their name. The “First name” information reflects the patient’s first name as recorded in the DSH ledger. Note that spellings are neither accurate nor consistent, especially when compared to online records such as [www.ancestry.com](http://www.ancestry.com), [www.familysearch.org](http://www.familysearch.org), and [www.findagrave.com](http://www.findagrave.com). People often used nicknames, or went by their middle name or initials, or even gave false names. In some cases, various alternate names or spellings are provided. The “Middle name” consists of the patient’s middle initial or name, if provided. The “Last name” information reflects the patient’s last name as recorded in the DSH ledger. The same caveats apply as for first names.

Additionally, female patients may have one entry under their maiden name and a later entry under their married name. Most names have only one entry in the list of names, sometimes with multiple code numbers. Sometimes the code numbers refers to different people of the same name. For very common names, I went ahead and listed each code number separately. You need to look at the database records for various spellings of the name, different first names, different middle initials, etc., then check to see if the other information such as age, ethnicity, sex, place of origin, etc. confirm that you have found the person you were seeking. Also note that within one surname, such as “Smith,” the entries are not necessarily in alphabetical order by first name, so carefully check everyone with the last name you are interested in. The last column notes the grave number if the person was buried in the DSH “Spiral Cemetery.”

The ”Patient code number” is a unique identifier consisting of three parts. The first digit represents the ledger volume number of the patient entry (Volumes 3-9); the next three numbers represent the page number in the ledger, from 001-499 for each ledger; the final four digits represent the patient number assigned by the hospital upon admission. Thus, patient code 54332013 refers to Arnold Morris’ third and final admission to the hospital. The original ledger entry can be found in Volume 5, page 433, patient #2013. Note that a single patient can have multiple patient code numbers, one for each separate and distinct hospital admission. Lena P. Houston had the most separate admissions to DSH, with 8 during the period covered by the ledgers (and 8 more after 1920).

Database. The Microsoft Access database is titled “Demographic info and clinical notes.” In the database, people are identified only by their “Patient Code Number” – not by name. For researchers interested in general trends over the years, or particular types of patients where the people’s names are not relevant, this section of the database will be all that is needed. Most columns can be sorted in ascending or descending order, and the columns are permanently connected, so sorting by any variable will bring all the information about each person along. Sorting is done by clicking on the downward facing triangle just to the right of the name of the column, and then choosing among the options. Empty values are listed before the first in alphabetical order, or the oldest if searching a date field. For example, if you sort by occupation, you will first get all the people for whom that field is blank, then alphabetically beginning with accountant, actor, agent, animal trainer, etc. If you sort by religion, in reverse alphabetical order, you will see “unknown,” “spiritualist,” and “Romanist,” etc. You can sort by nativity, to find everyone from the same state, or by “suicide” to find everyone *for whom it was noted in the ledgers* that they had attempted suicide. You can sort on the various date columns either from oldest to newest, or newest to oldest. You cannot sort either the “History and clinical notes” column or the “Additional notes” column.

In addition, you can use the “find” function by putting the cursor over the title of the column and clicking to highlight the column, then clicking on the “find” icon above the table (a magnifying glass) and entering the information you are searching for. Various options allow you search either “current field” (the one you have highlighted) or “current document” (the entire table), and to search for a match in “any part of field,” “whole field,” or “start of field.” The find function works for either individual terms or phrases. For example, you can search for “former inmate” in *current document*, *any part of field*, and each time this phrase appears, anywhere in the table, the search function will find it. This allows you to find everyone, for example, who has the word “tumor” anywhere in their record, or the word “murder,” or the word “schizophrenia,” or “depression,” or any other term or phrase you want to search on.

The fields in the database are defined below:

ID A number generated by the database program as the information was entered.

City Self-explanatory.

County Delaware has only three counties: New Castle, Kent, and Sussex. If a county from another state was provided, it was typed in as written.

Ethnicity Black or white were pretty much the only options in use at the time.

Patient Code Same as “Patient Code” in the List of names, explained above. Remember that a single patient may have multiple patient code numbers, one for each separate and distinct hospital admission.

“No for year” (number for year) This refers to the patient count, which began each year (for some reason) on December 1. If you want to know how many people were admitted in one year, look up the last person who was admitted on November 30th for each year, and their “No for year” will be the number of people admitted in the prior 12-month period.

Sex Male or Female were the only options in use.

Age The source of this information was either the patients themselves, or whoever brought them. At the time, people didn’t necessarily keep close track of their ages, so the accuracy of these data cannot be guaranteed. Additionally, different sources will list different years of birth (such as on birth records, marriage certificates, death certificates, and headstones) or people’s ages will change by more or fewer than 10 years from one census to the next. It is especially important to be aware that user information supplied to [www.ancestry.com](http://www.ancestry.com) can be wildly inaccurate, for a number of reasons.

Date of Death This field was created in order to establish that the patient had died more than 50 years prior to the publication of their medical records, to satisfy HIPAA regulations. In other words, because the database is being made public in the fall of 2019 – and was updated in March 2022 -- people had to have died prior to 1969/1972 in order for their information to be made publicly available in connection with their real name. Information about date of death came from a variety of sources, including:

* The ledgers themselves, if the person died while a patient at the hospital
* Online Certificates of Death (most from Delaware) that could be clearly matched to the patient
* Delaware Death Records on file at the Delaware Public Archives (3” X 5” cards)
* Online obituaries from [www.genealogybank.com](http://www.genealogybank.com) and [www.newspapers.com](http://www.newspapers.com)
* Information posted on [www.ancestry.com](http://www.ancestry.com)

A *caveat* about “date of death” information. The data are only as accurate as the source(s) from which they were obtained. Sometimes several sources gave different information. There were some people for whom an official date of death could not be found. In those cases, if the person’s age at the last known date that they were alive indicate that it has been 50 years or longer since they would have turned 100, they are given a death date of 1/11/1111. This date in the “date of death” field indicates that although the precise date of death is not known, it is assumed that HIPAA requirements have been met, because the person would have had to live more than 100 years in order to have died after 1969, which is highly unlikely. In a handful of cases, no information could be found for the person after 1920, so even though we don’t know when they died, they are assumed to have died prior to 1969.

Civil condition Options for this field include single, married, widowed, and divorced.

Children This field lists the number of children the patient has. It is not always accurate.

Age Youngest Child Self-explanatory, but again, not always accurate.

Occupation Generally self-explanatory, but with a few words of caution. Women who were not employed outside the home might be listed as having no occupation, or as housewife or housekeeper. If a woman was employed as a housekeeper in someone else’s house, they were often listed having the occupation of “domestic.” Some researchers have assumed that “housekeeper” meant employment outside of one’s own home, but this is not necessarily the case.

Circumstances This field referred to socio-economic status and was generally limited to the options of poor, moderate, fair, or good. The vast majority of patients were labeled “poor.”

Education This field contained a wide variety of responses, including whether or not the person could read and/or write, had “poor” or “limited” education, or “fair” or “good” education, whether they had gone to “common school” or “public school” or “high school” or, in a few cases, if they had college educations, or were a physician or academic.

Religion This entry on the ledger form garnered a variety of answers, including the general one of “Protestant” or some denomination thereof (especially Methodist). RC in the database stands for Roman Catholic, but most Catholics are indicated just as “Catholic” in the ledger. Jewish people were labeled as “Jewish” or “Hebrew” or in one case, “Israelite.” Quakers were labeled with either Quaker or “Friends” designations.

Habits This field was most often used to indicate whether or not the person consumed alcohol (temperate or intemperate) or used drugs or smoked cigarettes, but other options included: good, untidy, uncleanly, perverted, and masturbation, along with a variety of other labels.

Nativity This field refers to the patient’s place of birth, and is not always accurate or consistent with other online records. Most of the patients were born in Delaware or surrounding states (Pennsylvania, Maryland, New Jersey, and New York), but some came from more distant states or were born in other countries. The foreign-born provide a good indication of the sources of most immigrants to Delaware, and included Canada, England, Ireland, Germany, Italy, Austria, Hungary, Poland, Russia, and others. Note that some online databases interpret the abbreviation N.S. to mean Nova Scotia, and will claim that the person was born there. In actuality, N.S. almost always refers to “Not Specified” (it isn’t known where the person was born).

Insane Relatives This field was used to note if the person had close relatives who were known to be insane. At the time, mental health professionals thought that at least some forms of insanity and other brain-related issues (epilepsy, cognitive impairments) might have heredity aspects, so they inquired about each new patient’s close relatives. For most people, this field either says “no” or is left blank. In other cases, parents, siblings, or other relatives were also patients at the hospital, or had been in the past.

Suicide This field is used to note if the patient had ever attempted suicide.

Homicide This field is used to note if the patient had ever attempted to kill someone, or had killed someone.

Complications This field is mostly empty, but includes various sorts of health problems, blindness, paralysis, tumors, etc., that might complicate care.

Brought by This field indicates who accompanied the person to the hospital. It was usually a family member or a police officer or sheriff, but includes entries such as friends, neighbors, self-commitment, or the director of the Almshouse or Workhouse. Occasionally a person was sent to DSH on the train or dropped off at the front gate by someone who didn’t come in with them.

On order of This was a civil servant, clerk, or administrator who was appointed to oversee the admission papers.

On certificate of For most cases, a person had to be certified as eligible for care by two medical doctors. This was especially true for people who were residents of Wilmington. In other cases, it was a court order that required the person to be committed. There were usually two specific doctors in Wilmington who served as the gate-keepers, keeping people out of the hospital who didn’t really need or deserve to be there.

Cause Many patients do not have any cause listed for their entry. For those who do have a cause listed, they include heredity, traumatic injuries, illness/poor health, grief, worry, syphilis, congenital imbecile, sunstroke, puerperal (related to childbirth), overwork, nostalgia (depression), adolescence, menopause, senility, masturbation, intemperance/alcohol/excesses, excesses, epilepsy, domestic trouble, and so on.

Form The form of the mental condition usually indicated depression/melancholia or mania (recurrent and intermittent), toxic insanity, senile psychosis/senile dementia, paranoia, “not insane,” manic depression (md), general paralysis/general paresis (syphilis), imbecility, epilepsy, dementia praecox (schizophrenia), alcoholism, and others.

Predisposition Only a few patients had anything in this field, usually heredity or ill health.

Duration of this attack The length of time the person had been noticeably affected.

No of attack Whether this is the first, second, third, or more attack of insanity.

No of Admission Whether this is the first, second, third, or more admission to the hospital.

History and clinical notes This field contains all the information that was hand-written in the ledger about the patient’s history, as it was recorded when they were admitted, and then intermittent notes about their condition over time. For some patients, these notes were detailed and frequent, while for others they were sparse and infrequent. Sometimes years might go by without anything being written on a patient’s ledger page. As time passed, whoever was recording the notes changed – as indicated not only by the length and style of written content, but also by the handwriting. For some time, the notes included details of the patient’s treatment and diet, how their behavior/condition was – either improving, declining, or staying the same, and so on. It isn’t clear who wrote any of these notes, or under what circumstances. There were frequent occasions when I was not able to read the handwriting, and those instances have been noted with the abbreviation “ill.” for “illegible” – sometimes with my best guess from the context. Many archaic medical terms and old-fashioned terms for medicine and foods were used. This field in the database can be quite long. The easiest way to read an entry is to copy and paste it to a Word document, rather than scrolling through the visible field in the database.

Keywords 1, 2, 3 For some cases, I provided “keywords,” to help find a patient with a particular condition (TBI for traumatic brain injury, ABI for acquired brain injury, MR for mental retardation, syphilis, sunstroke, suicidal, etc.), but I was not consistent in doing this for all patients. I decided just to leave these fields in the database, even though most of them are empty.

Date of final disposition The date of the final entry in the ledger notes. Note that patients were often released “on parole” for a trial at home or on their own. If they were doing well some months later, they were then officially “discharged” from the hospital and their case number retired, as it were. If they came back to the hospital before being formally discharged, then they picked up with the same case number and the same ledger page. If they came back after a formal discharge, then they were given a new page and a new case number. Thus, many people left the hospital some months before the “date of final disposition” as noted in the database. In some instances, the person was never heard from again, so just being officially discharged doesn’t necessarily mean they were flourishing on their own.

Final disposition Entries in this field are my classification of the patient’s status when they left or when the record ends. Many people were “still in hospital” at the time the ledger notes end (1920 or shortly before). Many people died while at the hospital, and when known, their cause of death and place of burial are noted here or in the “additional notes” field. For those who were discharged, they could be discharged as “recovered,” “improved,” or “unimproved.” Some were discharged with the note that they were not insane. Many people were taken out of the hospital against medical advice.

Additional notes This field was used by me to include a wide range of other information about the patient, either comments from me, or information gleaned from other sources. The accuracy of this information cannot be guaranteed. If a person was buried in the DSH Spiral Cemetery, that was noted and the grave number listed in this field.

Note

There was one other space on the pre-printed form at the top of each ledger page that was often filled out, but the information was not transcribed into this database. That space was for “Correspondent” – the name and contact information of someone who was to be kept informed about the patient, such as their next-of-kin. I chose not to include this information for several reasons. First, the surname was often the same as the patient and would have comprised their anonymity. Second, for people who stayed at DSH for many years, the correspondent information would be periodically updated with new names, new addresses, new phone numbers, or all three. Some individuals had multiple correspondents over the years.