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NO ORDINARY DEATHS

A People's History of Mortality

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INTRODUCTION

When I studied history at school, the Grim Reaper hovered above our lessons. The dynastic deaths of kings and queens, aristocrats, bishops and generals, of prime ministers and presidents, of the notorious, criminal and rebellious. These deaths were presented, in today's parlance, as the dynamic 'influencers' of historical change, the epoch-shifters, the mortalities that made and broke countries, governments, beliefs and laws. They were A-list deaths.

Except for two world wars, our lessons never really investigated the deaths of 'ordinary' people, and even then, their deaths were represented as statistics, not individual events, or tragedies worthy of consideration. And yet, as I found out when I returned to study history many years later, the 'everyday' deaths of your ancestors and mine have shaped our lives, politics, beliefs, rituals, culture and even landscapes just as much as the deaths of the wealthy and well connected. How we die, the rituals and rites that follow death, the kind of wake, funeral and memorial (if any) that occurs, all reflect years of often value-laden social history that was excluded from our school lessons, but that continues to resonate today. Describe a modern funeral, and everything from the kind of vehicle used to convey the body to its resting place, to flowers, style of memorial, poetry or music, even food at the wake, reverberates with the influence of the past, and of practices and attitudes that continue to shape the present.

This book, then, is about ordinary, everyday deaths in Britain, from late medieval to modern, told through the stories of real people, who lived and died, but who left no obvious mark on the

history books. Over the last ten years or so of researching histories of dying and death, I found their stories in archives and church records, census listings and Poor Law notes, newspapers and journals. They did not make laws, accrue large amounts of money or have dynastic marriages. Nonetheless, their stories show how social, economic and cultural changes impacted on the dying and the dead, as well as those who were left behind. The deaths discussed in this book reveal the moving ways in which our forebears prepared to die, cared for the bodies of their loved ones and coped with their grief. In doing so, they left us clues and legacies that can be found in our villages, towns and cities; in our graveyards and cemeteries; in our landscapes, folklore and rituals.

Their stories, I argue, also leave us insights into coping with dying and death, of ways to hold respect for the dead, and comfort those who are grieving. As the book shows, how we approach dying and death evolves along with changes in myriad social norms and economic conditions, but along the way we can also lose ways of behaving that we might benefit from re-adopting. When someone we know is bereaved, even if we consider ourselves to be close to them, we can sometimes struggle to find the right words to say – 'sorry for your loss' sounds so insipid in the face of what might be a life-changing grief. But having a grounded way of talking about death might help us to begin to interact again, in a supportive, compassionate way, one that genuinely acknowledges the emotional chasm of loss.

The stories in this book are about working people, who experienced their world in some cases through a small geographical area, and in others by crossing counties, countries and continents; some died in rural settings, others urban; some had longevity, others the briefest of lives. We meet people from a range of backgrounds: from a late-medieval sheep farmer in her Devon village, to an eighteenth-century Newcastle printer, and a Victorian undertaker in rapidly urbanising Surrey; as well as those who worked in factories, docks, farms and workshops. We witness how very local interpretations of the signs, symbols and folklore of death

could shape the ways in which their disposal, memorialisation and bereavement was managed. They lived and died through tectonic historical shifts, including scientific developments, political turmoil, mass migration, exponential population growth, industrialisation and the rise of capitalism. These were changes in which the dead also played their sometimes surprisingly important part in shaping a changing society.

Decisions taken about what was 'right and proper' to do for the dead were influenced by practices bound up with diverse cultures, beliefs and social, economic and political pressures. Death rituals have always been fluid in meaning and risen and fallen up and down the social scale. What was once considered a shameful pauper interment is now a fashionably bourgeois 'green burial'; poorer households were denounced for observing several 'watching' days between death and burial, whereas the aristocracy sometimes lay in state for weeks. Class and social status bound the dead as much as the living, as they continue to do so in our own time. As sophisticated and data-savvy twenty-first-century citizens, it comes as no surprise that how we die is shaped by our social and economic situation, just as it was for our ancestors. While we may all wish for what we might describe as winning the 'death lottery', peacefully in our own bed, surrounded by loving family after a long and fulfilled life, the reality is shaped by numerous other factors, many beyond our control. In wealthy Western economies like Britain, longevity has increased over generations, but the fruits of technological and social progress have not been evenly distributed. We are an ageing and unequal society. Death both is and is not the great leveller, in the sense that class and access to resources continue to play a large part in the kind of death we experience. We must face uncomfortable issues about the different 'value' placed on lives, which exposes economic instrumentality in ways we sometimes choose to ignore. This is underlined by the fact that, even though in the twenty-first century we are living longer than ever before, life expectancy is beginning to diverge, as people in wealthier areas continue to extend their lives, while life expectancy in economically deprived areas declines.[1]

The Covid-19 pandemic sharply exposed these deep fissures of social and economic deprivation in both infection and mortality rates. It also underlined that despite our many social advances, societies are still adjusting to 'new' kinds of death, just as our ancestors had to cope with novel diseases like bubonic plague and cholera, or accidents caused by a changing and expanding industrial economy. Death and taxes may be the only certainties in life, as the old saying goes, but the ways in which we die, the responses of our family, friends and communities to this eventuality, and the ways in which we dispose of the dead, are all deeply historically rooted and contextual, as we shall see through the stories of 'ordinary' death in this book.

Death is *the* collective experience it is impossible to record first hand – no one ever returns from the 'undiscovered country' to leave an account for posterity – but the universality of death means writers and philosophers have explored its spectral influence over us for millennia. Our awareness of our own death was one of the fundamental factors that Aristotle believed separated human consciousness from that of animals. Roman emperors employed servants to whisper '*memento mori*' – 'remember you must die' – to them, a reminder that however powerful they were, they should never forget the brevity of life and inevitability of death. Thousands of books and guides have been produced across time and cultures offering advice on how to die a good death, cope with the idea of death philosophically and emotionally, comfort the dying, and grieve. Our ancestors created tumuli, monuments and even cities for their dead. They debated whether the dead should be burned, buried, composted or sent out to sea. For some, the dead were to be kept at the centre of the community, to be interred in special or sacred spaces such as graveyards; others moved the dead out, far beyond the city walls. But regardless of the changing fashions and styles of disposal, death was and is everywhere, determining our destinies and behaviours, and permeating our surroundings and sense of place and space, whether we choose to memento mori or not.

Roman mosaic memento mori, Pompeii, Italy. Skeletal imagery was common in Roman mosaics and paintings, reminding the viewer of the brevity of life and certainty of death. In this image a mason's plumb line holds the skull, which rests on a butterfly, symbolising the soul, and a wheel of fortune. To the left are the sceptre and purple robes of the powerful, and to the right, the ragged garments of a beggar – underlining that regardless of worldly status, death is the great leveller.

Historical and artistic interest in representing dying, death and the changing culture of disposal and memorial is often revived during times of social stress, turmoil and technological change. For example, the late-medieval fascination with *Ars moriendi*, lavishly illustrated best-selling guides about how to die well, was influenced by the trauma of the plague years and subsequent economic and social upheaval in Europe. These guides were rendered possible because of innovations in printing, which made the production and dissemination of books and pamphlets cheap and accessible to a wide audience. As a sudden, undignified and agonising death from plague had rendered a 'good death' of meditative peace, settling of worldly affairs, and last rites and sacraments impossible for so many during the years of pestilence, it is perhaps unsurprising that subsequent generations, raised within the collective memory of the horrors of mass death, might turn to books of advice on how to create the conditions to die well.

The antiquarians of the seventeenth century, many of whom had been shaped by the political violence of the English Civil War years of the 1640s and 1650s, tried to restore a sense of order to 'a world turned upside down' through an interest in, among other things, death rituals, ancient burial practices and monuments.[2] Sir Thomas Browne's 1658 essay *Hydriotaphia, Urn Burial, or, a Discourse of the Sepulchral Urns lately found in Norfolk* explored the discovery of Anglo-Saxon burial urns in East Anglia as a starting point for considering the death customs of the old world, creating a narrative of mortality which emphasised the ephemerality of life and fame.[3] As antiquaries often focused on our empirical, material relationship to the past, burial sites and the changing style of memorial frequently captured their attention and analysis, perhaps unconsciously helping them to process and contextualise the violence and destructiveness of their own times.

In more recent decades, studying death as an interdisciplinary historical and sociological subject became fashionable during the Cold War years, particularly in the United States, but also in Western Europe.[4] French historian Philippe Ariès's immense and

ambitious book *The Hour of Our Death*, which he began researching in the 1960s but was eventually published in 1977, was one of the most groundbreaking early studies of death history. Ariès's tome reflects how academic and public debates about death were increasingly framed by issues such as the growing role of medical intervention in dying and death; the changing ways in which people were dying, such as car accidents or diseases associated with longevity like cancer and dementia; and an increasing awareness of social and economic disparities in life expectancy between different countries and social classes. Ariès's thousand-year survey of mainly Catholic and European death focuses largely on the monuments and memorials of the wealthy, underlining a rather conservative relationship to material culture, at a moment when his changing world teetered on what felt like at times the brink of possible nuclear annihilation. Sir Thomas Browne would have doubtless empathised with the attempt to try and make sense of the fragility of human endeavour and how to memorialise it, in times of existential vulnerability.

Far less grandly, although my own generation also grew up under the 'shadow of the bomb', the seeds of my own interest in researching dying and death were first nurtured through something that happened when I was at school. A history homework project required us to ask grandparents or older people we knew what the most significant social change had been during their lifetime. Without hesitation, two of my grandparents, quite independently of one another, answered 'child mortality'. This was despite the fact they had both lived through war, displacement and migration, devastating economic collapses, the social transformations of the 1960s and the Cold War. My maternal grandfather, born in 1905, was a Holocaust survivor and had come to England as a refugee. He was old enough to remember the First World War in Berlin, including the tragic aftermath of hunger, hyperinflation and violence. My paternal grandmother had been born in Belfast in 1921, her ultra-Protestantism and complex relationship with the politics of her British-Irish identity forged through her devotion to

the Orange Order, in which her father had been heavily involved. How could child mortality be the first thing they both thought of?

Now I am older and have had my own experiences of bereavement, I immediately understand their replies. Both had lost siblings to diphtheria, a bacterial infection of the nose and throat which can, if left untreated, block the airway and cause an agonising death. My grandfather had lost a second sibling to sepsis, meaning his parents lost two of their four children before they reached the age of three. For both, their childhoods had been profoundly shaped by their own grief, and that of their parents. By the time I was at primary school, for someone to lose a sibling was tragic, but very unusual, but for their generation, their experiences were not that uncommon. Until well into the twentieth century, child mortality in the UK remained high; in the 1920s around 14 per cent of children still died in their early years.[5] Vaccines for diphtheria and scarlet fever were not developed until the 1920s, and for measles and mumps, the 1960s. Although better hygiene and diet began to improve the chances of mothers and babies from the late nineteenth century onwards, high child mortality rates still impacted many families like my own.

These horrifying statistics have led some historians to claim that grief was felt less profoundly in the past, and that the regular losses, especially of small children, had the effect of to an extent inuring parents from bereavement.[6] It is undeniable that many more people would have experienced the death of a child compared to today, at least in wealthy Western countries, but it is far more tenuous to suggest that our forebears experienced grief any less intensely than we might now. While our relationship to loss must be placed in historical context – people used different words or expressed their emotions in different ways – I am yet to find any convincing evidence that their sense of bereavement was any less deeply felt.

Death shapes us in deeply personal ways, then, through family stories and memories, and our complex relationship to the past

and how it intersects with the present. People are with us, and then they are gone. Witnessing the transition from life to death is for many of us the most profound thing we will ever experience. And as we grow older, our losses multiply, and grandparents, parents, siblings, lovers, friends and companion animals leave us with the disordered processes of grief to cope with. The interleaving of our contemporary relationship to mortality with historical reflections on dying, death and loss is central to my purpose in this book. As well as my academic research on death, I am a death-walker (which sounds more sinister than it is) and a bereavement counsellor, privileged to listen to people speak about their many different experiences of loss and the multifaceted nature of grief. Talking therapy cannot 'cure' the complicated range of emotions we feel after a death, but it can offer a supportive, non-judgemental space in which to explore the terrain.

Sometimes I take conversations 'outside' by guiding group walks to talk about dying and death. Some of these walks have been oriented towards looking at social history, and others have had a more therapeutic angle, but in either case I have found that walking can create a more relaxed space in which to explore some of our complicated feelings about these subjects.[7] Exploring the history of a place is to tread in the footsteps of those who went before us, inviting us to use our historical imagination as we try and understand their world, with all its possibilities and limitations. Being outdoors also helps some people to openly discuss their feelings; it can feel less inherently overdetermined or hierarchical than being in a class or counselling room. And walking connects us with death in a more literal historical sense as well. A death creates the rare circumstance in modern times in which we, the living, are actively *expected* to walk if we are able. We carry our dead to their last resting place; we step in solidarity with them to the graveside or the crematorium. In the eighteenth century you were not asked to a funeral, you were invited to 'accompany the corpse', as though you were going on a journey together. For me, then, histories of 'ordinary' death are not just about detached,

academic assessment. They are about finding the ways in which we weave together these threads of our collective experiences, how we build bridges with the past and think about the possibilities of shared futures, to include our ever-evolving relationships with dying, death and the dead.

We do not have an accurate record of the cause for most of the deaths described in this book. Nowadays dying and death are, at least in the Global North, mostly institutionally managed and medically determined. We define death as the moment when the brain, consciousness and biological functions necessary to sustain a living organism cease. Like the famous Monty Python dead parrot sketch, it is when a living thing 'is no more, has ceased to be, bereft of life, it rests in peace'. We have the expertise and equipment to assess and certify the moment of death and it is filed as an official statistic, and in the UK all of us will be recorded, along with our cause of death, when we too join 'the choir invisible'.

For our ancestors, however, dying and death were not always obvious or clear-cut matters. Without easy access to a doctor, a stethoscope (not invented until 1816) or the technology we have today to assess when heartbeat and brain function have stopped, the end of life could be open to all kinds of interpretation. A mirror, a feather to the lips, the last rasp of agonies, a magpie landing on the roof, a black dog barking – all kinds of signs and symbols could signify the end. But until the body began to putrefy, which could take several days, the time between alive-but-near-the-end and dead was not always precise and could be open to debate. This meant the status of dying and death was much more fluid in the past, and people spent time watching and minding it, even more so as until well into the last century, most people died at home, rather than in the professional setting of a hospital or hospice. Ministering to the needs of the dying and dead was an intimate, important and mostly female domestic duty, and it required specialist knowledge, understanding and interpretive skill. Furthermore, the time between death and burial was a dangerous, liminal period, when

Laennec stethoscopes. René Laennec was a French physician and musician who made his own flutes. His skill at carving and acoustics led him to invent the stethoscope in 1816, while working at the Hôpital Necker in Paris. He used it to diagnose various chest conditions, and to hear heartbeats – prior to his innovation, physicians would simply rest their ear to the patient's chest to check for illness or signs of life.

the body had to be closely guarded to ensure its integrity at burial. In some communities, quite elaborate rituals were developed to ensure a safe despatch to the afterlife (which is discussed in more detail in chapters 2 and 5 of this book).

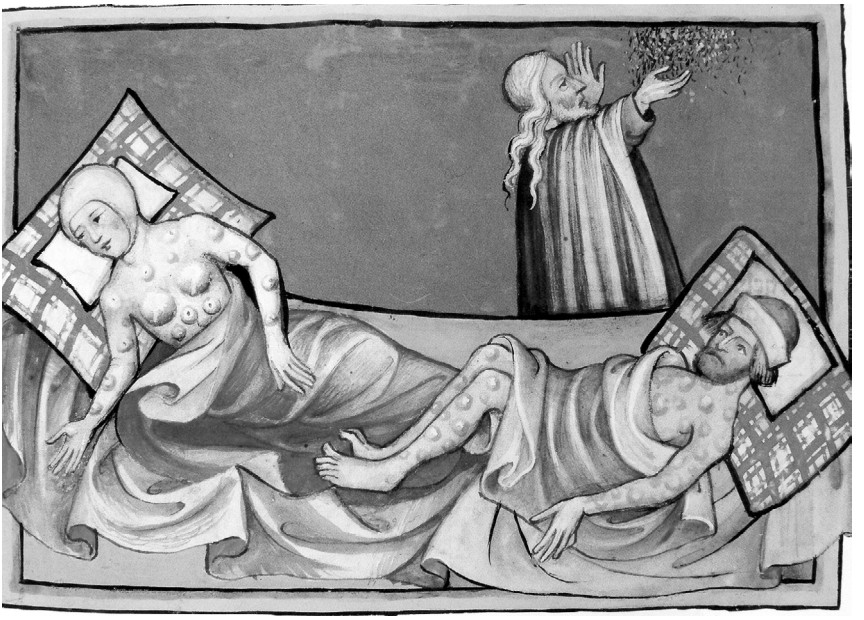
Although we will all die, the ways in which we do so are historically, socially and culturally located. As medical certification of death did not become a legal requirement until 1837, and even then, was sometimes rather vague – I have seen death certificates that say things like 'decline', 'apoplexy' or even 'Act of God', all of which could cover a host of conditions – much of our information about historical causes of death has come from burial excavations, forensic archaeology, contemporary medical accounts, and epidemiological studies. Church, parish and, later, workhouse records can shed light on things like the years of bad epidemics, or the

extent to which geography and social and economic circumstances impacted on longevity, and local records can reveal how devastatingly dangerous some work environments were.

Death is, then, our constant, if mutable historical companion, who changes style, form of representation and method of delivery in accord with the changing times. How people perceived death, and how it was contextualised by the times in which they lived, is an important part of understanding our historical as well as philosophical relationship to what metaphysical poet John Donne described as the 'soul's delivery'. Medieval and early modern death, unless it was the result of violence or accident, was predominantly caused by diseases and infections related to lack of hygiene and poor living conditions, and the lack of antibiotics or other means with which to treat them. Until well into the seventeenth century, sickness was believed to be caused by an imbalance in the four humours of phlegm, blood, yellow bile and black bile, which is why early medicine often relied on draining excesses of blood, or purgatives to induce vomiting or sweating. Bloodletting and purging continued to be medical practice until well into the nineteenth century.

Common causes of death in the past, now thankfully eradicated or generally not life-threatening, included dysentery, measles, typhoid, typhus, influenza, smallpox and scarlet fever. Cuts and fractures could quickly become infected by erysipelas or sepsis. The plague that rampaged through Asia and Europe in the 1340s was known to contemporaries as the pestilence or the great mortality (the name Black Death was an invention of the eighteenth century) and may have killed over 50 per cent of some local populations. It was probably several different diseases, including bubonic and pneumonic plague, and it continued to bubble up in localised outbreaks across the centuries.

Until the last quarter of the nineteenth century, birth and early childhood remained the most dangerous time of life for women and their babies, and child loss was an experience that many people, from all social and economic classes, shared. Tiny bodies could



A miniature from the Toggenburg Bible (Switzerland), *c.*1411, depicting a sick couple in bed, covered in lumps or buboes. This has been interpreted as depicting bubonic plague, although some medical experts think the distribution of lumps is more consistent with smallpox, as buboes tend to cluster around the armpits, thighs, neck and groin. The doctor attending the couple appears to be trying to fumigate the air, which was one of the treatments for the plague.

quickly be overwhelmed by vomiting or diarrhoea contracted from dirty water or infected food, or strep infections like scarlet fever. Periodic famines during the years of terrible harvests, particularly during the early modern period, also took the lives of the youngest and oldest, who were most vulnerable to malnourishment and its attendant health problems.

The early modern population was predominantly a rural one, and most people were employed on the land, and tied to a manor and lord. By the later fourteenth century, as post-plague feudal society began to break down, increasing numbers of people began to move to the cities, a trend that would snowball over the following centuries. The expansion of urban Britain was hugely

significant on several fronts, not least epidemiologically. As the first nation to industrialise, Britain by the end of the nineteenth century had become the first country in the world to have more urban than rural dwellers. The intensity and rapidity of urban growth, particularly during the eighteenth and nineteenth centuries, created several significant challenges, not least those related to what would, by the mid-1800s, become known as 'public health'. Put simply, infrastructure in urban areas did not keep up with the influx of people moving to towns and cities for work in the new industrial economies.

For working people in rapidly growing towns and cities, living – and therefore dying – conditions were generally terrible. The lack of adequate housing, the open sewers, dirty water and intensely crowded domestic spaces, often with several people sharing a room and even a bed, and other limited facilities, resulted in several epidemiological effects. Contagious diseases like influenza, scarlet fever and diphtheria could pass quickly from person to person. Typhoid, dysentery and, later, cholera rapidly spread through infected water and food, racing through the same watercourses used for sewage disposal as were tapped for domestic cooking and cleaning. Typhus, also known as gaol fever because of its preponderance in prisons, was carried by lice and fleas, which thrived in overcrowded homes that crawled with bugs and vermin. Tuberculosis, a lung infection which has thoroughly undeserved Romantic connotations, due to the wasted, pale, 'poetic' appearance of its victims, also flourished in damp, inadequate housing, and was probably the country's most prolific killer by the first half of the nineteenth century.

Changing patterns of work also impacted on how people were dying. In an era before even basic health and safety, falls, cuts and wounds could be a death sentence if infection set in. Longer-term conditions for miners, steel grinders, quarrymen, masons, pottery workers, bakers and textile factory workers included lung infections from dust, such as silicosis and pneumoconiosis ('dusty lung'), as well as severe asthma and dermatological conditions. Other factory illnesses included phossy jaw, or necrosis caused by

white phosphorus used in the match industry, and paintworks lead poisoning, which led to dizziness, nausea and immune-system and neurological breakdown. Dye and glass workers were vulnerable to cancers caused by the chemicals they worked with, and hatters, fur and other textile-processing workers were susceptible to mercury poisoning – one explanation for the origin of the term 'mad hatter'.

There were few burdens placed on employers to offer a safe working environment, and any glance at coroners' records from the eighteenth to the early twentieth centuries reveals all kinds of industrial accidents, from being crushed by carts to falling off ladders and through cellar doors, drownings in docks, beer tuns and cauldrons of molten jam, or being buried under bricks and soil (I even found a case of someone being gored by an antelope at Southwark docks). Work created long-term chronic problems as well. We know from graveyard excavations that most people over the age of thirty suffered from some kind of osteoarthritis, and nearly everyone had tooth decay, which can also lead to more serious infections, especially after sugar became cheaper in the nineteenth century.

Home life was little safer, and landlords were under no obligation to provide secure or sound lodgings for their tenants. Common domestic accidents included scalding from hot water or open fires and falls from rickety stairwells and windows. Tragically, many of the victims were small children, who were often left unattended for hours if necessity required that both parents work outside the home.

Those working people who made it to old age often ended their days in poverty. Before the first Old Age Pensions Act of 1908, which offered a few shillings to those aged over seventy if they could prove they had resided in the UK for at least twenty years and were able to pass a 'good character test', there was no means of support beyond charity or the workhouse. Many older and sick people entered the workhouse at the end of their lives, which is partly why workhouse mortality statistics are so terrible. Depending on the institution they entered, some at least received

Death is depicted as 'the poor man's friend' in this *Punch* cartoon by John Leech from 1845. The reality for many working-class people was an old age in poverty, once they were no longer able to earn a living, especially if they had no family willing or able to care for them. Lying under rags, the broken spade and cap of his labouring days beside him, the man shown here appears to be praying for death to release him.

rudimentary medical care, with the added advantage that the costs of their pauper funeral could be covered by the parish if necessary.

The health and longevity of the population began to increase in the latter part of the nineteenth century. Better hygiene, improving

diets, and medical breakthroughs which yielded vaccines, and later, in the twentieth century, antibiotics, greatly improved life chances. The NHS, founded in 1948, offered universal healthcare, free at the point of delivery, an innovation that transformed the experience of medical care for the working population. In our own time, an ageing population has created different challenges, increasing demand for treatment of chronic conditions, cancers and dementia, as well as basic, day-to-day care, all exacerbated by political choices about funding a national health service.

The way we die now is also changing. Well into the twentieth century, most people died at home, cared for by family, neighbours or paid help. Now we are far more likely to die in a clinical, hospice or care setting. Has the fact that we die in institutions now changed our relationship to death? Do we, as some claim, feel distanced, alienated, embarrassed or scared about death because it is not integrated into the household and community, in the way of our ancestors? How many of us, unless we work in health or palliative care, see a dead body these days? The reality is, as ever, complicated. Our relationship to death, and the ways in which we die, has always changed with the times that we live in. Although some may find a healthcare setting alienating, others may find comfort in being in expert and professional hands, with pain medication on demand. Hospices are among the most joyful places I have ever visited, attested by people who have worked and volunteered in them.

We are part of a far more individualistically oriented society than the people described in this book. We expect to exercise an amount of agency over our daily decisions in ways that would be unimaginable to people even a few generations ago. Why would our relationship to death be any different? The world turns; and climate change, population movement, changing fashions and cultural mores, 'new' diseases and medical breakthroughs will continue to impact on our relationship to dying and death. What we can do is try and understand how we got from there to here, and what we have learned along the way about handling ill-health and

end of life with compassion for both the dying and those they leave behind.

This book is organised around eleven themed chapters that follow the stages of preparing and waiting for death, the process of dying, funerals, grief and notions of the afterlife, rather than an historical sequence from late medieval to the present day. It also contains stories about the deaths of people who were accused of capital crimes, those who were dissected, and others who were marginalised in various ways, for example through the expression of their sexuality, or by fact of their ethnic identity. While these latter categories might not seem like 'ordinary' deaths per se, the chapters are included to reflect the fact that lives lived, often on the fringes of society, are also part of our collective historical trajectory and memory. Punishment by execution, for example, rippled beyond the individuals who suffered this fate and into a broad, popular cultural realm which was very much part of an everyday relationship to dying, death and memorial.

Each themed chapter draws on the stories of 'ordinary people' whose lives and deaths I have researched in archives and other sources over the last decade or so. These stories, and the historical context for them, are chosen for their relevance to the theme in each chapter and do not follow a strict chronological order. The non-chronological nature of the structure is deliberate, for three main reasons. First, death may be universal and a fact of life, but the way we conceptualise and manage our responses to death is not 'timeless'. There are periods and moments in our history which can be identified as having changed or challenged our perceptions about dying, death and disposal. This is not to say that people altered their behaviours or belief systems overnight, and of course it is near-impossible to demarcate neat historical boundaries around changes of attitude or practice. Nonetheless, certain events, processes, discoveries and so forth – such as the sixteenth-century Reformation and the (theoretical) abolition of purgatory, or the growth and spread of the industrial economy and its concomitant

impact on migration as thousands moved from the countryside to the expanding cities, or the spread of Nonconformist religion with its great emphasis on deathbed revelation – all played their part in changing views on different aspects of dying and death. Therefore, taking individual stories in different historical moments enables reflection on what changed and why, over a broader timescale than a strictly linear narrative might allow for.

Second, the use of a thematic approach also creates a shifting narrative between stories about dying and death, which reflect the importance of historical *lived* experience, such as mentioned above: migration, industrial and economic change, political and social upheavals as witnessed through 'ordinary' lives and deaths. I hope this approach enables a narrative that gives death a social and historical context, but that also enables reflection on why end of life was approached in such different ways across different times and places, and how this has even helped to shape our contemporary attitudes towards dying and death.

Finally, and on a perhaps more philosophical note, when we experience the death of loved ones, or speak with those facing their own end of life, death and its aftermath is not necessarily experienced in a temporally sequential way. We stray into past regrets and pleasures, loves enjoyed or lost, thoughts of roads not taken, feelings of achievement or frustration. These can emerge in all kinds of unexpected ways as we try to make sense of what our life has been about. Death – facing our own, or that of the ones we love – is fundamentally disruptive, as is the grief that may follow. It can be complex, messy and hard to resolve, as well as being a peaceful release. There is not necessarily a neat chronological boundary between the living and the dead, and this book also tries to reflect that fact.

Death cultures are often very localised, so it would be quite the epic task to capture the richness and diversity of practices in the different countries of Britain, let alone counties, towns and villages. I have attempted, then, to give a flavour of different experiences through individuals, in different geographies, and at

different times, while accepting that there is never a single story or truth to be told about a life and death. The people in this book did not live and die as statistics. They lived and loved, had and lost children, worked and struggled, and, as most of us will, died in obscurity. In the following pages we reanimate them, to explore how they, and their families, friends and communities, responded to death. In doing this, I hope I have treated them with the dignity and empathy they deserve.

The lives and deaths of the people I have described were sometimes messy and compromised; in some instances, they experienced traumas and difficulties in which I became quite emotionally invested during my research. Life *can* be nasty, brutish and short, but it is important to remember these individuals all had experiences before their ends, and this involved, we can hope, at least some joy, love and laughter as well as difficulties and pain, as they navigated their complicated and contingent worlds. And these are the kinds of lives and deaths that I *wish* I had learned about in school history lessons, because my interest in the past was not just kings and queens, or the rich and powerful, but how 'ordinary' people shaped their lives and expectations, sometimes against overwhelming difficulties and odds. Or to paraphrase Virginia Woolf, to note that, in the end, there really are no ordinary deaths.

1

WATCH

When I was about six or seven, I found a fledgling in our garden that had somehow dropped out of its nest. As I grew up in the countryside, to find a dying bird or mammal was not particularly unusual, but around that age children often get interested in the 'idea' of death, which may be why this memory has stayed with me. It fluttered and flapped pathetically, and my mum tried to find where it had belonged to replace it. All to no avail, and the tiny little thing opened and closed its beak a few last times and seemed to die very suddenly. I insisted on a decent burial in an empty matchbox, but that experience of watching its moment of demise haunted me for a long time afterwards. How did something go suddenly from 'alive' to 'not alive', and all while we hopelessly stared at it? What did it mean to watch something at its transition from being to not-being?

Until well into the twentieth century, people were generally more familiar with watching the processes of dying and death than most of us are today. These days the majority of us will die in a hospital, care setting or hospice, but our ancestors mainly died at home. Relatives and friends kept a close eye on their sick and dying, and someone would be tasked to watch them through the last days or hours of life. Watchers were present to offer physical, emotional and sometimes spiritual comfort and company.

The practice of watching appears to have crossed all social and economic groups, and religious affiliations, until well into the twentieth century. The need to directly tend to the last hours was partly because of the religious and emotional significance of the

'moment' of death, and may be bound up in pre- or non-Christian beliefs, as many cultural traditions attach complex layers of significance to the threats and possibilities that can reside in the liminal moments between life and death.[1] Failure to follow certain practices and rituals might result in restless spirits, bad luck, or danger to the living associates of the dying person. Older women were often engaged as watchers, comforters and companions, and they might also have other responsibilities, such as 'passing', which could involve gathering the wider community of kin and neighbours to witness the moment of death (over time 'passing' or 'passed' has become a more generic term for death). Watchers might also be charged with trying to restrain death until key family members could be gathered for the important end moments.

Watchers might also have other roles in their community, as midwives, nurses, or washers and dressers of the dead in readiness for their burial. While men were usually (if not exclusively) associated with the public side of death and disposal and therefore charged with leading funerals and eulogies for the dead, the end of life was intimate, domestic and generally the responsibility of women. Caring for the terminally sick included the expectation that, if possible, they should not be left alone, for reasons outlined above. But as anyone who has spent time with the dying knows, the last days and hours of life can be hard to judge. Although there are signs, such as subtle and not-so-subtle changes in movements, or breathing patterns, which can start, stop and grow belaboured – the so-called 'death rattle' – these states can last several hours or days.[2] Watchers needed to be cognisant of these delicate shifts and changes, which could be brief or lengthy.

By the nineteenth century the growing (male) medical profession was taking an increasingly active interest and role in supporting the dying. What had hitherto been a female-dominated area of expertise was gradually coming into the purview of trained experts. This does not mean that the medical profession took a unitary view of how the end of life should be managed, and then, as now, there were different attitudes towards the right

A woman watching over the sickbed of an old man. Professional 'watchers' might be paid to care for the very ill or dying, to offer comfort and gather family to pay last respects.

approach to care. Should the role of the doctor be to prolong life, or to ease the end? Sir William Jenner, physician-in-ordinary to Queen Victoria, took the latter view; that, in his own words, the physician's role was to 'prevent disease; failing that, to cure; failing that, to alleviate suffering and prolong life'. But a counterview was offered by his contemporary Dr William Munk, who wrote a book in 1887 called *Euthanasia, or, Medical Treatment in Aid of an Easy Death*, in which he argued for a liberal use of pain relief, particularly opium, as 'equal to most of the emergencies in the way of pain that we are likely to meet with in the dying'. And the debate about how best to care for the dying is far from resolved in our own time: in October 2024, MPs again debated whether to legalise assisted dying (whereby a physician gives a terminally ill person the means to end their own life). Parliamentarians, and doctors, particularly those who work in palliative care, have a range of different views on this emotive subject, to the extent that well over a century on

from Drs Jenner and Munk, there seems to be no immediate resolution to this question.

But before the twentieth century, while most people did not die in the care of a physician or doctor, they might have had a watcher, whether paid or voluntary. And in this chapter, we meet one such woman, a nurse called Mary Yen, whose life spanned the late eighteenth to mid-nineteenth century. Mary's story is instructive for two main reasons. Her life (and death) straddled a period in which the process of dying was increasingly coming under medical scrutiny and control. As the debate between Jenner and Munk illustrates, the formal medical profession was expanding in confidence and influence, and male doctors were gradually replacing the local, working-class, female carers like Mary who for so long had supervised the sick and dying. Over time, the role of nurses would also become more professionalised, and earlier generations of carers like Mary actively marginalised, even ridiculed, for their perceived crudity and unscientific, unhygienic folk-like ways of caring for the sick. Mary's life and experience, then, marks an important transition in the way that our forebears managed these last moments of life, which, by the time she died in the mid-1850s, were on the cusp of change. Her story invites us to reflect on how dying was managed in a pre-medicalised age, and whether, indeed, there are some things we can learn about comforting and supporting those at the very end of life.

Signs of dying

Unless a death was sudden and unexpected, to be able to read the signs and portents of its arrival was a matter of great interest to our forebears. There were different ways of predicting death, some of which were based on intimate living conditions and physical observation and first-hand experience of witnessing the dying. Weight loss, sudden pains, loss of vision, intense dizziness and rashes are all things we recognise today as indications that all is not well, and we head to the doctor as quickly as possible for a

diagnosis. But as, at least until the later nineteenth century, most people had little recourse to medical help, such conditions had to be incorporated into a form of domesticated prognostication, with an added acceptance that nature would take its course, or God's Will would be done. In this sense the states of sickness and dying were fluid because the possibilities of intervening in the outcome were so limited. This did not necessarily mean people were passive and fatalistic about illness, but it did make comfort and emotional support a focus of caring for the unwell.

The lack of human agency in preventing or curing disease placed an emphasis on learning how to read the messages that the universe was trying to share regarding both individual and collective fates. Everything from strange dreams to uncanny or unexplained sights and sounds could indicate incoming sickness and death. Hearing the deathwatch beetle, seeing a candle guttering in the shape of a coffin, the latch lifting unexpectedly in the night, or feeling a strange presence by one's side, could all portend that someone nearby was dying, or about to.[3] Wildlife and nature were, as historian Keith Thomas has observed, heaving with prognoses if one knew how to read them. The sight of flickering lights, such as those caused by marsh gas – also known as ignis fatuus, fool's fire and will-o'-the-wisp – predicted sickness and death. So did a robin tapping on the window, a raven landing on the roof, an unknown dog barking in the night or dreaming of owls. Lone magpies were similarly doom-laden, and suggested death, a funeral or general bad news. The cry of the kittiwake was heard by some as the shrieks of the dying or the dead, and gulls and albatross carried the souls of sailors who had drowned. Black cats and dogs were often interpreted as bringing bad luck (although black cats are also considered lucky in some contexts), and bats could also foretell a death or be inhabited by the spirits of the dead. Plants did not escape these interpretations either; it was considered unlucky to bring hawthorn inside the house because it smelled like death or the plague, although it was also used by some herbalists to ease grief. Violets on the other hand

were considered to ward off evil and death and were often displayed around the home.

Feathers held a great deal of power over the dying; historian of folklore Helen Frisby describes how bags of pigeon feathers might be placed under the body of the dying to 'hold them back' until loved ones arrived to say their farewells. Was this because pigeons were used as messengers, and would hold on to their missives (in this case, of a death) until released? Or that the feathers symbolised the flight of the soul? Precise meanings are lost; but there are records well into the twentieth century of the removal of feathered pillows to help the dying 'give up the ghost', and even of people being hauled from bed in case the mattress contained feathers, particularly in the case of drawn-out deaths. And, as Frisby points out,

> All these items share an underpinning assumption that living people might legitimately exert control over the timing and manner of departure of those who were dying from this world, and that it was possible to either delay or expedite the event as circumstances required; and is therefore evidence of profound social and emotional ties between the living and the soon-to-be-dead.[4]

Frisby posits these activities as part of a 'moral economy', an unspoken contract between the living, dying and dead, into which, I believe, we can situate the role of the watcher. The moral economy was an idea developed by historian E. P. Thompson, based on a critique of capitalism written by Irish Chartist leader James Bronterre O'Brien in 1837. O'Brien argued that 'true' economy was not just exploitative work and capital accumulation, it was also based on affective relationships, like care and community. Thompson illustrated O'Brien's idea by exploring eighteenth-century food riots, which were not necessarily disorderly and violent, but focused on rightful redistribution of resources. The crowd, or community, were rectifying what they saw as a 'moral' wrong in the economy;

if people were hungry, then those hoarding food should be made to share it.

The moral economy, in Thompson's view, was a complex intertwining of obligations and mutualism, not so much based on monetary exchange but in doing what was right and proper for the greater whole. Although watchers were sometimes paid for their caring responsibilities, the role was also rooted in the complex obligations the living owed the dying and the dead in the early modern world – a theme that we return to many times in this book.

By the later eighteenth and early nineteenth centuries, the growing role of doctors in the sickroom was beginning to diminish the authority of local nurses and watchers. Although those who were clearly dying were perhaps not the most 'interesting' patients for doctors, they did enable them to exercise the power of giving a diagnosis, a founding principle of modern medical training, embedded in the Hippocratic approach (from the ancient Greek physician Hippocrates, considered to be the 'father of modern medicine').[5] And medical diagnosis was based in science, observation and probabilities, not robins tapping on windows or dreams of owls. Furthermore, Hippocratic medicine emphasised the importance of giving a prognosis, or assessing the course and likely outcome of a disease. This approach helped to determine what treatment was possible or desirable, or whether to prepare and make the patient comfortable for dying and death.

In our own time, medical and scientific advances have meant an emphasis on 'curing' (where possible), superseding the nineteenth-century steps of diagnosis and prognosis; diseases are sometimes framed as enemies to be battled and beaten; lifestyle choices are corralled to avoid certain diseases and conditions. Contemporary medicine works with a great deal more chronic illness and comorbidities than in the past, as our understanding of the body, and our longevity, has increased. Complex and multilayered levels of expertise mean that when we are sick, we may see a range of clinicians who will be working on different aspects of

our care, rather than the single physician our forebears might have seen. And from the 1970s, palliative care also began to be defined as a distinct area of medical expertise, drawing on the old watcher skills perhaps, with its emphasis on psychological and social as well as medical support for terminally ill patients.

Mary Yen

Mary was born in 1788, the year before the French Revolution, in Christ Church, a parish in Southwark, Surrey.[6] Because she was born thirteen years before the first census of 1801, we have very little information about her early years.[7] But we do know that Southwark, like so many other places on the fringes of urban areas during the late eighteenth and early nineteenth centuries, was a site of transition. Population growth and migration meant that some areas were expanding at an exponential rate, and Southwark was appealing because there were so many employment opportunities, in the docks along the River Thames, and in breweries, warehouses, workshops and manufactories.

According to historian James Vernon, migration was the experience *ne plus ultra* that made Britain truly 'modern', if we think of 'being modern' as the development of a capitalist and predominantly urban economy. And one of the most important dynamics underpinning the development of capitalism was movement – of money, people and goods. At the time of Mary's birth, more British people lived in the countryside than in the city. But by the time she died, Britain was rapidly becoming urbanised, as more and more people moved to towns and cities. Migration has push-pull factors, and the move from the countryside to the towns and cities was precipitated by the collapse in rural living conditions, and the (perceived) greater urban opportunities due to jobs created by rapid industrialisation. This process is sometimes referred to as the Industrial Revolution, a term used to cover the tectonic economic shifts of the late seventeenth to nineteenth centuries, but it is perhaps more helpful to think of it as phases of development,

which profoundly changed the economic and social order over time in ways that are still debated today.[8]

But to put the big historical picture of industrialisation in the context of things that Mary directly experienced in her own environment: during her adulthood the population of Southwark doubled or in some places quadrupled; building work proliferated to house and service the growing population (although not by nearly enough, resulting in dangerous overcrowding); the new London Bridge was constructed and opened in 1831, sweeping away its chaotic medieval predecessor, and was followed in 1836 by the arrival of the railways. The latter two projects caused a major reordering of the street layout in Southwark, with courtyards and alleys demolished to make way for modern, wide thoroughfares. New residents arrived from all corners of Britain, Ireland and the world, mainly in search of work, and there was also a middle-class exodus to the growing suburbs of Camberwell and Peckham. The streets became exponentially busier, thronging with traffic and people. The number of businesses mushroomed – and so did poverty. People made homeless by the building of the new bridge were reported to be living in tents nearby years after it had reopened. Even telling the time changed – as Greenwich Mean Time was adopted by the railways in the 1840s, for the sake of consistent train timetables.[9] How did Mary feel about these changes of place, geography and community over the course of her sixty-odd years? Perhaps her world was so local that change was 'elsewhere', or she simply adapted to new realities as they happened. In any case, she either actively or passively decided to stay in Southwark, so must have found some way to absorb the shock of the new.

We do not know how old Mary was when she started nursing, or what her route into this kind of work was. It may have been that she helped her mother or neighbours with childbirth or younger siblings. In 1851, when the census began to request details about family employment, one of the most touching yet sad descriptors is of young girls as 'assistant mothers'. Daughters were often expected – sometimes from a very young age – to care for siblings

Mrs Gamp in *Martin Chuzzlewit*.

or local babies and young children while their mothers went out to work. There was certainly no formal training for nurses – that would come later with Florence Nightingale's reforms of the 1860s, which were aimed at making nursing a 'respectable' profession for middle-class young women.[10] Before Nightingale, nursing had