Indiana Law Review

Volume 36 **2003** **Number 1**

ARTICLES

CALIFORNIA DEATH TRIP

LAWRENCE M. FRIEDMAN*
PAUL W. DAVIES**

There is basically only one way for a person to enter the world; but there are many, many ways to leave it. In some sense, all men and women are born equal, or almost so; and all normal children follow more or less the same trajectory of development. But people die in most unequal ways—some old, some young, some violently, some peacefully, some by accident or disease or otherwise, some in bed, some in hospitals, some alone, some surrounded by family and friends. Death, of course, is the common fate of humanity. No one gets out of here alive.

The title of this article contains a reference to Michael Lesy's odd and disturbing book, *Wisconsin Death Trip*, published in 1973.[1] Lesy reprinted photographs from around the turn of the century made by a photographer in rural Wisconsin named Charles Van Schaick. Interspersed with the photographs are newspaper accounts of suicides, murders, insanity, and other bizarre forms of behavior, from the same general locale. We read, for example, for 1899, that Christ Wold, a farmer, "committed suicide by deliberately blowing off his head with dynamite"; and that "John Pabelowsky, a [sixteen] year old boy of Stevens Point, was made idiotic by the use of tobacco."[2] Lesy's general thesis is this: by the turn of the century, "country towns had become charnel houses and the counties that surrounded them had become places of dry bones."[3] The countryside was, in short, a place of violence and madness; perhaps out of boredom, isolation, and the terrors of social uncertainty. This is one reason, Lesy thinks, for the flight to the cities. Whether Lesy is right or not, the local newspapers he read do record an extraordinary amount of pathological behavior. Much of this behavior ended in sudden or violent death. And sudden or violent death is the realm, par excellence, of the coroner.

There are, as we said, deaths and deaths. Each society has its own way of classifying deaths. Each society considers some kinds of deaths as "normal," and others as unnatural, or even supernatural. In modern society, "normal" death is the death of old, worn out bodies, of people who die in bed or in a hospital. Young people sometimes die, too, and at one time death in childbirth or infancy

* Marion Rice Kirkwood Professor of Law, Stanford Law School.
** J.D., 2001, Stanford Law School; Ph.D., 2001, University of California, Berkeley.

1. MICHAEL LESY, WISCONSIN DEATH TRIP (1973).
2. *Id.*
3. *Id.*

HeinOnline -- 36 Ind. L. Rev. 17 2003

or childhood, from cholera, smallpox, diphtheria, and other calamities, were almost if not quite normal; adults too, even in the prime of life, fell victim to such diseases. This became less and less the case as medicine improved its power, and began actually curing people. In any event, there has been and still is a category of deaths that are socially defined as non-normal: murders, suicides, weird accidents, among others. These were grist for the coroner's mill.

The office of the coroner is ancient. It is part of the medieval inheritance of the common law. Shakespeare has a reference to the coroner's inquest ("crowner's quest law") in Hamlet.[4] The American states took over the institution from England, just as they took over the sheriff and the jury system. It seems to have always operated, however, in a kind of obscurity. John G. Lee published, in 1881, a handbook on the work of the coroner in the various states;[5] even then the literature was described as "scanty" and "scattered."

The coroner is still very much a living office in some of the states. It is also, in the opinion of many, something of an anomaly. Massachusetts abolished the position in 1877, and created the post of "medical examiner;" the examiner had to be a medical doctor. New York took this step in 1915. Rhode Island tried having both a medical examiner and a coroner. By the 1990s, most states had either gotten rid of the coroner altogether, and replaced this office with a medical examiner, or with a mixed system of some sort—both a medical examiner and a coroner; or a system in which some counties had coroners, and others had medical examiners.[6] California retains the office of coroner, pure and simple, in many of its counties. But not in all of them. A law of 1969 empowered the Board of Supervisors of the counties to abolish the office "by ordinance" and provide instead for "the office of medical examiner, to be appointed by the said board." The medical examiner was to be a "licensed physician and surgeon duly qualified as a specialist in pathology"; and he would "exercise the power and perform the duties of the coroner."[7] At the beginning of the Twentieth Century, however, the coroner, anomaly or not, was an important official in California's local government. Each county had a coroner. It was, in most counties, an elective office.[8] From 1893 on, the term of office of the coroner was four years.[9]

The literature on the coroner and his work, more than a hundred years after Lee, can still be described as "scanty." Historians have made surprisingly little

---

4. WILLIAM SHAKESPEARE, HAMLET act 5, sc. 1.

5. JOHN G. LEE, HAND-BOOK FOR CORONERS: CONTAINING A DIGEST OF ALL LAWS IN THE THIRTY-EIGHT STATES OF THE UNION, TOGETHER WITH A HISTORICAL RESUME, FROM THE EARLIEST PERIOD TO THE PRESENT TIME (1881).

6. *See* Randy Hanzlick & Debra Combs, *Medical Examiner and Coroner Systems: History and Trends*, 279 JAMA 870 (1998).

7. CAL. GOV'T CODE § 24010 (1969).

8. In Los Angeles County, from 1956 on, the coroner's office was, by law, to be led by a forensic pathologist, whose title was to be "chief medical examiner-coroner." TONY BLANCHE & BRAD SCHREIBER, DEATH IN PARADISE: AN ILLUSTRATED HISTORY OF THE LOS ANGELES COUNTY DEPARTMENT OF CORONER 39 (1998).

9. 1893 Cal. Stat. 367.

HeinOnline -- 36 Ind. L. Rev. 18 2003

use of the files of coroners. Yet these files are of great legal, and social interest. Hence this study. The basic data of this preliminary report consists of the contents of the files of the coroners' inquests in Marin County, California, supplemented by data from two other counties, San Diego and Yolo counties, all from the year 1904. Some data will also be presented from later years in Marin County (1904, 1914, 1924, and 1934). The number of inquests was never great. In Marin, there were twenty-eight inquests in 1904, forty-two in 1914, fifty-four in 1924, and twenty in 1934. Yolo and San Diego were also small counties, with relatively few inquests. By way of contrast, the Coroner of Cook County (Chicago), conducted 3,821 inquests in 1904.[10]

I. MARIN: THE SETTING

Marin County lies just across the Golden Gate from San Francisco. It is linked to San Francisco by a long, narrow, and elegant bridge. The land mass of the county amounts to something more than 500 square miles. Its western border is the fog-bound shore of the Pacific Ocean. The eastern portion is separated from the ocean by a chain of high hills, or low mountains, as you please. Most of the population is concentrated in the towns and cities in the lowlands, along the rim of the north end of San Francisco Bay. Today, the county is booming, and the population is growing fast. The bay is dotted with yachts, house-boats, and pleasure-craft; and new developments crawl up the steep sides of the wooded hills. The coastal towns are bustling centers of the tourist trade; and so too of the cities that rim the Bay, very notably Sausalito, whose shops and restaurants on the water provide views of San Francisco, gleaming in the distance. The population of the county, as of 2000, was 247,289.

Marin at the turn of the century was a much quieter place.[11] There were no bridges linking Marin to San Francisco. The 1890 census counted a mere 13,072 people. Marin at that time had a very high percentage of the foreign-born—men (52.6%) and women (about 30%). Men outnumbered women—69% of the inhabitants were males. Consequently, there were relatively few families. Yolo County was also small (12,684); but mostly native-born. By 1900, Marin's population had risen to 15,702; and the gender imbalance had dropped noticeably—the county was now about 61% male. By 1910, the population had risen to 25,000, and the gender gap had continued to narrow. Yolo County's population hardly rose at all—it was 13,618 in 1900. San Diego County in 1900 had a population of 35,090; about half of these people lived in the city of San Diego itself.

In 1900, both Marin and Yolo counties were mostly rural. Marin had a rural

---

10. Administration of the Office of Coroner of Cook County Illinois: Report Prepared for the Judges of the Circuit Court by the Chicago Bureau of Public Efficiency, at 29 (1911) [hereinafter Cook County Coroner's Report].

11. The source of the information for Marin and Yolo counties is INTER-UNIVERSITY CONSORTIUM FOR POLITICAL AND SOCIAL RESEARCH UNITED STATES HISTORICAL CENSUS BROWSER, *available at* http://fisher.lib.virginia.edu/census.

population of 11,823, and an urban population of 3,879 (if you can call this urban). In Yolo, the rural population was 10,732, the urban population 2,886. In 1900, Marin had eighty manufacturing establishments, Yolo ninety.

No place is "typical," and Marin has its own special character. Many of the deaths in Marin were deaths by drowning; the county is bounded on three sides by water—ocean and bay. It is hard to drown in landlocked Yolo. Marin was also the home of San Quentin prison, an old and famous establishment, and the habitation of many violent men. The prison sits on a spit of land, overlooking the northern end of San Francisco Bay.

The coroner's office, like other offices of the county government, is housed today in the Marin County Civic Center, a stunning building from Frank Lloyd Wright's last years, constructed with great swooping semi-circles on a hilly site on the edge of San Rafael, the county seat. The coroner's office has maintained, virtually intact, all the inquest files from 1852 to the present. From 1904 on, the inquest files usually contain a typed transcript of the proceedings. The Yolo County records contain some typed transcripts, but more often simply a record of the statements of witnesses. The San Diego records (housed in the Research Archives of the San Diego Historical Society) are much skimpier, at least for 1904; they are usually only one page long, and give only the barest essentials of the inquest; transcripts of testimony are rare.

II. CROWNERS' QUEST LAW: THE STATUTES

At the beginning of the Twentieth Century, as we said, laws establishing the office of coroner were still in force in most states. In some of the states, the role of the coroner was quite restricted. In Wisconsin, the coroner was to hold an inquest if the district attorney ordered him to do so, and only if the district attorney had "good reason to believe that murder or manslaughter has been committed."[12] In Utah, inquests were to be held on the deaths of "persons as are supposed to have died by unlawful means;"[13] and in Tennessee, only when there was probable cause to suspect homicide.[14]

The statutes usually set out the basic procedures for coroners to follow. In Illinois, for example, the coroner, "as soon as he knows or is informed that the dead body of any person is found, or lying within the county, supposed to have come to his or her death by violence, casualty, or any undue means," must "repair" to the place where the dead body is located, summon a "jury of six good and lawful men of the neighborhood," and, "upon view of the body . . . inquire

12. WIS. STAT. STAT § 4865 (1906).

13. 1907 Utah Laws, tit. 37, § 1221. But in Utah, it was the "justice of the peace" who had the duty to hold inquests.

14. In Tennessee, under TENN. CODE ANN. § 7274 (1896), no inquest was to be held without an "affidavit, in writing . . . signed by two or more reliable persons, averring . . . that there is good reason to believe" that the dead person came to "his, her, or their death by unlawful violence at the hands of some other person or persons."

HeinOnline -- 36 Ind. L. Rev. 20 2003

into the cause and manner of the death."[15] This notion of viewing the body was an essential element of the historic role of coroner's juries; in England, according to Lee, the inquisition was "void," except "*super visum corporis*."[16]

The California statute in force in 1904[17] was somewhat ambiguous on the question of exactly what deaths fell under the coroner's jurisdiction. The statutory trigger read as follows: the coroner steps in when he is "informed" that "a person has been killed, or has committed suicide, or has suddenly died under such circumstances as to afford a reasonable ground to suspect that his death has been occasioned by the act of another by criminal means."[18] We will later discuss exactly what this language means. At any rate, once informed of a death which triggers use the coroner, the coroner was supposed to pick a jury. The minimum number of jurors was six, and the number of jurors varied from case to case, for reasons not very obvious. In Yolo county, six was the normal number; but in San Diego and Marin, there was much more variation. Sometimes there were seven, or even nine or ten jurors. In one case, in 1904 in Marin, a jury of eleven was convened.

The jury was, as we said, required to look at the dead body (many of the inquests were held in funeral parlors), and they could summon and hear witnesses. The jury would pick a foreman, and listen to the testimony of doctors, eye-witnesses, and others. Witnesses were a normal part of the coroner's inquest. In some cases, there were as many as ten witnesses.

It is not clear how the jury was selected—exactly what the process was. No challenges were allowed to the coroner's jury, but a juror who was biased was not supposed to serve on the jury. It does not seem that there was any mechanism for enforcing this rule. What is clear is that many jurors in Marin and Yolo served more than once. Once in a while, the exact same jury would sit on two different inquests (if they were held, for example, on the same day). In 1904, the Coroner of Marin County held multiple inquests on three different occasions, involving seven of the twenty-eight inquests. On one noteworthy day, there were three inquests.[19] Often, one or two jurors would hold over from inquest to inquest. A Chicago report on the Cook County Coroner's office (1911) reported a problem of "professional jurors." The report claimed that some fourteen jurors served on the vast majority of the coroners' inquests in Cook County; and that this was one of the "worst abuses" of the system. The jurors were paid for their labors, and there was a concern that these professional jurors would not exercise independent judgment, but simply do what the coroner wanted.[20]

---

15. 1907 Ill. Laws 213.

16. LEE, *supra* note 5, at 20-21.

17. CAL. PENAL CODE § 1510 (1904).

18. CAL. PENAL CODE § 1510 (1906). The coroner could—and indeed had to—exhume dead bodies if the deaths arose under suspicious circumstances, and the body had already been buried. There were no examples of this in any of the files we examined.

19. This problem—if it was a problem—seemed to get worse over time. In 1934, it was common for the coroner to hold multiple inquests; one day, he held six of them!

20. Cook County Coroner's Report, *supra* note 10, at 8-9, 41-45.

HeinOnline -- 36 Ind. L. Rev. 21 2003

Who were the coroners? The San Diego coroner, Addison Morgan, was in fact a medical doctor.[21] The Marin County coroner, in 1904, F. E. Sawyer, was a funeral director and embalmer who advertised in the local papers.[22] Perhaps he was a doctor as well (he was referred to as "Doctor Sawyer" at least once in the newspapers), but if so, he did not practice. A doctor was nearly always needed at the inquest, and Sawyer nearly always had a doctor available to testify. It appears that undertakers and owners of funeral parlors were, in many states, popular selections or elections as coroners.[23] This continued to be the case. In the early 1950s, in Kentucky, a survey of eighty-two counties found eleven doctors and thirty-one undertakers in the ranks of the coroners (there were also "farmers, farm laborers, taxi drivers, and persons with no occupation"); in Minnesota, however, there were forty-seven doctors, and only twenty-six undertakers (along with a scattering of others—three osteopaths, one dentist, two insurance salesmen, among others).[24]

In Marin and the other counties too, the coroner tended to dominate the proceedings, as far as we can tell. The coroner, or a deputy, sometimes did some investigative work. In one case, concerning Frederick M. Walsh, who drowned in the Bay, the Coroner testified that he tracked down the person from whom the deceased had rented a room in San Francisco, in order to ask him questions[25]; in another case, when an unknown body was found at Angel Island, the coroner put ads in local papers, trying to find out who the man was (with no success).

The inquest was, if the records can be trusted, rather informal, compared to a trial. The jurors were, however, sworn in. Lawyers were not normally present; and the strict rules of evidence were not followed. Jurors could and did ask questions, and some of them seemed to take a more active part in the goings-on than trial jurors would. But the coroner asked most of the questions. He took the leading role in extracting information out of witnesses. Sometimes his statements and questions had a decided slant; and he commented freely on the evidence. Of an Italian man, struck and killed by a train, the coroner remarked, "As far as I can ascertain, he liked his 'vino.'"[26] At an inquest into the death of Mrs. Mattie Jackson, hit by a train at Larkspur, the coroner remarked that he had

---

21. Morgan died on his seventy-eighth birthday; his obituary appeared in the San Diego Union, January 10, 1937.

22. *See, e.g.*, MARIN JOURNAL, Jan. 14, 1904, at 4.

23. Since the coroner has control of the dead body, an undertaker-coroner would be in a terrific position to get the right to do the funeral for the deceased, hence the office of coroner could become a "feeder" for the undertaker's business. At least this was suggested by some observers. *See* Pete Martin, *How Murderers Beat the Law*, SATURDAY EVENING POST, Dec. 10, 1949 (the piece is a general attack on the amateurishness of coroners).

24. NATIONAL MUNICIPAL LEAGUE, CORONERS IN 1953: A SYMPOSIUM OF LEGAL BASES AND ACTUAL PRACTICES (3d ed., May 1955) (unpublished typescript on file with the Stanford Law Library). Funeral directors were also frequent coroners in New Jersey. In Ohio, after 1945, the coroner was required to be a licensed physician.

25. Marin County Coroner's Inquest (MCCI) 752 (Sept. 27, 1904).

26. MCCI 1648 (Dec. 10, 1924).

HeinOnline -- 36 Ind. L. Rev. 22 2003

visited the site with the witness and a representative from the railroad and "I found that his statement, that is, as far as that part of it as to the station was concerned, was absolutely correct."[27] In the case of Michal Grandi, who died in a bakery after eating some meat, the coroner poured cold water on the idea that Grandi had choked to death: "I am positive . . . that he died from chronic alcoholism, and that he was troubled with cirrhosis of the liver and fatty degeneration of the heart. Of course, that could only be determined by an autopsy. Under the circumstances, if you think it unnecessary to have an autopsy, we will render a verdict." A dutiful jury took the hint, and returned a verdict of "acute alcoholism" as the cause of death.[28] At the end of the inquest, the coroner instructed the jury, although these instructions were much less formal than in a regular jury trial. As we have seen, he sometimes almost put words in the mouth of the jurors. In one case, for example, where a woman had died of tuberculosis, the coroner said to the jury: "I think, Gentlemen, it is a clear case of a natural cause of death."[29] However, the jurors were not forced to take the hint; and they did retire outside the presence of the coroner, to deliberate, reach a decision and render a verdict.

The statute, as we saw, was fairly vague on one crucial point—which deaths call for a coroner's inquest? Murder and suicide seem clear enough; but what does "killed" mean? The answer is hardly obvious, and apparently the language gave the coroner considerable leeway. The inquest records show that the coroner interpreted his powers pretty broadly; he conducted an inquest in all sorts of situations where it was not clear whether anybody had been "killed" in the statutory sense. Many inquests were of sudden deaths that, on inquiry, turned out to be from "natural causes." The coroner also investigated quite a few accident cases. Presumably, these were incidents where there was *some* vague chance that a crime had been committed: if not murder, then perhaps recklessness or manslaughter or the like.

By rare good fortune, a reported California case sheds light on the question of the coroner's jurisdiction—and also on the way the coroner actually worked. In 1906, Addison Morgan, the San Diego County coroner—a medical doctor in private practice—sued the county to recover "compensation for his services in some fourteen inquests."[30] The county, apparently, felt it was under no obligation to pay. Its excuse was that the inquests were unnecessary. The coroner described the fourteen cases—in each one there was a sudden death, and the coroner argued that in each one there was at least some hint or possibility of gross neglect, or suicide, or foul play. The court agreed with the coroner, and ordered the fees to be paid. It seems very clear, from the records, that the coroner in Marin County took the same point of view as Addison Morgan. Because of the fee structure, it was clearly in the coroner's interests to stretch a point and look at as many dead bodies as possible.

---

27. MCCI 762 (Dec. 2, 1904).
28. MCCI 1212 (July 8, 1914).
29. MCCI 750 (Aug. 11, 1904) (death of Clara Amelia Ross).
30. The case is *Morgan v. San Diego County*, 86 P. 720 (Cal. Dist. Ct. App. 1906).

HeinOnline -- 36 Ind. L. Rev. 23 2003

This was not exclusively a California problem. The Illinois statute defined the coroner's domain as deaths which came about "by violence, casualty, or any undue means," which is certainly even more ambiguous and opens the door even wider to discretion. Under the Arkansas statute, if the "dead body of any person" was found and the "circumstances of the death" were "unknown," or "if any person die and the circumstances of his death indicate that he has been foully dealt with," the coroner was to become involved. An Arkansas case turned on the same point, more or less, as the San Diego case. A man was sawing wood, "took a fit," fell down and died. The coroner held an inquest, and then sued the county for his fees. In this case, the coroner lost. The court held for the county: "It is not the duty of the Coroner to inquire of sudden deaths, unless there is reasonable ground to believe that they are the result of violence or unnatural means."[31]

Other statutes differed in small or large details from the text of the California law. Some were broader, some were narrower. In Pennsylvania, the coroner came in when the cause of death was "of a suspicious nature and character." In Oregon, there had to be suspicion of criminal means; or of suicide.

III. WHY DID THEY DIE?

The basic question for the coroner's jury was: how did this person meet his or her death. The inquest ends with a verdict. Here is the breakdown of the results (verdicts) of coroners' inquests, in the four sample years in Marin County:

"Natural causes"	27
Suicides	32
Railroad accidents	15
Automobile accidents	12
Drowning	21
"Accidents"	20
Homicides	2
"Other"	15
Total:	144

Of course, we cannot assume that the inquest results were entirely accurate; the jury could make mistakes, or, in some cases, simply lack enough information to come to the right conclusion. Some of the "accidents" could have been suicides; some of the "drowning" entries might have been suicides as well. Many in the "other" category could have been differently classified. But on the whole, we may assume some sort of rough and ready accuracy.

IV. WOMEN AND MEN

What do we learn from the inquest files? Unusual death, at least as far as the coroner was concerned, was a macho business. In the four sample years in Marin County, there were 144 inquests. All except eighteen of the dead bodies were male. This despite the fact that in the entire sample, there were only *two*

31. Clark v. Calloway, 52 Ark. 361 (1889).

HeinOnline -- 36 Ind. L. Rev. 24 2003

homicides—a category that would be expected to be heavily male. Scattered data from other places also show, quite uniformly, a preponderance of men. In Baltimore, in the Nineteenth Century, 75% of the inquests were of men.[32] A study of the City of Westminster, England, in the Eighteenth and Nineteenth Centuries found that men outnumbered women two to one, in almost every category of death.[33] Both in Yolo and San Diego, most of the victims were men.[34]

The Marin County data are not discordant with other data. The suicide rates for men were consistently higher than those for women, throughout this period. In 1904, men committed suicide at a rate more than three times that of women; the national rate was 12.2 per 100,000. In 1914, the national rate had risen to 16.1; in 1924, it had dropped to 11.9; in 1934 it was again higher, to 14.9. Most suicides continued to be men, and by more than a three-to-one ratio. For 1934, there were recorded 18,828 suicides in the United States; 14,564 were men, and 4,254 were women.[35]

Men killed themselves under various circumstances and used all sorts of methods. John C. Tait, age forty-three, a native of England, committed suicide, by "self-administered" chloroform, on March 17, 1904. Tait was despondent because he could not find work; he had tried to commit suicide three times before. He wanted to be "buried in a plain wooden box in the common burying ground . . . . I am wholly and solely to blame in this matter";[36] Mathias Enos, a native of the Azores, hanged himself on July 17, 1904, "while suffering from mental trouble";[37] an "unknown white man," who drowned in San Francisco Bay in February, 1914, left a note that said, "Too much rheumatism; not enough money";[38] two men and a woman committed suicide that year "while temporarily insane," two by shooting themselves, one by drowning;[39] Christensen Bungaard, a native of Denmark, thirty-one years of age, was despondent over a girl who rejected him;[40] eighty-two-year-old Rudolph Huber, who was going blind, took strychnine in August 1914.[41] In 1924, Pedro Cano, a twenty-four-year-old

---

32. Suspicious Deaths in Mid-19th Century Baltimore: A Name Index to Coroner Index Reports (Baltimore City Archives) [hereinafter Suspicious Deaths].

33. Maria White Greenwald & Gary I. Greenwald, *Coroner's Inquests: A Source of Vital Statistics: Westminster, 1761-1866*, J. LEGAL MED. 51, 60 (1983).

34. Coroner's inquests did, however, play a role, at some points of time, and in some places, in investigating the deaths of women who had had illegal abortions. On this point, see LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973, at 118-29 (1997), reporting Chicago data in the period after the Second World War. There were no examples of abortion deaths in our sample.

35. 2 HISTORICAL STATISTICS OF THE UNITED STATES 414 (1975).

36. MCCI 740 (Mar. 3, 1904).

37. MCCI 748 (July 17, 1904).

38. MCCI 1191 (Feb. 26, 1914).

39. MCCIs 1199, 1200, 1201 (respectively, May 9, 1914, Apr. 23, 1914, Apr. 18, 1914).

40. MCCI 1207 (June 25, 1914).

41. MCCI 1218 (Aug. 11, 1914).

Mexican, an inmate at San Quentin, fractured his skull "by jumping off [third] tier in new prison with suicidal intent";[42] Albert W. Lane, fifty-three, who had "trouble in the head," severed his jugular vein with a razor, in August 1924;[43] Alex M. Olsen, age forty, inhaled gas from a gas stove, and left a note to his wife (who was divorcing him) saying "Now I hope you are satisfied."[44] The only suicide in the 1934 group was Robert Grimes, who threw himself "under an oncoming truck with suicidal intent."[45] These Marin suicides, with three exceptions, were men. Catherine Dubrow, thirty-five, who died on April 25, 1904, was despondent over the death of a child;[46] and Florence Duddy, twenty-two years old, who ingested lysol "with suicidal intent while temporarily insane" and suffering from "melancholia"; her father testified that she was despondent over anemia.[47]

By way of comparison, in San Diego County (1904), there were about thirteen suicides, out of thirty-six coroners' inquests. Possibly one or two others could be included in this category. The inquest papers are often extremely laconic, and in some cases, the cause of death was listed as "unknown." All of the suicides labeled as such were men. Like the men in Marin County, they chose all sorts of ways to kill themselves: Rupert Reisinger took arsenic; Joe Clemens cut his throat with a razor; James Holohan, arrested for drunkenness, hanged himself in jail; W. J. Smith used "illuminating gas"; August Hourteinne took "carbonic acid"; while Filberto Castillo poisoned himself by taking a product called "Rough on Rats." Shooting oneself with a gun was, however, the most popular way out of this earth for these despondent men.[48]

Why is it that men were so much more at risk of killing themselves, or getting themselves killed, than women? The coroners' inquests tended to blame mental illness, "brain trouble," and the like for the suicides—in fact, almost universally. But it is difficult to understand why men should be so much more prone to mental illness than women. Part of the answer to the gender issue might lie in another feature of the inquest records. The men who died were disproportionately immigrants, disproportionately loners, men who lived by themselves, men without obvious family attachments. The 1904 San Diego records included natives of New Brunswick, England, Germany, Norway, the Azores, Switzerland, Wales, Ireland, and China. Eleven of the twenty-eight were foreign born. Most of the Americans were not Californians, but came from somewhere else. Locals tended not to end up in the coroner's files. People with families, homes, connections, jobs, settled routines were less prone to the kinds of sudden or mysterious death that led to the coroner's inquest. And women,

---

42. MCCI 1608 (Feb. 12, 1924).

43. MCCI 1629 (Aug. 30, 1924).

44. MCCI 1652 (Dec. 10, 1924).

45. MCCI 2016 (May 29, 1934).

46. MCCI 743 (May 2, 1904).

47. MCCI 1223 (Oct. 19, 1914).

48. These files are found in the San Diego Historical Society archives, Collection R. 2.69, Box 22.

HeinOnline -- 36 Ind. L. Rev. 26 2003

more than men, had these characteristics. The lonely people, far from home, in boarding-house rooms, were men, not women.

V. ACCIDENTAL DEATH

The information on accidents is, so far, fairly fragmentary. But the issue of accidental death was, apparently, of some importance to the work of the coroner. The coroner's job was to decide whether somebody was responsible (criminally or otherwise) for an accidental death. The goal was to explain, to blame, or exonerate. In one of the 1904 inquests, John Frederick Hansen, who worked on a ship, was struck by a train of the North Shore Railroad. The accident was fatal. The train engineer testified that he saw Hansen on the track, and blew the whistle, but did not have time to stop the train. The verdict: an accident, "and we hereby exonerate the engineer and crew from all blame."[49] In the same year, Alfred Iten, a native of Switzerland, stepped in front of the "gravity car on Mt. Tamalpais Scenic Rr." But the jury said, "we believe his death was due to his own carelessness."[50] Lillien Keefe, nineteen years old, was hit by a train as she walked over a foot crossing. In this case, there was considerable testimony about how the accident happened, and whether it could have been avoided; the general thrust of the questions, however, went toward absolving the engineer of the train, and pinning the blame on Lillien. The verdict: "Being struck by Electric Train at foot crossing . . . and believe no responsibility rests with N.S.R.R.Co for accident."[51] In general, the coroners' juries seemed quite anxious to absolve railroads and other companies from liability. In a rare exception, an inquest in San Diego, in 1904, found that a minister had drowned accidentally, by "falling from a Sale Boat in the Bay of Sandiego." The jury went on to say: "We hereby Recommend that the Harbor Commissioners or those who have Authority to not allow Pleasure Boats or Public Boats carrying Passengers to go out on the Bay or the Ocean without Life presservers."[52] This, of course, did not actually place any *legal* responsibility on anybody in particular. In a Marin case, where an inmate of San Quentin, William Stanley, killed himself with a knife, the coroner's jury recommended that prisoners in "Crazy Alley" not be given

---

49. MCCI 747 (June 21, 1904).

50. MCCI 751 (Aug. 30, 1904).

51. MCCI 756 (June 2, 1904); the very next inquest, into the death of Elmo M. Dempsey, twenty-one, concluded that the cause was "[c]arelessness in attempting to board a train at Larkspur station on the Northshore Electric Rail Road, while the train was in motion." MCCI 757, June 29, 1904. The railroad was exonerated in all four cases of railroad accidents that led to inquests in Marin in 1904.

52. And of course there was the occasional coroner's inquest that *did* find someone culpable; for example, an inquest in Jackson County, Illinois, in 1905, on the death of James Bostic, shot to death by a "night policeman, Fred Jacquot . . . . We find that shooting not justifiable and recommend that Fred Jacquot be held to await the action of the Grand Jury." Coroner's Inquests, Jackson County, Illinois, *available at* http://www.iltrails.org/jackson/coroner1.htm (last visited July 22, 2001).

HeinOnline -- 36 Ind. L. Rev. 27 2003

knives.[53]

The coroner's inquests do thus shed some light on norms of responsibility (or non-responsibility); and they have some relationship to developments in the law of torts. Over time, the meaning of the plain English word "accident" seems to have shifted. In the famous *Farwell* case,[54] for example, the leading case on the fellow servant rule in the United States, Lemuel Shaw uses the word "accident" or "pure accident" to mean an event that was nobody's fault—and for which nobody was really accountable. The United States, particularly in the first half of the Nineteenth Century, could be described as a legal culture of low accountability. All sorts of rules developed, whose thrust was to limit liability for personal injuries—perhaps in order to encourage enterprise; but in any event, sustained by a view that "accidents" simply happened, as bad luck, fate, or the victim's own fault. Over time, a legal culture of high accountability replaced the culture of low accountability. The era of the "liability explosion" (the Twentieth Century) reflects a frame of mine that does not really believe, for the most part, in "accidents," to the same degree and with the same meaning as the earlier period. An "accident" in the Twentieth Century is usually an event that has a cause; and that cause comes to rest on the an organization (or an insurance company) which bears some responsibility for the accident; and will therefore have to pay.

In 1904, this shift was underway but incomplete. For the coroner, "accidental" apparently did not mean mysterious or random or without a cause. But it still implied a lack of legal responsibility. The coroner's work in general assumes that any death, of course, has some sort of cause: death is either "natural," or it calls for some explanation, but the explanation is always in rational, scientific terms.

In the Nineteenth Century, there were many rules of tort liability, but they did not open wide the doors to compensation, in civil cases. Criminal responsibility was at least sometimes a substitute for tort liability in the Nineteenth Century. That is, when the incident was not a pure "accident," there was a tendency to find some *individual* to blame for the occurrence (criminally), or sometimes as an alternative to a civil suit for damages. The very strong trend in the coroners' reports is to blame the victim himself for carelessness, or in any event to excuse a company or corporation.[55] Another example of exoneration, of another sort, is found in a file from Yolo. The dead man is a suspected prowler, shot by a constable. The prowler, who was sixty-nine years old, apparently fired at the constable, who fired back (he said). The coroner's jury found that the constable "was entirely justified in said act."

---

53. MCCI 755 (Oct. 19, 1904).

54. Farwell v. Boston Worcester R.R., 45 Mass. 49 (1842).

55. *See* WILLIAM GRAEBNER, COAL-MINING SAFETY IN THE PROGRESSIVE PERIOD: THE POLITICAL ECONOMY OF REFORM 98 (1976), on the tendency of coroner's juries in West Virginia to exonerate in mine accident cases.

HeinOnline -- 36 Ind. L. Rev. 28 2003

VI. INQUEST FINDINGS AS EVIDENCE

When the coroner's inquest makes a finding of accident, or suicide, or excuses or blames someone for a death, what weight does this verdict have in a court of law? For example, take the case where a coroner's jury brings in a verdict of suicide. What impact does this have in a lawsuit brought by the dead man's family against his insurance company? Many insurance policies provided that the company would not have to pay if the insured killed himself. The formal question was whether the coroner's inquest was "judicial" or "ministerial." If "judicial," the inquest material could be admitted in court. This would not be true if the finding were merely "ministerial." A few cases held the inquest to be "judicial," and hence admissible. *United States Life Insurance v. Volcke*[56] was an Illinois case from 1889; the insured allegedly committed suicide. At least so the coroner's jury found. The court held that the inquest material was admissible as evidence that the dead man killed himself. In 1919, Illinois amended its statute to read that in any negligence case, and in any lawsuit "for the collection of a policy of insurance," the coroner's verdict was not admissible "as evidence to prove or establish any of the facts in controversy." And, indeed, in most states (though not California), the coroner's inquest was *not* acceptable, in cases of this sort.

Aetna Life Insurance Co. v. Milward, a Kentucky case from 1904,[57] was another instance of alleged suicide. Here the court refused to allow inquest evidence to be used in an action against an insurance company. If courts admitted evidence from inquests, the court said, there would be a "race and scramble to secure a favorable coroner's verdict," in order to influence a later tort case, or a claim against an insurance company. Inquests, said the court, are often conducted with "carelessness" and to allow them to be used in a later case would "introduce an element of uncertainty into the practice which would be contrary to public policy, and pernicious in the extreme." This was the prevailing view; it reflects, no doubt, some of the more general suspicion courts had about insurance companies, and their propensity to refuse to pay off claims.[58]

VII. NATURAL CAUSES

In quite a few cases, the coroner's inquest in Marin found that the death was due to natural causes. It is not always clear, in some of these cases, why the coroner was called in at all; we do know (as we mentioned) that it was often to his benefit to investigate, since his income depended on fees. But how often this was a factor is impossible to tell.

Many of these "natural" deaths were, however, rather sudden and therefore

---

56. 129 Ill. 557 (1889).

57. 118 Ky. 716 (1904).

58. *In re L. P. Sly*, 9 Idaho 779 (1904), was a murder case. Sly was accused of murdering one John Hays. After a preliminary examination, he was held without bail on the charge of murder. He filed a writ of habeas corpus, arguing that the proceedings were improper, because no coroner's inquest had ever been held. The Supreme Court of Idaho rejected this argument.

HeinOnline -- 36 Ind. L. Rev. 29 2003

at least vaguely suspicious. In mid-Nineteenth Century Baltimore, 29% of the inquests resulted in a finding of natural causes. The Baltimore coroners investigated, apparently, not just suspicious deaths, but also sudden ones; perhaps another way of putting it, is that a sudden death seemed presumptively suspicious.[59] Typically, an autopsy was held in such cases. In Marin, this happened, for example, in the case of Michael White, an Irishman, whose roommate found him dead in bed. The autopsy doctor decided White had had "hypertrophy of the heart," and a serious kidney problem, caused by drinking; these were what brought on his death. Again, these cases of sudden but natural death were mostly unattached men, who died alone, or in a boarding house. Men with families, attended by doctors, were much less likely to evoke the interest of the coroner, and their deaths would appear "natural" even without an inquest.

VIII. DEATHS FROM MOBILITY

What the coroners' records reveal is the seamy side of American mobility. It was a loose, transient society (for men). It was easy to go off to "seek your fortune"; but lots of men never found this fortune. Just as there were no formal barriers to going up in the world, there were no formal barriers to going all the way down—down as far as it was possible to go. One of the Marin suicides of 1904, John Holtz, a native of Germany, drowned in San Francisco Bay. He was described as a man who once had been wealthy, but had lost his fortune. At the time of his death, he was living in a hotel in San Francisco. He was seventy-four—an old, broken man; and alone.[60] Some men died unmourned and unknown. There were dead bodies that were apparently never identified, like the middle aged man hauled out of the water by a fisherman, in November 1904.[61] Men without family or connections had no way to cushion themselves against disaster, depression, and failure. Even when the death itself turned out not to be abnormal, it was hard to be sure, when a man died alone, without family around him. Alexander Paulsen, a laborer, working on a tunnel, got sick and died: the cause of death was supposed to be "Conjestion [sic] of the lungs." An autopsy was performed; and then "Coroner Sawyer took charge of the remains." Paulsen "was a stranger and no one seems to know anything about him."[62]

There were, during this period, thousands of men (and mostly men), who wandered about in the United States, from place to place. They were looking for work, or a new start, or were simply seized with wanderlust. If they fell toward the bottom rungs of the ladder, they were classified as "tramps" or "hobos" or drifters," and became objects of suspicion and worse.[63] In most states, there were

---

59. *See* Suspicious Deaths, *supra* note 32, at iv.

60. MCCI 760 (Nov. 1, 1904).

61. MCCI 759 (Nov. 1, 1904).

62. THE MARIN JOURNAL, Jan. 21, 1904.

63. *See* PAUL T. RINGENBACH, TRAMPS AND REFORMERS, 1873-1916: THE DISCOVERY OF UNEMPLOYMENT IN NEW YORK (1973); ROGER A. BRUNS, KNIGHTS OF THE ROAD: A HOBO HISTORY (1980).

HeinOnline -- 36 Ind. L. Rev. 30 2003

rather stringent vagrancy statutes; these covered a variety of sins,[64] but were excellent weapons in the police war against tramps. New York passed a specific anti-tramp statute in 1880.[65] Interestingly, the Pennsylvania statute on vagrants and tramps stated specifically that the act was not to apply to any "female."[66] The West in particular was full of "unattached young men" who were looking for work, and "formed a new American underclass," in the late Nineteenth Century.[67]

The California death trip reflects a wider malaise than Lesy found in Wisconsin. Lesy thought the pathologies he found were pathologies of an isolated, rural life. But the same, or worse, pathologies could be found in the cities—and in counties like Marin. Lesy's rural areas, in a way, were pockets of immobility; but the California death trip is much more a tribute to American mobility. Or, if you will, American rootlessness, which is an aspect of the same thing.

Mobility was a central fact of American life—geographic mobility, and also social mobility. From the start, this was a society with its share of risk-takers, entrepreneurs, men (and mostly men) who were trying to climb the greasy pole of success. Sometimes this meant starting a business in one's home town; but often it meant picking up and going somewhere else, to start over, or simply to start. It meant leaving family behind and going to hunt for gold in California. It was a restless society, although it was mostly males who were restless—or who were allowed to be restless. Society encouraged seeking one's fortune. Even the middle class joined in the California gold rush—men who wanted adventure, money, and an escape from the strictures of bourgeois life.[68]

Mobility had an impact on every aspect of society. Among other things, it meant that the population—or a significant part of it—was constantly on the move. Whole communities were made up of strangers; and even in older, settled communities, there were always new people coming in—either from abroad, or from elsewhere in this very big country. Mobility spawned new forms of criminality—forms that depended on a shifting, restless population.[69] Bigamy was one of these crimes—a crime that depended on the ability of men to leave a family behind, and start a new life in some distant community. The strangers in town could include confidence men, sly, cheating men who pretended to be what they were not. Blackmail was another crime that thrived on mobility: it was, in some cases, the crime of threatening to reveal a man's past, in a place where he had started life over again, and thought he had buried that past.

---

64. In the southern states, vagrancy laws were used to control black labor and keep it tied to white landholdings, see, for example, 3 ALA. CODE §§ 6849-50 (1907); the statutes of course did not specifically mention the race issue. *See* William Cohen, *Negro Involuntary Servitude in the South, 1865-1940: A Preliminary Analysis*, 42 J. SOUTHERN HISTORY 31 (1976).

65. RINGENBACH, *supra* note 63, at 23.

66. PA. STAT. ANN. tit. 19290, § 21432.

67. WALTER NUGENT, INTO THE WEST: THE STORY OF ITS PEOPLE 113 (2000).

68. On this, see BRIAN ROBERTS, AMERICAN ALCHEMY: THE CALIFORNIA GOLD RUSH AND MIDDLE-CLASS CULTURE (2000).

69. *See* Lawrence M. Friedman, *Crimes of Mobility*, 43 STAN. L. REV. 637 (1991).

HeinOnline -- 36 Ind. L. Rev. 31 2003

The coroner's bodies represent another aspect of the same mobility. Some at least of the men whose corpses went under the knife, some of the dead bodies that lay in the parlors of undertakers, to be gawked at by the jury—were *victims* of mobility. In many cases, this was literally true: they were killed by railroads, and, later on, automobiles—society's prime instruments of mobility. But in a deeper sense mobility had victimized these men. They were the failures, the losers, the hopeless: men who went off to seek their fortunes, or came to a far-off place to make a start or a fresh start in life; and discovered only sickness, despair, and a lonely death. Their voyage ended in a California death trip.

HeinOnline -- 36 Ind. L. Rev. 32 2003