

The Burden of Ageing: Old Age, Poverty, and Attitudes toward Social Issues in the 19th-Century Austrian Littoral

At the end of the 19th century, the Italian neurologist and physiologist Paolo Mantegazza, reflecting on ageing wrote that although the attitudes towards the elderly in the society of his time were not as bad as they had been previously, they were often despised and blamed for their weakness and infirmities.¹ At most, he says, elders are treated with empathy, almost never with sympathy or love, not even with respect. In his view, an old man can arouse sympathy for his weakness and respect for his many experiences, but also for his ‘unconscious admiration for everything that has been able to resist the tyrant of all tyrants: time’. However, Mantegazza continues, this cannot be generalised to all segments of society. Where social conditions are poor, old age is perceived differently (e.g. in impoverished, working-class families, where there are many hungry mouths to feed, the elderly are redundant, and here compassion and respect towards them disappear).²

Similar implications—understood within the broader context of welfare and social provision, which at the time remained limited and closely tied to the criterion of incapacity for work, as well as within the framework

1 Mantegazza, Paolo: *Elogio della vecchiaia*. Milano: Fratelli Treves, 1895, 5.

2 Mantegazza, *Elogio della vecchiaia*, 11.

of bourgeois perceptions of labour and poverty³—can also be found in Slovenian newspapers in the second half of the nineteenth century.

Often, the literary pieces published in the Slovenian daily press reflect an image of the old man that is closely associated with poverty, misery, and the contempt of relatives and other household members.⁴ One example is a poem about an old man who comes to the nativity scene at Christmas and complains to the newborn Jesus about being despised and mistreated by his young relatives.⁵

However, it is difficult to say to what extent such publications were reproducing stereotypes and to what extent they were a reflection of a certain reality,⁶ or whether they had a moral message aimed at preventing undesirable behaviour (such as children refusing to help elderly parents, marginalising elderly members of the family and community, neglecting the elderly, or even other forms of immoral attitudes towards the elderly, including various forms of violence).

In any case, the images of old age were diverse and linked to different factors; in addition to social status, also to gender, occupation, social influence, cultural environment, etc. Contemporary historiographical studies on ageing emphasise that old age is a socio-cultural construct, pointing to the plurality of meanings and perceptions attached to it, as well as to the heterogeneity of perceptions and experiences of the ageing process – not only in different societies but also within different segments of the same

3 See f.e. Čeč, Dragica: «Srce vsakega je treba pripraviti za dejavno udeležanje zapovedi ljubezni do bližnjega»: začetki sistemske oskrbe revnih in pomen kulture osebne dobrotelčnosti. In: *Pomisli na jutri: o zgodovini (samo)odgovornosti* (Studen, Andrej, ed.). Ljubljana: Inštitut za novejšo zgodovino, 2012, 37–70.

4 The same is true for some other areas in Slovenia; for the case of Pohorje, see Ramšak, Mojca: *Starost in staranje v pohorski pravljici*. In: *Starost – izzivi historičnega raziskovanja* (Šorn, Mojca, ed.). Ljubljana: Inštitut za novejšo zgodovino, 2017, 35–44. The author notes that fairy-tale prose about old age and the elderly in Pohorje in the 19th century reflects the key problems of old age, such as health, lack of means of subsistence (due to the absence of social and health insurance), and partly also the contemptuous attitude towards the elderly (Ramšak, *Starost in staranje*, 43).

5 F.e. Radoslav: «Starček pri jaslicah». *Zgodnja Danica*, XXV/1, 1872, 1.

6 For example, oral sources in some ethnographic studies in Istria (see e.g. Brumen, Borut: *Sv. Peter in njegovi časi: socialni spomini, časi in identitete v istrski vasi Sv. Peter*. Ljubljana: Založba / *cf., 2000, 111) testify that good upbringing was judged by the respectful attitude of the young towards the elderly.

society,⁷ and that the study of ageing has also been influenced by cultural gerontology with its interest in understanding old age in terms of its cultural significance, which is, of course, manifested in different dimensions.⁸

There were certainly many images of old age. An ageing bourgeois experienced the last phase of his life differently from an elderly peasant or worker, but in addition to self-perception, there were also differences in social perception of how old age should be lived and what an ageing person represents. Thus, even the 19th-century writers sometimes noted that the old man evoked mainly sympathy for his frailty in the upper classes but also respect for his experience, whereas the elderly member of a working-class or poorer family could be perceived as a burden.⁹

The elderly and poverty

In the nineteenth century, older people often represented a substantial share of those receiving welfare support. Social assistance at the time took two main forms:¹⁰ non-institutional care, which included so-called *external charity* such as regular or occasional relief in money¹¹ or in kind (food, rations, clothing, and similar goods) and institutional care, which meant accommodation in dedicated social institutions. Information on long-term or permanent support is limited, especially in regions without

7 See f.e. Ottaway, Susannah R.: *The Decline of Life: Old Age in Eighteenth-Century England*. Cambridge University Press, 2004; Pelling, Margaret, Smith, Richard M.: Introduction. In: *Life, Death and the Elderly* (Pelling, Margaret, Smith, Richard M., eds.). London: Routledge, 1991, 1-32, etc.

8 Higgs, Paul: Social and Cultural Gerontology and the Importance of the Ageing Body. In: *Old Age before Modernity: Case Studies and Methodological Perspectives, 500 BC–1700 AD* (Neumann, Christian Alexander, ed.). Heidelberg: Heidelberg University Publishing, 2023, 272.

9 In these, we do not usually find positive images of the elderly as a wise educator, nor as someone who enjoys the respect and esteem of the community because of his or her experience and knowledge (especially not in an urban environment) (Čeč, Dragica: Podobe starosti v začetku 19. stoletja. In: *Starost - izzivi historičnega raziskovanja* (Šorn, Mojca, ed.). Ljubljana: Inštitut za novejšo zgodovino, 2017, 22).

10 As S. Woolf (*Porca miseria. Poveri e assistenza nell'età moderna*. Bari: Laterza, 1988, 37) points out, however, it is not possible to speak of two completely separate segments of aid, as they were often complementary.

11 This has usually been the social measure with the least presence, due to its financial weight. In Trieste, too, historians (cf. Fabi, Lucio: *La carità dei ricchi: povertà e assistenza nella Trieste laica e asburgica del XIX secolo*. Milano: F. Angeli, 1984, 38) have noted that there was a marked tendency to reduce cash grants and to replace them with less costly forms of assistance.

an established system of outdoor relief or without Poor Institutes, which elsewhere routinely recorded such data and thus left a clearer documentary trace. The latter emerged from the reforms of Emperor Joseph II, which centralised institutions responsible for collecting, managing, and distributing charitable funds under state supervision.¹² This model, however, did not extend to Istria, which in the eighteenth century still belonged to the Republic of Venice. Even so, Habsburg Trieste did establish a Poor Institute, and it continued to operate well into the nineteenth century.¹³ Institutional care in the area was placed mainly in charitable institutions, such as almshouses or asylums for the disabled, the elderly and the sick,¹⁴ which were financed mostly by rents, the sale of produce (and legal revenues, e.g. from certain fines, including in Trieste a tax on wine¹⁵), bequests and charitable donations.¹⁶ Municipalities did allocate funds under the heading of “charity,” but this designation largely referred to covering care expenses in hospitals¹⁷ and health facilities for the mentally ill, women giving birth, newborns, the deaf, and similar groups. At the same time, local authorities were expected to provide for the rest

12 Čeč, Dragica: “Donacije Janeza Nepomuka Kalistra- tržaškega ‘self-made mana’- in njegove vdove Marije v meščanski kulturi darovanja”. *Annales. Series historia et sociologia*, 33, 2023, 1, 105.

13 On it, see in particular A. Di Fant (Pauperismo e assistenza medica: l’Istituto generale dei poveri di Trieste dalla fondazione alla metà dell’Ottocento. In: *Tra Esculapio e Mercurio: medici e sanità nella Trieste dell’Ottocento: con note sulla vita di un primario chirurgo, Emerico Pepeu* (Ponte, Euro, ed.). Trieste: EUT, 2011, 78–107; “Contro la questua molesta e a pro della vera indigenza”. L’Istituto generale dei poveri di Trieste dalle origini alla Prima guerra mondiale. In: *Carità pubblica, assistenza sociale e politiche di welfare: il caso di Trieste* (Vinci, Anna Maria, ed.). Trieste: EUT Edizioni Università di Trieste, 2012, 17–40) and occasional publications reporting on its activities (e.g. Rossetti, Domenico, Formiggini, Saule: *Cenni storici intorno a l’istituto generale dei poveri in Trieste*. Trieste: A. Levi, 1903 and *Cenni storici intorno all’istituto generale dei poveri in Trieste dall’epoca della sua prima fondazione fino a tutto il 1858*. Trieste: Lloyd austriaco, 1859).

14 Among others, there were almshouses in Koper, Piran, Motovun, Lovran, Bale, Umag, ... (*Handbuch für das Küstenländische Verwaltungs-Gebiet Gefürstete Grafschaften Görz und Gradisca, Markgrafschaft Istrien und die Stadt Triest mit ihrem Gebiete für das Jahr 1855*. Trieste: Weis, 1855; cf. Madonizza, Antonio: “Di alcune pie fondazioni nell’Istria”. *Porta Orientale*, 1857, 59–71).

15 Cfr. Di Fant, Pauperismo e assistenza medica, 80.

16 For more detailed information on this type of financing in the case of the Koper almshouse (which was annexed to the civic hospital), cf. in particular Z. Bonin (“Ustanovitev in delovanje koprškega vrtca ter dobrodelne ustanove Grisoni do konca prve svetovne vojne”. *Arhivi*, 35, 2012, 2, 455ff).

17 At the time when the public health system was still developing, hospitals were intended mainly for the poor, who did not have adequate conditions for medical treatment in their own homes (which was the most common practice), nor the means to pay for a physician; for those who did not formally demonstrate poverty, hospital care was chargeable, as was physician’s visit at home.

of the poor, so the responsibility for financing all other aspects of social assistance also rested with them.¹⁸

In the Vormärz period, social welfare was generally a symbiosis between Poor Institutes (where they existed), private charity and church institutions, but after 1848 there was already a shift of administrative autonomy in this area to the local (municipal) level.¹⁹ Initially, also in Istria, it was still the Provincial Fund that covered institutional care.²⁰ The Province, it was argued in the Istrian Provincial Assembly in March 1863, had to bear a great deal of the cost of hospital care for the poor inhabitants of Istria, which was attributed, on the one hand, to the freedom of the latter to move freely around the Province, and, on the other, to the public hospitals' duty²¹ to admit anyone to their care, irrespective of their pertinence,²² and to the ease with which certificates of indigence were believed to be issued.²³

At the end of the same year, responsibility for (institutional and other) social care was, as the Provincial Assembly had hoped, devolved to the municipalities, which meant that they were also responsible for the flow and

18 Cfr. Scheutz, Martin: Demand and Charitable Supply: Poverty and Poor Relief in Austria in the 18th and 19th Centuries. In: *Health Care and Poor Relief in 18th and 19th Century Southern Europe* (Grell, Olle Peter, Cunningham, Andrew, Roeck, Bernd, eds.). Aldershot: Ashgate, 2005, 68.

19 Scheutz, Demand and Charitable Supply, 66.

20 A decree of the Luogotenenza of 1 March 1855 already stipulated that the costs of the hospital were to be reimbursed by the province to which the patient belonged (*Atti della dieta provinciale dell'Istria in Parenzo*. Rovigno: Antonio Coana, 1863, 377).

21 From 1856, those institutions that had the status of public hospitals (this did not apply to municipal hospitals) could apply to the provincial government for reimbursement (*Atti della dieta provinciale*, 1863, 377).

22 The right of domicile was first formalised by an imperial decree of 1754 and a decree of the Court Chancellery of 1789, which stipulated that domicile was to be acquired either by owning a house, by acquiring the right of bourgeois or artisanal tenure, or by continuous residence for 10 years. The next related provision was the Conscription Patent of 1804, which counted as "native" all persons born in the locality, followed by the provisional Municipal Law of 1849 (distinguishing between citizens and foreigners). The last phase included the Municipal Law (1859) and the Homeland Law (1863) (Stariha, Gorazd: "Z nobenim delom se ne pečajo, le z lažnivo beračijo": odgon kot institucija odvrčanja nezaželenih". *Zgodovina za vse*, 14, 2007, 1, 40–41). It is also necessary to add the 1896 amendment (which entered into force in 1901), which made it somewhat easier to obtain the right of domicile in the Austrian part of the monarchy, by reviving the 10-year continuous residence in the municipality condition – abolished by the Homeland Law (cf. Steidl, Annemarie: *On Many Routes: Internal, European, and Transatlantic Migration in the Late Habsburg Empire*. Lafayette: Purdue University Press, 2020; Kirchner Reill et al.: "Redefining Citizenship After Empire: The Rights to Welfare, to Work, and to Remain in a Post-Habsburg World". *The Journal of Modern History*, 94, 2022, 2, 326–362; Čeč, "Donacije Janeza Nepomuka Kalistra").

23 *Atti della dieta provinciale*, 1863, 377.

distribution of funds, which often required a great deal of ingenuity. This was concerning the determination of domicile, i.e. municipalities were responsible for the poor with a right of domicile,²⁴ and could claim reimbursement from their home municipalities for the foreign poor.

The 1863 Homeland Law (*Heimatrecht*) stipulated that whenever the provision of poor relief exceeded the capacities and resources of charitable institutions, the municipality was obliged to support those poor who were pertinent to the municipality.²⁵ At the level of the monarchy, the law established jurisdiction over social welfare matters and, through the concept of domicile, determined which community was responsible for covering the costs of care, for example in hospitals or almshouses.²⁶

However, the free disposal of funds for charitable purposes by municipalities has also meant different criteria for determining who is entitled to this aid, as highlighted by some European studies.²⁷ Increasingly, the individual circumstances of applicants were becoming a criterion for the distribution of poor relief support, while municipal administrations were approving the rights of residency²⁸ and discussing it at municipal council meetings. In these cases, it was up to the management structures of the bourgeois elites²⁹ to decide on eligibility for social assistance and to determine the

24 Scheutz, Demand and Charitable Supply, 67; Anžič, Sonja: *Skrb za uboge v deželi Kranjski: socialna politika na Kranjskem od srede 18. stoletja do leta 1918*. Ljubljana: Zgodovinski arhiv, 2002, 210; Grošelj, Branka: *Na dnu: položaj beračev in brezdomcev od konca 19. stoletja do leta 1940*. Ljubljana: Inštitut za novejšo zgodovino, 2018, 210; Dobaja, Dunja: "Pregled razvoja socialne zakonodaje v Avstro-Ogrski monarhiji v letih 1867–1918". *Zgodovina za vse*, 16, 2009, 2, 50.

25 Reichs-Gesetz-Blatt, 1863, § 22. For the area in question see esp. Tonicich, "Inside and Outside the Habsburg Public Health System. Managing Complexity Within the Austrian Littoral (1849–1880s)." *Annales: anali za istrske in mediteranske študije. Series historia et sociologia*, 32, 4, 2022, 523–534; see also Mezzoli, Erica: "Safe waters: Austrian seafarers between charity and welfare, ca. 1850–1920." *Annales. Series historia et sociologia*, 32, 4, 2022, 574.

26 Čeč, "Donacije Janeza Nepomuka Kalistra", 106.

27 Cfr. Zimmermann, Susan: *Divide, Provide, and Rule: An Integrative History of Poverty Policy, Social Reform, and Social Policy in Hungary under the Habsburg Monarchy*. Budapest: Central European University Press, 2011, 12.

28 Stariha, "Z nobenim delom se ne pečajo", 41; cfr. Globočnik, Anton: *Nauk slovénским županom, kakó jim je delati, kadar opravljajo domačega in izročenege podróčja dolžnosti*. Ljubljana: Klein in Kovač, 1880, 70.

29 For example, it is important to note that donors who contributed at least 50 gld. annually to the Poor Institute in Trieste had the right to vote and could become members of its directorate – the latter was superior to the Fathers of the Poor, who determined eligibility for support in the field (Di Fant, *Pauperismo e assistenza medica*, 82).

type and modalities of care (which also included the choice of the appropriate institution). It should be added that there was no special poor law for Istria³⁰ (such as the one obtained by Carniola in 1883³¹), but the provisions of the Homeland and Municipal Laws were required.³² However, there were nevertheless municipal funds for the maintenance of charitable institutions and social care, among other things.

In times of extraordinary circumstances and increased needs (e.g. epidemics, economic crises, natural disasters, etc.), the vulnerability of the system became even clearer, burdening municipalities whose capacities were not equivalent. It is clear that many municipalities were not always able to help themselves, especially when there was an increase in the need for social assistance. Funds were therefore often raised through personal charity.³³ It should be pointed out that charity was an important component of the bourgeois ethic and could be relied upon by the power structures as a source of additional funds.³⁴ In Trieste, with its strong economic elite, a number of private bourgeois foundations were formed, especially from the mid-century onwards, which also gave their funds annually to a certain number of poor individuals or families, widows with children and, to a lesser extent, to the elderly without a source of income and to workers who had become incapable of working.³⁵ At the turn of the 20th century, “private charity” was in decline and individuals (philanthropists) were

30 These were formed after the abolition of the Poor Institutes (Scheutz, Demand and Charitable Supply, 68), which took place in 1883 (Dobaja, “Pregled razvoja socialne zakonodaje”, 52).

31 Cf. Anžič, *Skrb za uboge*, 40ff.

32 Pančur, Andrej: Problem samoodgovornosti beračev, potepuhov in brezposelnih na Slovenskem pred drugo svetovno vojno. In: *Pomisli na jutri: o zgodovini (samo)odgovornosti* (Studen, Andrej, ed.). Ljubljana: Inštitut za novejšo zgodovino, 2012, 145.

33 Cfr. Bratož, Urška: “‘Kruha in dela’: o reševanju socialnih vprašanj v Istri in Trstu 19. stoletja”. *Annales. Series historia et sociologia*, 32, 2022, 4, 547-558; Čeč, “Donacije Janeza Nepomuka Kalistra”.

34 On the subject see f.e. Čeč, “Srce vsakega je treba pripraviti”, 49–50; Čeč, Dragica: “Revni- ostareli v času kriz: družba na dlani”. *Arhivi*, 43, 2020, 2, 323.

35 E.g. the foundation of L. Riess, founded in 1873, as well as those of Baron P. Revoltella, M. Radich, and others (*L'amministrazione comunale di Trieste nel triennio 1900-1902*. Trieste: Il Municipio di Trieste editore, G. Caprin, 1903, 306ff). This does not include the workers' mutual aid societies that had been established since the first half of the century, which targeted specific professional groups, such as hatters, merchants, coopers, etc. (Bratož, Urška: “Delalcu ne ostane družega, nego, da sam premisli, kako bi se preskrbel tudi v slučaju bolezni---”: o delavcih, obrtnikih in podpornem društvu v Kopru. In: *Historični seminar* 13 (Šter, Katarina, Žagar Karer, Mojca, eds.). Ljubljana: Založba ZRC, 2018, 122).

replaced by associations, societies, often politically motivated, which used charity to build consensus and support.³⁶

Incapacity for work, an integral element of old age

In 1864, the Municipality of Trieste set up a special commission for the poverty ('Commissione sul pauperismo'), composed of two municipal councillors and four representatives of the charitable directorate, to study and present proposals for improving the social situation. The report³⁷ presented by the commission at the end of its task highlighted the problem of job scarcity. In this context, it is possible to agree with the opinion of the time that old age, illness, and unemployment have been the key social problems and drivers of poverty in the Istrian region.³⁸ However, the important discourse related to eligibility for social assistance or the debate on "deserving" and "undeserving" poor cannot be overlooked here. The demand to divide the poor into two groups (employable beggars on the one hand, and the poor who could not support themselves, e.g. because of their age or physical condition, on the other) existed in the secular authorities, in particular with the economically justified (mercantilist) moralisation that man's work should be useful to the state and its economy. According to this logic, only the poor who were unable to work for objective reasons (i.e. the elderly, the sick, the disabled, etc.), were truly worthy of pity (and entitled to assistance).³⁹ The remaining poor have, for the most part since the 18th century, been seen as an untapped potential labour force. There was also an important distinction between permanent and temporary

36 Di Fant, "Contro la questua molesta", 19, 30.

37 On this cfr. Fabi, *La carità dei ricchi*, 145–146; Rossetti, Formiggini, *Cenni storici*, 87; Finzi, Roberto: Gli ultimi non saranno i primi. I poveri a Trieste fra Sette e Ottocento. In: *Storia economica e sociale di Trieste*. Vol. I. (Finzi, Roberto, Panjek, Giovanni, eds.). Trieste: Lint, 2001, 416ff; Scartabellati, Andrea: *Prometeo inquieto: Trieste 1955-1937. L'economia, la povertà e la modernità oltre l'immagine della città della letteratura*. Roma: Aracne, 2006, 40ff.

38 Cfr. also Scheutz, Demand and Charitable Supply, 59.

39 This is how the "deserving poor" were defined in the 1818 Regulations of the Poor Institute in Trieste: "The truly poor are distinguished into those who, through misfortune, bodily defects or old age, have rendered themselves completely incapable of earning their livelihood by work, and those who, through similar circumstances, have become only partially incapable of work, who cannot earn their entire livelihood from themselves, but rather at least part of it." (Kandler, Pietro: I poveri ed i pitocchi. In: *Raccolta delle leggi, ordinanze e regolamenti speciali per Trieste*. Trieste: Lloyd Austriaco, 1861, 11).

incapacity for work; if the latter was sought to be remedied as soon as possible (also within the framework of existing health and social welfare institutions), the former usually already implied the granting of some kind of social care.

Work as a value and a guarantee of personal happiness and social well-being was also firmly anchored in 19th-century bourgeois cultural codes, whereby the task of society was to produce as many able-bodied (useful) members of society as possible.⁴⁰ For example, in 1845 Carlo Combi – then head of the bureaucracy staff of the Poor Institute in Trieste – wrote about this, summarising the mindset of the merchant elite of Trieste and the common discourse on the pauperisation of (urban) society. His idea was, that “to educate and moralise” is the key task of philanthropy and charity, and that there must also be public (not just private) charity that contributes not only to the temporary solution of problems but also to the longer-term elimination of the causes of poverty for the public good.⁴¹

However, public charity in the sense of re-education of the poor was also not feasible for all; adults (especially the elderly) were, in Combi’s words, “plants already lost to society”, either deprived of the strength to work by old age or deprived of employment for moral, physical or other reasons (competence). Even at the opening of the new Triestine almshouse in 1862, the inaugural addresses echoed the message that charitable institutions offered two things – shelter and work – and that this was the most that the poor could ask of society.⁴² The doctrines of the time promoted the belief that by providing work, true and benevolent mercy⁴³ was being exercised and that everyone, according to his or her own abilities, determined by

40 On the ideology associated with work, see Studen (Človek mora delati za svojo srečo!: pretekla razpravljanja o delu s poudarkom na drugi polovici 18. stoletja in prvi polovici 19. stoletja. In: *Pomisli na jutri: o zgodovini (samo)odgovornosti* (Studen, Andrej, ed.). Ljubljana: Inštitut za novejšo zgodovino, 2012, 9–36); Stariha (“Z nobenim delom”), and in the context of vagrancy, e.g. Wadauer (“Establishing Distinctions: Unemployment versus Vagrancy in Austria from the Late Nineteenth Century to 1938”. *International Review of Social History*, 56, 2011, 31–70).

41 In general, the Poor Institute was the key regulator of private charity, and presented itself as the only valid intermediary for private charity, which could have otherwise been abused by the undeserving poor if the means had been channelled through individuals rather than through the institution (Di Fant, ‘Contro la questua molesta’, 23).

42 Rossetti, Formigini, *Cenni storici*, 68.

43 “... col dare lavoro si opera la veritiera e benefica carità”.

gender, age, and physical strength, was contributing to the common good. Only those who are incapable of work should thus be exempted.⁴⁴ Even some almshouses infiltrated the doctrine of work and its benefits into their operations to a certain extent; in these institutions, in return for a place to stay, it was customary to expect unpaid work, insofar as the individual was able to perform it.⁴⁵

The temporary incapacity of wage-earners is also worth mentioning; for these workers, benefits from workers' mutual aid societies, insurance companies, etc., could go some way to alleviating their hardship, in exchange for the membership fee. Austria introduced accident insurance in 1887 and health insurance a year later, but organised forms of self-help for workers had existed for decades before that.⁴⁶

Those who were permanently unable to work were entitled to some form of social support (albeit usually insufficient); apart from institutional care in an almshouse, they could receive food or commodity assistance. Particularly common (e.g. in larger cities such as Trieste) was the distribution of free meals (soup) under the auspices of the Poor Institute – the need for these is said to have risen from 800 to 2,000 or more meals distributed between 1837 and 1845 (due to economically motivated labour immigration).⁴⁷ This distribution of free rations was intended as a broader, albeit temporary, form of charity, not strictly tied to the right of domicile.⁴⁸

The concurrent complaints that social care is concentrated in predominantly urban spaces or does not meet enough of the needs manifested in rural areas were probably also partly justified. In Trieste, for example, the distribution of meals was also intended for the inhabitants of the

44 Rossetti, Formigini, *Cenni storici*, 66.

45 See f.e. the regulations of the Besenghi almshouse in Izola (SI PAK KP 250, b. 1, m. 3).

46 See f.e. Bratož, 'Delalcu ne ostane družega'; Bratož, "Kruha in dela" ...

47 Fabi, *La carità dei ricchi*, 41. Also later (1862), there are reports of 1,200 to 2,000 free meals cooked daily for all the needy outside the care of institutions, the number of which varied according to the needs and the season (Rossetti, Formigini, *Cenni storici*, 67).

48 Di Fant, 'Contro la questua molesta', 22 and 30.

neighbourhoods and villages (surrounding areas),⁴⁹ but this was carried out in the city, which could be a problem for the elderly living outside it. They were also unable to take part in another “social measure”, namely paid public works (road repairs⁵⁰), for which the municipality allocated some funds in 1863,⁵¹ which were then paid to the workers involved. Unemployment, even temporary one, was a pressing problem, which increased the quota of those in need.⁵² It was repeatedly pointed out that rural poverty was seasonal,⁵³ as people “work in the fields in summer ... but in winter they are almost all poor”.⁵⁴ Measures such as making public works available in winter and the distribution of goods (flour, salt, etc.) were occasionally tried to address this, but there was no systematic organisation of formal or informal charity in the countryside.⁵⁵

Old people and their bodies

Since it was in the interest of the state that people should be able to work for as long as possible and not be a social burden, medical imperatives were also geared towards appropriate lifestyle habits that would enable healthy ageing and the maintenance of a strong body even in old age. For example, medical and hygiene manuals of the 19th century depict, above all, the inevitable decline of vitality; the body undergoes noticeable changes, visible in

49 Of the 580 families receiving free meals in Trieste, more than 47% were from the surrounding area, which also accounted for almost half of the rations distributed (*Verballi della Dieta provinciale di Trieste*. Trieste: Lloyd Austriaco, 1864, 215).

50 And also on the railways, but only the population living nearby was to be involved (*Atti della Dieta provinciale dell'Istria in Parenzo*. Trieste: Lloyd Austro-Ungarico, 1873, 76).

51 In the amount of 1,400 (Bazovica), 720 (Padriče), 204 (Bane), and 700 gld. (Lonjer) (*Verballi del Consiglio della Città di Trieste*, 1863). In Istria, too, part of the funds, “to help the healthy and working man”, were allocated in the form of public works (*Atti della dieta provinciale*, 1863, 310).

52 *Verballi del Consiglio della Città di Trieste*, 1863, 35.

53 This was not only the case for agrarian workers; dockers were often out of work in winter, as the weather prevented ships from sailing, and fishermen were similarly without income (Fabi, *La carità dei ricchi*, 42) and could become occasional paupers.

54 *Verballi della Dieta provinciale di Trieste*, 1864, 215.

55 Čeč, “Donacije Janeza Nepomuka Kalistra”, 108. Although it appears to have been at least a distribution network operating through rural parishes in the Triestine territory, which received raw ingredients for the soup from the Institute and then distributed them to the poor (see Gonnella, Anna: *L'assistenza pubblica a Trieste: l'alimentazione nell'Istituto dei poveri (1818–1918)*. In: *Gli archivi per la storia dell'alimentazione*. Vol. III. Roma: M.B.C., 1995, 1596).

the skin, physiognomy, hair, senses, and in the decline of physical strength and the functioning of the organs.⁵⁶ Most often, advice on prolonging life and living healthily in old age were contained in general hygiene reading, usually aimed at young people to ensure a better quality of life through a healthy lifestyle, especially by following the principles of Hufeland's macrobiotics.⁵⁷

The guidance notes recommended that the elderly should have a sparing and regulated diet; their food should be easily digestible and less irritating, in smaller quantities; they should avoid purging (purgatives, blood leaks, heavy sweating, etc.), as this weakens the strength and further dehydrates the body. The elderly need order, calmness, a steady movement of the body without great effort, and as little mental restlessness, strong passions as possible, while joy, optimism, hope for a long life and also for life after death are beneficial.⁵⁸ However, this advice was often difficult to implement for the lowest social classes (especially with regard to diet, limiting physical work, etc.), as it followed mainly bourgeois lifestyles and values, and hardly even reached the lower social strata, due to illiteracy or unwillingness to follow the collective health-related imaginary⁵⁹).

Work was recommended in old age, but in a moderate way – preferably in the fresh air, and certainly not in the form of strenuous tasks.⁶⁰ Older people should have the right to get some well-deserved rest in the last years of their lives and to devote more time to maintaining their own

56 On this see Bratož, Urška: Staro telo: medicinski pogled 19. stoletja. In: *10. Istarski povijesni biennale = 10th Istrian History Biennale: Corpus, Carnalitas ---: the body and corporality in the history of the Adriatic* (Mogorović Crljenko, Marija, Uljančić-Vekić, Elena, eds.). Poreč: Zavičajni muzej Poreštine, Pula: Sveučilište Jurja Dobrile, Filozofski fakultet, Pazin: Državni arhiv, 2023, 102-114.

57 Christoph Wilhelm Hufeland (1762–1836) incorporated traditional dietetics into a new scientific discipline that he called macrobiotics. Its aim was not cure, but prevention and longevity (Remec, Meta: "Živeti dolgo ali živeti srečno?": Christoph Wilhelm Hufeland in njegov vpliv na dožemanje starosti in staranja v dolgem 19. stoletju". *Glasnik Slovenskega etnološkega društva*, 63, 2023, 2, 7-21). See also Prelog, Matija: *Makrobiotika ali nauki, po katerih se more človeško življenje zdravo ohraniti in podoljšati*. Maribor: self-publishing, 1864.

58 Prelog, *Makrobiotika*, 256–259; see also Ricciardi, Giuseppe: *Trattatello d'igiene, ossia Medicina senza medici e senza farmaci*. Firenze: Stabilimento Civelli, 1869, 53; Guyétant, Sebastien: *Il medico dell'età regrediente e della vecchiaia ossia consigli alle persone d'ambo i sessi, che transcorsero l'età dei 45 anni*. Venezia: Bazzarini, 1841, 126–127.

59 See also Bratož, Urška: "Podobe starosti v ljudski in uradni medicini 19. stoletja". *Glasnik Slovenskega etnološkega društva*, 63, 2023, 2, 22-30.

60 *Dizionario classico di medicina interna ed esterna*, vol. 21, Venezia: Giuseppe Antonelli, 1835, 38.

health. Of course, as contemporary writers have noted, this was only realised by those who could afford to take a break, unlike peasants and workers who had to work even in old age to ensure their survival.⁶¹ Similarly, other recommendations (e.g. rest, peace of mind, proper diet, optimism, etc.) reflected the bourgeois ethic and were an ideal that was difficult for the general population to attain, conditioned with financial means and social networks.

The ideal that was probably attainable by few was, of course, an old age free from suffering and pain, and at the same time free from the deprivation that the elderly were largely confronted with. On the other hand, the outward appearance of an impoverished man, marked by hunger and physical exhaustion, closely resembled that of an ageing man, suggesting that the “ageing” of the poor was, at least superficially, more rapid.⁶² It is generally accepted that the well-being of the elderly—multifaceted and encompassing physical, economic, and emotional dimensions—depended to a large extent on economic status, nutritional levels, living conditions, and other factors that define “quality of life.”⁶³ Yet examining the historical implications of these conditions remains a significant research challenge.

Older people have faced a variety of health problems that have affected their quality of life, their ability to earn a living and, ultimately, could be the cause of death in old age. What is interesting in this context is a particular category of causes of death which – most often under the label of *marasmus senilis* (referring to physical weakness, wasting away, depletion of the life force, deterioration, degeneration of the human body), not only because of its frequent occurrence, but also because of its indirect implications. Although wasting away could be the result of various chronic

61 S. Guyétant, *Il medico dell'età regrediente*, 122. On the fact that the elderly were often compelled to work as long as their bodies allowed, see e.g. Studen, Stari, onemogli, 208; the problem was addressed also in the case of seafarers in Mezzoli, “Safe waters”.

62 Cf. also Čeč, *Podobe starosti*, 22–23, who at the same time highlights the body and the biological changes visible in it as a criterion for defining a person as old, especially in the context of social care (Čeč, Dragica: “Revščina kot grožnja družbenemu redu v 18. stoletju”. *Acta Histriae*, 24, 2016, 2, 302).

63 Pelling, Smith, Introduction, 8.

medical conditions (especially tuberculosis, gastroenteritis, cancer, etc.⁶⁴), “marasmo senile”, “debolezza senile”, etc. were the official medical categorisations of death in the last decades of the 19th century.⁶⁵

Viljem Lipič, physician in Ljubljana in the first half of the 19th century, classified old-age debility as a nervous disease, since the natural end of life was most often associated with a weakened mental capacity, but he also noted that the majority of those who died of marasmus came from poorer backgrounds.⁶⁶ Another revealing information is the number of the almshouses’ inmates, who died of marasmus; in Gorizia in 1891, for instance, the ratio was over 72% for men and 75% for women of all deaths in that year.⁶⁷

The social conditionality of marasmus is evident also in the case of Koper. Although between 1840 and 1845 more than 32% of debility cases recorded in the death registers were attributed to individuals whose occupation or social status was not clearly indicated, (age-related) debility – as a vaguely defined diagnosis – accounts for the highest proportions of causes of death⁶⁸ among the lower classes (servants, poor), farmers, fishermen, and

64 Cfr. F.e. *Nuova enciclopedia popolare italiana*, vol. 12. Torino: Società l’Unione tipografico-editrice, 1861.

65 Between 1880 and 1885, for example, we can see that the proportion of old-age debility in Koper was up to 12% of all deaths (excluding stillbirths and inborn debility) on an annual basis (see the health reports in SI PAK KP 7, b. 206, no. 1025; SI PAK KP 7, b. 179, no. 768; SI PAK KP 7, b. 197, no. 964; SI PAK KP 7, b. 216, no. 1004/XIV; SI PAK KP 7, b. 208, no. 1207; SI PAK KP 299, b. 9). About a half of people aged above 60 were diagnosed with marasmus at their death, which was a high proportion, when compared to data of some other case studies (see f.e. Katarina Keber, “Ostareli v Ljubljani v 19. stoletju: Mortaliteta na primeru Šempetrskega predmestja”. *Kronika*, 73, 2025, 2, 393–404).

66 Lipič, Fran Viljem: *Topografija c.-kr. deželnega glavnega mesta Ljubljane z vidika naravoslovja in medicine, zdravstvene ureditve in biostatike*. Ljubljana: Znanstveno društvo za zgodovino zdravstvene kulture Slovenije, 2003, 236. Recent studies have also highlighted the links between wasting and inadequate nutrition and hard work (von Kondratowitz, Hans-Joachim: *The Medicalization of Old Age: Continuity and Change in Germany from the late Eighteenth to the Early Twentieth Century*. In: *Life, Death and the Elderly* (Pelling, Margaret, Smith, Richard M., eds.). London: Routledge, 1991, 112–137).

67 Luzzatto, Aronne: *Rapporto sanitario del Comune di Gorizia per il triennio 1891-1892-1893*. Gorizia: Magistrato civico, 1894, 25.

68 At this point it should be clarified that – since the first half of the century – according to the Regulations on the Determination of Causes of Death (Trieste, 1819; Circolare del imp. Reg. Governo del Litorale, concernente la visita de’ morti, SI PAK KP 304, b. 9, a.u. 15), the cause of death was determined by the municipal mortuary inspectors, and this information was then forwarded to the parish priests for entry in the death registers. In their work, the mortuary inspectors also relied to a large extent on information from the deceased’s attending physician, and the cause was sometimes more difficult to determine if such information did not exist.

the lowest proportions among the middle and upper social classes (civil servants, landlords, clergy, etc.).

Most of the people to whom marasmus was attributed before the age of 70 were peasants or members of the lower social strata. This may indirectly suggest that those who became weakened the fastest and to the greatest extent were individuals who had to work hard for their livelihoods, were poorly nourished, and most likely lived in deprivation. The links between poverty and old age have been increasingly highlighted by scholars who deal with the history of old age.⁶⁹ This is evident by the data on the inmates of the almshouses, many of whom were elderly.⁷⁰ It also shows that society's preoccupation with the elderly has been predominantly with their actual or potential poverty and the appropriate means to prevent or alleviate it, with much less (or no) concern for their health.⁷¹ Physical weakness was also to be conflated with the category of incapacity for work, which was used to describe those who were usually involved in institutional social care.⁷²

The "marasmus senilis" was a fundamental concept linked to the irresistible process of the depletion of the life force (in the vitalist sense) and, from the Hippocratic-Galenic tradition,⁷³ a key marker of the medicalisation of old age since the 18th century.⁷⁴ In some European settings (e.g. Germany), it is noted that – while medical nomenclature became more sophisticated in the second half of the 19th century – the number of causes of death attributed to old age (or age-related diseases) increased, indicating that the

69 See f.e. Pat Thane: "Social Histories of Old Age and Aging". *Journal of Social History*, 37, 1, 2003, 93–111, and also Čeč, in this volume

70 Some data for Ljubljana in Čeč, "Revni – ostareli v času kriz", 326, and Čeč, in this volume; for Gorizia in Tavano, Luigi: *Assistenza e sanità a Gorizia: le suore di carità (1846-1984)*. Gorizia: Provincia religiosa di Gorizia delle suore di carità di S. Vincenzo de'Paoli, 1984, 200. In Gorizia, for example, in 1892, more than 70% of all the inmates of the almshouse (Casa di ricovero), both men and women, were over 60 years of age (Luzzatto, *Rapporto sanitario*).

71 Conrad, *Old Age and the Health Care System*, 505.

72 Kondratowitz, *The Medicalization of Old Age*.

73 The basis for these concepts was the composition of the four elements (fire, water, earth, air) and the four qualities (hot, cold, wet, dry), and the resulting division into the basic body juices (blood, mucus, yellow and black bile) – harmony, the balance of the body fluids, was thought to make health possible. Humoral pathology was also the basis for ascribing certain characteristics to the old body: it was understood as "cold" and "dry", while at the same time in the process of its tissues becoming more rigid and its life force waning (for more on this, see Bratož, Staro telo and Draženič, in this volume).

74 Kondratowitz, *The Medicalization of Old Age*, 120, 125.

concept of natural, inevitable death had taken over.⁷⁵ It can also be confirmed for Koper that the proportion of deaths specifically attributable to age (senility) among those over 60 years of age rose from 15% in the 1840s to just over 39% in the 1870s.⁷⁶

Among the elderly in Koper aged over 75 (who died in the period 1875–80), 76.5% were diagnosed with “marasmus” (“senilis”), and 87% of those aged over 80. This suggests that debility was an expected condition in old age, but probably also that the elderly rarely called a physician,⁷⁷ so that many of the causes of their deaths were vaguely identified conditions (such as *tabes* or *marasmus*), and that such apparently neutral and broad labels were probably convenient to accommodate all that was not always medically identifiable. Of the elderly people in Trieste who died of marasmus between 1888 and 1890, 60% or more were women, mostly *privates*,⁷⁸ but also many of them inmates of the almshouse and peasants. The last two groups were predominant among the men to whom this cause of death was attributed.⁷⁹ Data on marital status would certainly also have been informative, but they are unfortunately lacking here.

Some indications from the medical reports of the Trieste hospital⁸⁰ suggest that the elderly sought medical help very late, which probably led to a higher mortality rate, especially in cases of infectious diseases. The reasons

75 Thane, Pat (ed.): *The Long History of Old Age*. London: Thames & Hudson, 2005, 244; cfr. Kondratowicz, The Medicalization of Old Age, 128.

76 ŠAK, Death register 1832–1846; Death register 1875–1899.

77 See e.g. Pelling, Smith, Introduction, 7. This could be indicated by the absence of medical treatment that would have helped the medical examiner to determine the cause of death more accurately, as well as by data from individual epidemics of infectious diseases, where patients (including the elderly) sought help in hospital at a very late stage of the disease, which in most cases resulted in a fatal outcome of the disease (cf. Bratož, Urška: Epidemija in ostareli: kolera in domet oskrbe v Avstrijskem Primorju. In: *Epidemije in zdravstvo: zgodovinski pogled* (Keber, Katarina, ed.). Ljubljana: Založba ZRC, 2024, 219–232).

78 Usually women without a profession, who lived off their own resources or property, often widows.

79 Costantini, Achille: *Rapporto sanitario per il triennio 1888–90*. Trieste: Municipio, 1895, 86.

80 See De Giaxa, Vincenzo, Lustig, Alessandro: *Relazione sul colera nell'anno 1886*. Trieste: Municipio, 1887, 65–66 and Bratož, Epidemija in ostareli.

for this often lay in the shortage of physicians, especially in rural areas,⁸¹ the remoteness of trained medical personnel, and the limited financial access to formal healthcare. Equally important was the widespread distrust of conventional medicine,⁸² the cultural and linguistic distance between physicians (who were often outsiders in rural communities) and local populations, and the distinct cultural frameworks that shaped local understandings of disease.⁸³

In the 19th century, in both rural and urban settings, medical treatment (especially of the poor) was still mostly carried out in the home. In times of epidemics (in 19th century mainly cholera), temporary hospitals for infectious diseases were set up (often, for this purpose suitable spacious buildings in convenient locations⁸⁴ were used), where infected people were isolated, but only those who could not be treated at home were hospitalised, most often because they were living in inadequate conditions or did not have the necessary care or accommodation in the city.⁸⁵

81 This was certainly true for Istria, at least to a certain extent. In 1873, for example, there were 40 physicians in the province, but they were located only in the larger municipalities (*Atti della dieta provinciale* 1873, 118). As Carlo Apollonio, an Istrian physician and hygienist, reported just before the end of the 19th century, in 1895 there was supposed to be one physician for every 5,293 inhabitants in Istria, but many places (e.g., Dekani, Pomjan, Dolina, Boljun, Kanfanar, Plomin, Oprtalj, Croatian Tinjan, Savičenta, Bale, Vepriac, etc.) – according to author's calculations, with a total population of 60,073 people – were without a permanent physician, as the whole province (Istria) only had 60 of them altogether (Apollonio, Carlo: *La riorganizzazione del servizio sanitario nell'Istria*. Pula: La Camera medica istriana, 1896).

82 Cfr. Makarovič, Gorazd: "Prehrana v 19. stoletju na Slovenskem". *Slovenski etnograf*, 33/34, 1988/1990, 127-205; Židov, Nena: "Jurij Humar in njegovo zdravljenje ljudi z magnetizmom". *Etnolog*, 15=66/1, 2005, 323-343; Kovačič, Kristina: "Porodna babica šantla Ana iz okolice Trsta in njena zapuščina". *Etnolog: glasnik Slovenskega etnografskega muzeja*, 7=58, 1997, 71-85; Bratož, Urška: "Zdravnik med idealom in resničnostjo: zdravniško delo in ljudski odnos do zdravja in medicine v 19. stoletju". *Acta medico-historica Adriatica*, 8, 2010, 2, 295-328 etc. On the late calling of a physician (due to distance, high price, mistrust, etc.); see f.e. Makarovič, "Zdravstvena kultura", 484-485, as well as Bratož, "Zdravnik med idealom".

83 For the case of Istria see in particular Lipovec Čebren, Uršula: *Krožere zdravja in bolezni: tradicionalna in komplementarne medicine v Istri*. Ljubljana: Filozofska fakulteta, Oddelek za etnologijo in kulturno antropologijo, 2008, 120.

84 In Trieste, they were usually close to the poorer areas of the city and in locations where they could be accessible to the inhabitants of the wider urban territory (Bratož, Urška: *Bledolična vsiljivka z Vzhoda: kolera v severozahodni Istri (1830-1890)*. Koper: Znanstveno-raziskovalno središče, Založba Annales ZRS Koper, 2017, 172).

85 See Keber, *Čas kolere: epidemije kolere na Kranjskem v 19. stoletju*. Ljubljana: Založba ZRC – ZRC SAZU, 2007, 123; Bratož, *Bledolična vsiljivka*, 172.

Looking at the proportion of hospital admissions during one of the cholera epidemics (1886), we can see that about 36% of all cholera patients were admitted to an auxiliary cholera hospital, but the figures are more telling when divided by age: while for younger patients the proportion of admissions was less than half, for the 71–80 age group it was more than 70%.⁸⁶ A larger proportion of elderly patients were therefore treated in hospital, which may reflect their social deprivation, and also a lack of sufficient social network to provide them with adequate care and nursing.⁸⁷

Finally, age-related perceptions (expected higher mortality in old age) may have led the elderly not to seek medical help, ultimately making hospitalisation necessary because of delayed response to their health condition. The report for 1886 on the cholera auxiliary hospital in Trieste states that many patients arrived there at a very late stage of the disease and died after only a few hours. It is also worth noting that 75%⁸⁸ of all elderly patients (aged between 61 and 80) admitted to the hospital in Trieste died, and the records from the civil hospital where cholera patients were admitted in 1873 are very similar.⁸⁹ In the case of some other diseases, particularly respiratory ones, the mortality rate of the elderly was also relatively high. At the end of the 19th century, for example, data on mortality due to *pneumonitis* in Trieste show that (in addition to a high proportion of children under 5 years of age) between 23% and 29% of those who died were aged over 60.⁹⁰

On the other hand, these data may be linked to another important issue that cannot be neglected in the context of health care for the elderly: attitudes towards medicine and the refusal of medical assistance, and especially hospital treatment. In particular, bourgeois rhetoric highlights lower social status as an element that is associated with a higher degree of resignation, distrust of medicine, and recourse to “superstition” when confronted

⁸⁶ Giaxa, Lustig, *Relazione*, 63.

⁸⁷ In that year, 325 patients were treated for cholera at the St. Mary Magdalene Auxiliary Hospital; the female patients were dominated by housewives and housekeepers, with a large number of children, and the male patients included porters, as well as peasants, day-labourers, and various (petty) artisans (Gi-axa, Lustig, *Relazione*, 65). The data for the epidemic of 1873 are also comparable (Brettau-er, *Resoconto sanitario*, 61).

⁸⁸ Giaxa, Lustig, *Relazione*, 65–66.

⁸⁹ Brettau-er, *Resoconto sanitario*, 61.

⁹⁰ Costantini, *Rapporto sanitario*.

with illness. Already in the first half of the 19th century, warnings against “quackery” were sounded in the daily press.⁹¹ The supposed attitude of the lower social groups towards health or the medical profession (and also the somewhat disparaging attitude of the bourgeois towards the rural mind-set) is described in some of the treatises⁹² problematising the health and hygiene situation in the Austrian Littoral.⁹³ For example, people were said to seek spiritual rather than medical help for advice in the face of illness.⁹⁴ According to some studies,⁹⁵ the elderly were less likely to turn to conventional medicine and more likely to rely on untrained healers,⁹⁶ there was greater resignation in the event of illness, and many elderly people could not afford medical help because of their financial situation – all these factors, together with their often fragile and questionable social network, probably contributed to the overall mortality pattern among the elderly.

Conclusion

Perceptions of old age in the nineteenth century were inevitably linked to physical weakness, the decline of the immune system, and the depletion of vital force, but in many cases also to social deprivation or at least economic dependence resulting from reduced capacity—or complete inability—to

91 F.e. in Kreft, “Zakaj še ljudje v boleznih pri lažnjivih babah, in goljufnih mazačih pomoči iščejo?”. *Kmetijske in rokodelske novice*, V/39, 1847, 154.

92 But it also appears in personal accounts; for example, the Slovene writer France Bevk (1890–1970) mentions it when recalling his father’s sudden illness [translation made by the author of this paper]: “At that time there was no physician around. In our solitude, people lived and died without help, as if they did not like to interfere with God’s will.” (Bevk, France: “Začudene oči”. *Ljubljanski zvon*, 56, 1936, 1, 362).

93 F.e. Castiglioni, Arturo: *La mortalità a Trieste e le sue cause speciali. Brevi cenni statistici*. Trieste: B. Appolonio, 1877, 34.

94 Facchinetti, Antonio: “Degli Slavi Istriani”. *L’Istria*, II/25, 1847, 97; some decades later this was also mentioned by Rutar, Simon: *Samosvoje mesto Trst in mejna grofija Istra: prirodosnanski, statistični, kulturni in zgodovinski opis*. Ljubljana: Matica Slovenska, 1896, 188.

95 See f.e. Pelling, Smith, Introduction, 7.

96 It is true that this characteristic was not exclusive to the elderly, as it also appeared among various age and social groups in both rural and urban contexts. For example, the Triestine publicist Josip Godina Verdelski (1808–1884), who also lost his wife due to cholera during his stay in Koper, mentions in his autobiography that, in his forties, he resorted to the help of healers because he distrusted conventional medicine (Godina Verdelski, Josip: *Živenje Josipa Godine Vêrdélskega: opisal on sam leta 1879 s pristavkom raznih stranskih rêcij za razdélitev mej domačince po njegovi smèrti: s podobo zgoraj iménovanega*. Trieste: Centralgrafica, 1992, 119).

work. The bourgeois work ethic and prevailing attitudes toward ageing shaped contemporary views of poverty and old age, and the data that reveal ageing (and sick) bodies in all their vulnerability suggest that the image of old age characteristic of the lower social strata was likely the most common one at the time. This was not a positive image, and it differed markedly from bourgeois perceptions, which often carried more favourable connotations, as they were not associated with financial dependence in old age but rather with experience and wisdom that elicited respect. Meanwhile, the older bodies that emerge from medical statistics and parish records under the diagnosis of *marasmus senilis*—a common and expected condition in old age, and consequently a frequent cause of death—appear in great numbers. Their physical debilitation, whether biologically or socially conditioned, can be understood not only as a cause but also as a symptom of their social deprivation, since they were compelled to work for as long as they were able in order to secure their livelihood and meet societal expectations not to become a burden to their family or the state.

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