

Studies in Documents

The London District and Middlesex County, Ontario, Coroner's Inquests, 1831-1900

by GUY ST-DENIS

On 15 April, 1832, a meeting of between 600 and 800 loyalists was held at Vittoria, in Norfolk County, in order to counter increasing local reform sentiments.¹ To emphasize their support for the Crown, a cannon was powdered for a royal salute but, unfortunately for one Donald M. Ross, it seems that it was too well powdered. When he applied a match the cannon exploded, and, as well as causing other damage and injuries, killed him instantly.² Early in the afternoon of a July day in 1853, John Nichol and his wife stood conversing with several others near the door of the Anglican church in Wardsville. Nearby, two young boys in a wagon discovered a gun and began playing with it. Shortly afterwards a shot rang out, and Mrs. Nichol fell to the ground mortally wounded with a bullet lodged in the back of her head.³ In May of 1864, William Sewell's wife watched her husband as he entered a privy on their Caradoc Township farm. A few moments later she heard strange gurgling and dripping sounds. When she opened the door to investigate, Sewell collapsed into her arms with blood gushing from his slit throat.⁴ Shortly after Samuel Jepson arrived at work in the morning of 12 June 1894, he was called back to his London home where he was greeted by the lifeless body of his seven-month-old baby boy. His three other young children stood crying in the company of his wife, whose only concern was that she had not been able to send them all to heaven.⁵ These four deaths, although widely separated in time, place, and circumstance, each possessed an unnatural or questionable element. As a result, each was subjected to an investigation known as a coroner's inquest. It was the responsibility of the coroner and his jury to determine, if possible, the true cause of death and who or what was responsible. Like most nineteenth-century court proceedings, coroner's inquests throughout the period of the London District and after 1850 its successor, Middlesex County, generally produced a sizeable amount of paper. And although not all of it has survived, what remains still offers an expansive source on the subject of death in what is now southwestern Ontario.

To appreciate fully the documents of the coroner's inquests, and their research potential, an understanding of the coroner's office and the procedure by which these papers were generated is first necessary. The origins of the coroner's inquest evolved out of the duties of the coroner, who in early medieval England apparently assisted the sheriff in keeping the peace.⁶ In 1276, during the reign of Edward I, the coroner's primary duties were set down by statute, and they included investigations into slayings,

sudden deaths and woundings.⁷ Several hundred years later, England had become an empire and spread both its domain and system of justice to its possessions in North America. After the conquest of New France in 1759, the office of the coroner became one of many British judicial institutions introduced in the Province of Quebec, which was later divided into Upper and Lower Canada in 1791.⁸ Thus, by the time the London District was proclaimed in 1800, the tradition of the coroner's office was already well-established within its boundaries.⁹ Upper Canadian coroners were appointed by the lieutenant-governor, usually on the recommendation of a local MLA or MP. The coroners, often medical doctors, were theoretically appointed for a term only as long as the monarch's pleasure, which in practice meant that they usually held the office for life. While there was no limitation on the number of appointments made, they were in part governed by the requirements of the locality, and "possibly in part by the energy shown by those seeking the office."¹⁰

Although coroners could be appointed to several jurisdictions within a specified district, or county in later years, their authority could not extend beyond these boundaries. This sometimes caused confusion and difficulty.¹¹ One example is an incident that occurred between Middlesex and Elgin Counties. In June of 1884, the body of a baby was found floating in the Thames River near the now abandoned site of the former village of Cashmere, in Middlesex County's Mosa Township. Such incidents were not completely unheard of, as the Thames was used on occasion to dispose of the bodies of dead, usually unwanted, babies. The local Mosa coroner, however, refused to conduct an inquest because the corpse was found on the Elgin County side of the river, which made it a matter beyond his jurisdiction. Consequently, an Elgin County coroner from Rodney had to be notified, who then ordered a burial without an inquest! The citizens of Cashmere were not impressed, and not a little indignant.¹²

The purpose of the coroner's inquest was straightforward enough: to investigate the cause of death and assign responsibility. In this sense the inquest's findings also determined whether further investigation was in order. If an inquest found that a death had resulted from criminal intent, it became a case for prosecution in the criminal court. In most cases, however, death was assigned to natural causes, which not only closed the case but also limited the amount of documentation. Because coroner's inquests were courts of record, their proceedings resembled other higher level courts.¹³ Evidence was introduced, witnesses' testimonies were heard by twelve jurors, and a coroner presided who (like a judge) legally guided the investigation and received the verdict. Inquest proceedings were instituted upon notice of a questionable death, at which time the coroner would immediately empanel the jury. Potential jurors were to be local men who were honest, law-abiding, indifferent (meaning objective) and literate. These were the preferred qualifications, but, since they were not strict requirements, less qualified men might also be summoned. Witnesses, or anyone possessing information material to the investigation, were expected voluntarily to come forward and present their evidence. If a witness refused, the coroner had the authority to compel his attendance through a summons.¹⁴

The inquest would then be opened on the appointed day in any conveniently located building. The first duty of the jury was to examine the corpse, which had to be available as its viewing was an indispensable part of the procedure. After taking particular note of the wounds on the deceased and any stains or marks on the clothing, the coroner and jury removed to the place where the body was discovered. There they examined the

position in which the body was found, observed surrounding objects, and watched the bearing and conduct of those in attendance.¹⁵ All these factors were noted in order to draw evidence as to the type of death suffered, and for indications of guilt. The jurors then retired, and the inquest continued with the evidence of the witnesses. Once these statements were finished, and if the body was not required for a *post mortem*, the coroner could direct its burial or disposal. Then, unless there was medical testimony to be heard, the jury deliberated on the cause of death and returned their verdict.¹⁶

In earlier times, if the panel of twelve could not agree, they were kept without "meat, drink, or fire" until such time as they delivered their verdict. If this ordeal still did not help them reach a decision, they were adjourned until the next assize court met, when they could benefit from the judge's opinion and direction.¹⁷ No evidence exists to suggest that these harsh measures were ever invoked in coroner's inquests held in the London District or Middlesex County, and later the approach employed to resolve the same type of impasse was improved in that jurors were allowed reasonable accommodation and refreshments. As in earlier times, if undecided, their deliberations were adjourned by the judge, who could then discharge them if necessary.¹⁸ The various crimes for which the jury might return a verdict were infanticide, suicide, murder, manslaughter, homicide by misfortune, and homicide in self-defence.¹⁹ Any one of these findings would move the coroner to apprehend the accused and prepare for the prosecution. This he did by submitting the inquisition, or written verdict, to the clerk of the peace of the district or, in later times, the crown attorney of the county.²⁰

Each inquest proceeding involved a certain amount of paperwork, which formed a class of legal documents. While there can be great variance in the number of papers located in each inquest file, there are three basic types which are usually found to be extant: the witnesses' information or depositions, the *post mortem* report, and the verdict. The witnesses' information are transcripts of verbal evidence presented to the jury, which were written down by the coroner during the inquest. These papers are accounts of the events leading up to the victim's death, and can be quite detailed and graphic. Frequently, several witnesses were called upon to give evidence, which in the end could cover many pages.²¹ In cases of multiple deaths, however, the inquest was often based on the investigation of one arbitrarily chosen victim, whose death was considered representative of the whole. This was generally the method employed when coroners were confronted with multiple fatalities arising from accidents such as train wrecks. Such inquests often concluded with the jurors making recommendations to prevent the same type of accident from occurring again.

The *post mortem* was also known as a medico-legal (or doctor's) report on his examination of the corpse. These papers do not always appear in the coroner's inquest files, as doctors were not always called upon to prepare them. But if it appeared to the jury that such an examination was necessary to help determine the true cause of death, then a *post mortem* was arranged. A *post mortem* was often recommended in cases where there were no apparent signs of death associated with the body, or indications from the witnesses' information as to the probable cause of the fatality. The detail and sense of professionalism associated with the *post mortems* can vary considerably, particularly when early examples are compared with their later counterparts. On the whole, however, the *post mortems* offer a medically precise opinion as to the cause of death, depending on the extent of medical knowledge at the time in question. Perhaps this explains why two *post mortems* are given in some cases.²²

Inquest held May 5th 1878 on the body of
Robert Miller.

Patrick Dempsey Sworn

Deposed. On the evening of May 4 I went
in to see Mr Miller he was laying on the bed
and his legs were hanging out on the floor
I took hold of his hand and shook it and
called to him he made no answer. This was
about 20 minutes to 8 P.M. I came out and
saw Mr Nichol and told him there was something
wrong with Mr Miller and asked him to come
up. I ask told Mr McKellar whether came at
the time and then I went to Mr Spencer's and
he was not at home I came the second time
to Miller's house and put my ear down to
his breast and found that he was not
breathing I went to Mr McKellar's and
told them that I thought he was dead and
and some men that were there came up
with me.

As a Juror, his hands were cold, he had no
appearance of a struggle

Hugh Nichol Sworn

Deposed. About 8 P.M. May 4th Patrick
Dempsey came to me at Mr Kellon's store
and told me he thought Mr Miller was
dead. I said perhaps he was drunk he
said no. I told him to call a doctor. He
went to look for a doctor and found none
he came back the second time. Then
Mr McKellar, Mr McKellar & myself went with
him we struck a light and found the man
dead in the bed

As a Juror, did not see him during the day. I have
seen him under the influence of drink. Hugh Nichol

Figure 1: Although witnesses' information was recorded by the coroner, the witness had to attest the transcript with his or her signature.

G. A. Marlatt M.D. Sworn

deposed.

Dr. Spencer and I made a post mortem
~~examined~~ on the body of Mr Millar this morning May 5th
 paying attention in particular to the condition
 of the heart, on opening the pericardium we found
 from 4 to 6 ounces of fluid the heart was larger
 than normal, weighed 2 1/2 ounces, flabby the walls of
 the left side were rather thin, on opening the inside
 we found a large quantity of fluid blood in the
 right side, we also found a well organized clot
 in the left side near the apex, and we found
 fatty deposits, three in number, one attached to the
 valves of the right side, one to the valves of the left
 side, and one was found in the left auricle these
 deposits were quite long two of them extended into
 the large vessels the lungs looked healthy, the liver
 was enlarged, the liver showed some signs of former
 disease

Is a Juror. enlargement of the liver, ^{chiefly congestion of the liver} proceeds from some
 disease of the heart, death was caused by organic
 disease of the heart, never gave him medicine
 his habits of drinking would encourage the fatty deposit.

G. A. Marlatt, M.D.

Verdict of the Jury, that Robert Millar died
 of organic disease of the heart.
 Samuel Danson
 Foreman

James Campbell M.D.
 Coroner

Figure 2: This *post mortem* into the death of Robert Millar is an example of the excruciating detail recorded in these documents.

Province of Canada } An inquisition taken ~~at~~ ^{at} the townshp of Lobs in the County of Middlesex
 County of Middlesex } taken for our Sovereign lady
 to wit } the Queen Victoria & before
 at the townshp of Lobs in the County of Middlesex
 the 17th day of July in the 26th year of the reign
 of our Sovereign lady Queen Victoria & before
 Henry Hanson gentleman one of the coronors
 of our said lady the Queen for the said county
 in view of the body of William Harland then
 and there lying dead, upon the oath of
 Henry Edwards Jurman, Jos Lewis, Angus Campbell
 David Steed, John Hudson, John Polston
 Henry Bramble, Thomas Taylor, ^{John} ~~John~~ Whiting, Thos Dyers
 Thos Dury, Luther Stibber, Thos Harrison good and
 lawful men of the said county duly chosen
 and who being then and there duly sworn and
 charged to enquire how and after what manner
 William Harland came to his death do upon
 their oath say that the said William Harland
 came to his death on Thursday July 1st 1849
 2 p.m. in Mr Benjamin Knight's premises in the
 townshp of Lobs through the effect of intoxicating liquors
 In witness whereof as well the said coroner as the jurors
 aforesaid, have to their inquisition set their hands and
 seals, on the day and year, and at the place first
 above mentioned

Henry Hanson coroner	Henry Bramble Jurman	1
Henry Edwards Jurman	Thomas Taylor	2
George Lewis	John Whiting	3
David Steed	Thos Dyers	4
Angus Campbell	Thos Dury Jurman	5
John Hudson	Luther Stibber	6
John Polston	Thos Harrison	7

Figure 3: The most important document was the inquisition, or the signed, written verdict of the jurors

18 July 1879
Hart & Rowland, Law Stationers, Ac., King St. West, Toronto.

No. 30 INFORMATION OF WITNESSES

INFORMATION OF WITNESSES.

Province of Ontario,
County of Middlesex } Information of Witnesses severally taken and acknowledged on behalf of our Sovereign Lady the Queen touching the death of *Daniel Crossley*
City of _____

TO WIT:
 at the dwelling-house of *deceased* known
 by the name or sign of _____ in the
Township of *West-Missouri*
 in the County of *Middlesex* on the *Eighteenth*
 day of *July* in the year of our Lord one thousand eight hundred
 and seventy *nine* before me, *Stephen Smith*
Murray Esquire, one of Her Majesty's Coroners for the said County,
 on an inquisition then and there taken, on view of the body of the said
Daniel Crossley then and there lying dead,
 as follows, to wit: I *Samuel McConnell*
 of the *Township* of *West Missouri*
 in the said County of *Middlesex* being sworn
 saith: I am the owner of the place where *deceased*
 resided, I am a brother in law of the *deceased*.
 He has been living on my place about *three*
months. The *deceased* was in the habit of *free*
intoxicating liquor. He complained of being sick
occasionally. He was in his usual health on *Saturday*
the 5th of July in the present year. *Saw* him on
Sunday the 6th of July. *Saw* him the night
 before his death when he seemed to be in his usual
 health. *Saw* nothing unusual at that time
 but *in the morning of the 10th* when he
 complained of a pain in his back but of no
 other symptoms. *Heard* him say he was treat-
 ed for heart disease by *Dr. Woodruff and Kellie*

Taken upon oath and acknowledged *Samuel McConnell*
 this eighteenth day of July in the
 year of our Lord one thousand eight
 hundred and seventy nine before me
S. Murray Coroner
 County of *Middlesex*

Figure 4: By the mid-nineteenth century attempts were made to standardize inquest documents through the introduction of legal forms. As this example indicates, their success was limited.

3 July 1896

CANADA :
 PROVINCE OF ONTARIO :
 COUNTY OF MIDDLESEX : IN THE MATTER OF THE DEATH OF
 TO WIT :

J. R. James

I, *John R. Flood* of the City of *London* in the County of Middlesex, Coroner for the said County do solemnly declare:-

1. THAT on the *3rd* day of *July* new the death of a *man* name *Smuloh* *On^o James* having been reported to me, I from information then received made the declaration required by Section 4 of the Act respecting Coroners.

2. THAT since making my said declaration I have made such further enquiries as I deem necessary into the circumstances of the said death, the result thereof being that *He came to his death by drowning!*

3. THAT as a result of such further enquiries and after viewing the body of the said deceased I have come to the conclusion that an inquest is unnecessary and I have issued my warrant for burial of the body of the said deceased, the grounds on which such warrant has been issued being that *I believe the deceased to have been accidentally drowned while in a state of intoxication*

4. THAT *a* warrant for holding an inquest in the case *was* issued by me *but was subsequently* withdrawn.

Declared before me at the)
 City of *London* in the)
 County of Middlesex, this *3rd*)
 day of *July* A. D. 1896) *John R. Flood*

Justice of Peace
 Commissioner or Notary Public *[Signature]*
Commissioner in Charge
Middlesex

Figure 5: In 1894 legislation allowed coroners to waive inquests into deaths which they felt were obviously natural. This form was then filed in place of other inquest documents.

The last document produced during the inquest was the jury's written verdict. Formally referred to as the inquisition, this document recorded the jury's decision, and closed the inquest by either pronouncing the death natural, or by finding it criminal — in which case it became a matter for the criminal court.²³ Inquisitions are found in almost every file, with the cause of death definitely stated (even when attributed to an act of God), and with the signatures and seals of the twelve jurors attached.

The vague ancient mandate that inquests be performed on anyone "being slain or suddenly dead" left room for abuse in the form of superfluous and expensive inquests.²⁴ The lucrative fees associated with conducting a coroner's inquest may have benefited modern archivists and researchers with more records to consider, but the means by which this was achieved was distasteful in the extreme and remains so to this day. The problem of unnecessary inquests became so chronic that early coroners developed much the same reputation in their day as ambulance-chasers have in ours. That is to say, inquests were performed in situations where death had obviously resulted from natural causes, and where the coroner's services were not only unnecessary but obtrusive. Perhaps it is only fair to the early medical profession to note that doctors' fees were often low and sometimes unpaid. Yet some officious, or more likely unscrupulous, coroners were known to arrive at the victim's deathbed and watch "the advent of that which gives them jurisdiction with an avidity far from being creditable."²⁵ It was important to conduct an inquest as soon after death as possible before decomposition altered the prime evidence provided by the corpse. Still, the insensitive practice of anticipating the victim's death greatly intensified the suffering of the deceased's family.²⁶

Worse still, from a cost perspective, was the burden exacted upon the district, and later county, treasury. As early as 1836, the expenses incurred by the districts through unnecessary inquests were questioned in the Upper Canadian House of Assembly.²⁷ And throughout the nineteenth century, there were numerous reforms to the statutes of the province governing the activities of coroners. Subsequently, a bill was passed by the Canadian Legislative Assembly in 1850, which the government hoped would reduce the number of unnecessary inquests. This was done by restricting inquests to those cases where it was apparent that death arose from violent or unfair means, culpable or negligent conduct, and not through mere accident or mischief.²⁸ Although this legislation put a cap on unnecessary inquests, the number of inquests continued to mount in relation to the increase in population, and so did the amount of documentation associated with them.

Dissatisfaction remained, giving rise to a series of unsuccessful proposals for amendments to the legislation. In 1855, the Kent County Council petitioned the Canadian Legislative Assembly to have the appointment of coroners vested in the county councils.²⁹ In 1856, the same Council attempted to have the fees for medical testimony paid out of the Administration of Justice funds, rather than county treasuries.³⁰ The Middlesex County Council tried a similar but equally unsuccessful approach eight years later.³¹ In 1857, the Legislative Assembly defeated a proposal that county coroners be elected by the county's land-owners, and in so doing upheld the lieutenant-governor's right to make such appointments.³² Two proposed, but unspecified, amendments for Perth County in 1862, and Brant County in 1863, were also in response to the high expenditures caused by the increasing number of inquests.³³ The last such endeavour was undertaken by the Kent County Council, which in 1865 requested that the number of coroners be restricted to one for each town or township.³⁴

The counties were obviously trying to reduce costs by reducing the number of coroners who could perform inquests. It was not until 1879, however, that the problem was partially addressed by the government. Through an amending act, the financial obligations for city inquests were shifted from the counties to the cities; although this measure did not completely eliminate the expense of unnecessary inquests, it at least reduced the burden on the counties.³⁵

There were other legislative modifications affecting the finer points of the coroner's duties, but none altered the basic procedure of the inquest itself or the amount of documentation produced. At least, not until 1894. Legislation in that year allowed coroners to cancel inquests which they felt were not necessary. In these instances a typewritten form, with very limited information, was filed in place of the inquest.³⁶ These documents record the apparent cause of natural death, and precluded the necessity for an inquest. Usually these deaths were obviously accidental.

Although the London District was proclaimed in 1800, its coroner's inquest files date back only to 1831.³⁷ The post-1831 files are very incomplete, especially between 1836 and 1842, where there is only one inquest, which dates from 1841. Beginning with 1845, the inquests appear to have survived fairly intact, but even so a number of files from later years appear to be missing. For example, only one file exists for 1857, none for 1888, and merely three for 1900. The reason for the large number of obviously missing early files is unknown. A plausible explanation, however, might be that very few inquests were taken during the initial, and sparsely populated, years of the London District. Also, many inquest papers may have been destroyed after submission to the district, either accidentally or wilfully. Although the later Middlesex County series is not complete either, the number of files which have survived is much greater than those from the London District period. But considering the survival rate of coroner's inquests from adjacent southwestern Ontario counties, where they tend to be non-existent (with the exception of Huron County), Middlesex County has a very good representation.

Incomplete as they are, the London District and Middlesex County coroner's inquests offer a potentially useful source to a wide range of researchers, including anyone interested in the history of the coroner's office — not to mention the related studies of pathology and criminology. Generally, the scope of the coroner's inquests might also touch upon other fields of historical study. Those interested in the social aspects of death in Upper Canada and early Ontario, for example, will find the voluminous amounts of witnesses' information invaluable in reconstructing past attitudes towards death in this province. Those genealogists who have transcended their statistical name and date pedigrees, and now look for the story behind their ancestors, will be rewarded if they are lucky enough to find a family member unlucky enough to have been the subject of a coroner's inquest.³⁸ Unfortunately, the London and Middlesex coroner's inquests do not lend themselves to quantification because of their incompleteness, and the inconsistency of the information recorded. Finally, and if nothing else, the London District and Middlesex County coroner's inquests provide an interesting source of morbid reading material. Unfortunately, a problem encountered here is the difficulty in deciphering the handwriting of many coroner's inquests, which can be a frustrating drawback. This illegibility can probably be traced to the fact that most coroners were also medical doctors, who even in the nineteenth century had a poor reputation for penmanship.

Formerly the property of the County of Middlesex, the London District and Middlesex County coroner's inquests now form part of the local history collection housed in the Regional Collection of The D.B. Weldon Library, University of Western Ontario. In 1973, members of the Church of Jesus Christ of Latter-Day Saints arranged the files chronologically for one of their microfilming projects. This, unfortunately, disrupted what remained of the original numbered sequence, which in any case was extremely sketchy. Their work was carried on by the late Madaline Roddick, who prepared the first index for genealogical purposes. Over the course of 1988, the author refined the Mormon organization and prepared a new index incorporating the following components: date of the inquest, place of the inquest and cause of death.

Notes

- 1 *Canadian Freeman* (York, U.C.), 19 April 1832, p. 2, c. 4; 26 April 1832, p. 1, c. 3.
- 2 University of Western Ontario, The D.B. Weldon Library, Regional Collection, London District and Middlesex County Coroner's Inquests, Donald M. Ross, 5 April 1832.
- 3 *Ibid.*, Mrs. John Nichol, 14 July 1853.
- 4 *Ibid.*, William Sewell, 4 May 1864.
- 5 *Ibid.*, Jepson male baby, 12 January 1894.
- 6 William Boys, *A Practical Treatise on the Office and Duties of Coroners in Upper Canada* [hereafter Boys 1st] (1st ed.; Toronto, C.W.: W.C. Chewett and Company, 1864), pp. 1-2; William Boys, *A Practical Treatise on the Office and Duties of Coroners in Ontario and the Other Provinces, and the Territories of Canada* [hereafter Boys 3rd] (3rd ed.; Toronto, Ont.: The Carswell Company, 1893), pp. 1-2.
- 7 W.C. Keele, *The Provincial Justice or Magistrate's Manual* (3rd ed.; Toronto, C.W.: H. Roswell, 1851), pp. 202-203.
- 8 Upper Canada, Statute, 31 Geo. III, 1791, c. 31, s. 2.
- 9 The London District was originally made up of Middlesex, Oxford, and Norfolk Counties. See: Upper Canada, Statute, 38 Geo. III, 1798, c. 5, s. 37.
- 10 Boys 1st, pp. 4-5; Boys 3rd, pp. 6-7.
- 11 *Ibid.*, p. 22; p. 43.
- 12 *Bothwell Times*, 12 June 1884, p. 4, c. 1.
- 13 Boys 1st, p. 129; Boys 3rd, p. 208.
- 14 *Ibid.*, pp. 127, 129-130, 133; pp. 205, 209-210, 220.
- 15 *Ibid.*, pp. 138-145; pp. 230-245.
- 16 *Ibid.*, pp. 145-148, 150; pp. 242-245.
- 17 *Ibid.*, p. 131; pp. 214-215.
- 18 *Ibid.*
- 19 Infanticide is the murdering of children; suicide is the crime of self-murder; murder is the unlawful killing of another person; manslaughter is an unintentional illegal killing; homicide by misadventure is death from negligence; and homicide in self-defence is an illegal killing performed for self-preservation.
- 20 Boys 1st, p. 179; pp. 29, 292.
- 21 Edmond McMahon, *A Practical Guide to the Coroner* [hereafter McMahon] (Montreal, Que.: Wilson and Lafleur, 1907), p. 271.
- 22 Boys 3rd, p. 256.
- 23 McMahon, pp. 263-268.
- 24 Boys 1st, p. 8; Boys 3rd, p. 12.
- 25 *Ibid.*, p. 9; p. 13.
- 26 *Ibid.*, p. 8; p. 13.
- 27 Upper Canada, House of Assembly, *Journal*, 21 November 1836, p. 77.
- 28 Canada, Legislative Assembly, *Journal*, 1850: 31 May, p. 38; 11 July, p. 141; 12 July, p. 144; 15 July, p. 148; 22 July, p. 172; 24 July, p. 182; Canada, Statute, 13-14 Vic., 1850, c. 56, s. 1; *Kent Advertiser* (Chatham, C.W.), 17 October 1850, p. 2, c. 2.
- 29 Canada, Legislative Assembly, *Journal*, 15 March 1855, p. 689.
- 30 *Ibid.*, 1856: 5 March, p. 95; 5 May, p. 434.
- 31 *Ibid.*, 30 June 1864, p. 502.
- 32 *Ibid.*, 23 March 1857, pp. 124-125; Ontario, Statute, 31 Vic., 1868, c. 18, s. 1.

- 33 Canada, Legislative Assembly, *Journal*, 23 March 1862, p. 15; 20 April 1863, p. 219.
- 34 *Ibid.*, 13 February 1865, p. 101.
- 35 Ontario, Statute, 42 Vic., 1879, c. 17, s. 1.
- 36 *Ibid.*, 57 Vic., 1894, c. 31, s. 1-2.
- 37 At its height, the London District extended over a large area which included all the later counties of Middlesex, Norfolk, Oxford and Huron. Small portions of Perth, Bruce, and Haldimand Counties were also included. The reduction of the London District began in 1837 with the formation of the Talbot District within the boundaries of Norfolk County. In 1839 present-day Oxford County was proclaimed the Brock District, and in 1841 the Huron District was proclaimed encompassing Huron, Perth and Bruce Counties. Elgin County remained attached to the London District and the later County of Middlesex until 1853.
- 38 Frequently, if the date of death is known, the proceedings of a coroner's inquest can be reconstructed from local newspaper accounts, which are often similarly detailed. This was particularly true of the later nineteenth-century and early twentieth-century press. That such items were often communicated to other newspapers is important to keep in mind, especially when issues of a local newspaper are found to be missing.