pathology and having respect for himself and for the profession could take upon himself to say that death resulted from the injuries found upon the body of the deceased. If Dr. Hingston had carefully examined the patient at his first visit he would perhaps have ascertained whether she were the subject of paralysis, (Dr. Hingston examined her sufficiently at his first visit to satisfy him that she was *not* the subject of Paralysis) and not having done so, the spine ought to have been examined. Apoplexy terminated her existence. We are often called to cases of epilepsy produced by irritation of the stomach; the insensibility passes off, and in those cases ends in death. There is an illustration of how apoplexy might have been produced by irritation of the stomach. Apoplexy may come on without any premonitory symptoms. From my experience persons of intoxicated habits are more predisposed to apoplexy. Is it not probable that apoplexy might have come on without violence? Yes most probably. Apoplexy does not always leave a trace. Congestive apoplexy may disappear before death. I must infer that there was congestive apoplexy because there was no evidence as to cause of death. I have not heard of any congestion of brain in this case. I have of two ecchymotic spots in membranes these may have even led to the apoplexy. I call it a complicated case. Ecchymosis is not an extravasation of blood like a hemorrhage, and does not come from a ruptured vessel. This must have been an ecchymosis and not an hemorrhage for there were no ruptured vessels found. The treatment in this case would be likely in a person predisposed to apoplexy to induce it. A medical man would not give opium in a case of apoplexy. The apoplexy of the deceased was the *apoplexie foudroyante* of the French authors.

Cross-examined.—The idea of paralysis is inconsistent with the idea of patient being up next day.

To the Court.—The injuries would have, or might have, but not necessarily have predisposed to apoplexy.

(The above so much in accordance with the "modern researches of physiology and pathology"—were, for the most part, replies to interrogatories of prisoner's counsel.)

Dr. Peltier examined.—Was not in Court on Saturday—*had not heard evidence of medical witnesses for the Crown* but had that of Drs. Hall, Craik and Nelson, and had read that of Drs. Howard and Hingston before coroner. The present is one of those cases in which it was difficult to say what was the cause of death. My opinion is that immediate cause of death was apoplexy. The examination of the spinal cord would have contributed to clear up doubts. It is not necessary to open spine to determine whether apoplexy exists. The deceased could not have been benefitted by the treatment she received from her husband, on the contrary, injured. The marks in arachnoid corresponding to external marks might result from external violence. If no external injuries had existed I should have attributed death to apoplexy—if, on the contrary, external injury existed it might (the violence) have caused the apoplexy.

By the Court.—If I had made an examination of the body myself I should have been better able to offer an opinion. The medical witnesses for the prosecution had certainly an advantage over me; they spoke from what they saw at the *post mortem* examination; while I only speak from opinions founded upon the evidence I had heard them give, and from the depositions I had read.

This ended the case for the defence.

Dr. Hingston re-called. Mr. Johnson asked him whether on the 23rd of May there were any symptoms of apoplexy on the deceased.

Mr. Devlin objected to the question. The Crown had already examined their witnesses at length; it would be placing his client in a very bad position were the question allowed.

Mr. Johnson replied that the defence having started a theory which he was not prepared for, it was his duty to reply to it. He was prepared to charge in theory the prisoner with shooting a person through the brain, and the defence theoretically speaking supposed him to have died of the small-pox.