Agents of Change. The Evolution of Cause of Death Reporting in Sweden (1749–1950)

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To cite this article: Hiltunen Maltesdotter, M., & Edvinsson, S. (2025). Agents of Change. The Evolution of Cause of Death Reporting in Sweden (1749–1950). *Historical Life Course Studies, 15*, 65–74. https://doi.org/10.51964/hlcs23129

HISTORICAL LIFE COURSE STUDIES

Histories of Health

VOLUME 15, SPECIAL ISSUE 7

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HISTORICAL LIFE COURSE STUDIES
VOLUME 15 (2025), 65–74, published 29-08-2025

Agents of Change

The Evolution of Cause of Death Reporting in Sweden (1749–1950)

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ABSTRACT

Sweden has a long-standing tradition of recording causes of death, dating back to the establishment of *Tabellverket*, in 1749. At that time, parish ministers were responsible for documenting causes of death in parish registers and compiling related statistics, which were then used for national population data. This article explores the various agents involved in the development and maintenance of this reporting system. These include government officials (including medical scientists), practising physicians, clergy and the close social networks of the deceased. Each group played a vital role in shaping how causes of death were recorded and understood. The reporting system functioned as an information network, influenced by the differing levels of knowledge and perspectives on disease and mortality held by these agents. While the clergy initially occupied a central position in this system, the role of physicians — limited at first — gradually expanded as medical expertise and authority grew over time. Despite the limitations of the early reporting system, the preserved cause-of-death data offers invaluable insights into the changing landscape of public health, disease patterns and mortality in Sweden from the mid-18th to the mid-20th century.

Keywords: Public health statistics, Cause of death reporting, Death and burial registers, Sweden 1749–1950

e-ISSN: 2352-6343
DOI article: https://doi.org/10.51964/hlcs23129

1 INTRODUCTION

One of the most significant achievements in human health over the past few centuries has been the substantial increase in life expectancy, accompanied by improved control of disease. Although the broad patterns of this transformation — including the extension of lifespan and the epidemiological shift from infectious to non-communicable diseases — are well established (Omran, 1971), the specific determinants and mechanisms underlying these changes remain only partially understood. Longitudinal data on causes of death represent an essential resource for elucidating the processes that have shaped these long-term trends in mortality and morbidity. In this contribution, we explore the historical conditions and social structures that made such developments in mortality reporting possible.

This study takes Sweden (1749–1950) as a historical case through which to examine how cause of death reporting systems emerged and evolved in practice. We focus on the roles of four key groups — government officials (including medical scientists), practising physicians, clergy, and the deceased's immediate social network — in shaping these records. These actors contributed in distinct but interrelated ways to the recording and classification of causes of death. Government officials and medical scientists established the reporting framework, which physicians applied in their diagnostic work. Clergy and members of the community also played essential roles — not only by observing symptoms, interpreting them, and relaying information to the authorities, but also by fulfilling key administrative responsibilities in the registration and transmission of cause of death information. By illuminating their contributions, we show how administrative systems, medical practice, and community knowledge converged to produce the mortality data historians rely on today. Rather than tracing the broader development of medical knowledge or diagnostic theory — though these remain important contextual factors (Janssens & Devos, 2022) — this study centers on the reporting process itself and the main actors who shaped it. Our aim is not to evaluate their practices by contemporary medical standards, but to understand them within the frameworks and expectations of their time. The sections that follow assess how these roles influenced the development and functioning of the Swedish cause of death reporting system. To understand how these roles emerged and evolved, we begin by examining the historical context in which Sweden's system of cause of death reporting developed. Section 3 analyses government officials, Section 4 analyses physicians, Section 5 analyses the central administrative role of the clergy, and Section 6 analyses how the deceased's immediate social network contributed to the broader system of cause of death reporting.

1.2 SOURCES AND METHODS

As part of our methodological approach, we draw on a diverse array of sources — including official regulations[1] (state mandates), medical journals (professional reasoning), and parish registers[2] (local reporting practices) — alongside prior research. These materials allow us to triangulate and trace how each actor group influenced the development and operation of Sweden's cause of death reporting system.

The Swedish historical databases with causes of death that we have used are the Tabverk database (see Demographic Data Base, CEDAR online resource Tabverk) which contains population statistics obtained from Sweden's parishes during the period 1749 to 1859, and the databases with individual causes of death from parish records and death certificates hosted by the Swedish research infrastructure SwedPop.

2 HISTORICAL BACKGROUND

For a long time, Sweden was a predominantly rural society, with agriculture being the primary livelihood. From 1750 to 1850, approximately 90% of the population lived in the countryside. Although urbanisation began in the mid-19th century, it progressed slowly. It was not until the 20th century that urbanisation in Sweden really accelerated. As urban growth increased, the dominant role of agriculture in the economy diminished, giving way to industrial production, the service sector, and trade, which grew in importance.

1 See Swedish National Archive regarding Tabellverket (n.d.), Church Law 1686 (1885) and Svensk Författningssamling (1860, 1911)

2 Accessible through the Demographic Data Base at Umeå University and digitised archives at the Swedish National Archives.

In parallel with these social and economic changes, significant developments occurred in the area of population records. According to the Church Law of 1686, all parish ministers were required to maintain records of births (baptisms), deaths (burials), and marriages within their parishes. They were also obligated to keep registers of all residents in their parishes. Since membership in the Swedish Lutheran Church was compulsory, this effectively meant that the entire population was included in the registers. However, until the mid-18th century, detailed reporting on the causes of death was rare. A more systematic, annual reporting of causes of death began in connection with the creation of national population statistics, which started in 1749 under the name *Tabellverket* (for more on the reporting of causes of death, see Rogers 1999; Sköld 2001, 2004). In comparison to other European countries, Sweden was notably early in implementing comprehensive national statistics, encompassing both mortality rates and cause of death statistics. Distinctively, the Swedish state employed the clergy as agents in the collection of population and health data.

To facilitate these national statistics, parish ministers were tasked with submitting population data from their parishes, based on the parish registers (see Table 1). In the preprinted forms used for this purpose, reporting causes of death took up a substantial section. The parish ministers were responsible for categorising deaths according to predefined causes. However, between 1831 and 1859, the list of pre-printed causes was limited to just two options, resulting in a significant decrease in the national reporting of causes of death during this period.

Table 1 *Overview of forms and nosologies in Sweden 1749–1951, major milestones in bold*

Year	*Number of causes of death/ Cause of death groups (No.)*	*Specific characteristics & changes*
1749	**Diseases/disease groups (23)** **Violent causes of death (10)**	**Tabellverket — The Swedish National Population Statistics Agency was introduced and included all parishes in Sweden.** **Aggregated cause of death statistics reported in preprinted forms.** **Causes of death by age and sex.**
1774	Diseases/disease groups (41) Violent causes of death (16)	Aggregated cause of death statistics. Causes of death by age and sex.
1802	Diseases/disease groups (35) Violent causes of death (15)	Aggregated cause of death statistics. Causes of death by age, sex and month.
1811	Diseases/disease groups (33) Violent causes of death (15)	Aggregated cause of death statistics. Causes of death by age, sex and month.
1821	Diseases/disease groups (34) Violent causes of death (15)	Aggregated cause of death statistics. Causes of death by age, sex and month.
1831	Diseases/disease groups (2) Violent causes of death (14)	Aggregated cause of death statistics. Causes of death by age, sex and month.
1860	**Chapters (7)** **Causes of death-diseases (92)** **Violent causes of death (23)**	**Statistics Sweden — Nosology for causes of death was introduced with disease names in both Swedish and Latin.** **Instructions and regulations:** **All deaths in cities and other places with a physician must be reported with the cause of death, based on death certificates issued by physician or midwife.** **Death certificate stated primary and secondary cause of death.**
1874	Chapters (19) Causes of death-diseases (150) Violent causes of death (21)	New nosology for causes of death. Naming in Swedish and Latin. Death certificate stated primary and secondary cause of death.
1891	Chapters (19) Causes of death-diseases (105) Violent causes of death (13)	New nosology for causes of death in Swedish and Latin. Death certificate stating main cause and contributing causes of death.
1911	**Chapters (18)** **Causes of death-diseases (87)** **Violent causes of death (14)**	**Statistics Sweden — New nosology for causes of death.** **Instructions and regulations:** **All deaths in Sweden should be reported with the cause of death, based on death certificates or verified by physician.** **Death certificate stating main cause and contributing causes of death.**
1931	Chapters (18) Causes of death-diseases (170) Violent causes of death (22)	New nosology for diseases and violent causes listed in Latin.
1951	Sweden joins ICD-6	

A further shift occurred in 1860 when the collection of population data was reorganised with the establishment of Statistics Sweden (Svensk författningssamling, 1860). Instead of the locally produced statistics, excerpts from the parish registers were now sent directly to Statistics Sweden in Stockholm. At this time, a new requirement was introduced: deaths in towns and cities where a practising physician or midwife was available had to include a reported cause of death, and a signed death certificate became mandatory.

As public health awareness grew in the late 19th and early 20th centuries, the demand for reliable health statistics intensified — driven in part by the high morbidity and mortality of tuberculosis. In response, Sweden implemented mandatory reporting of causes of death in 1911 for all parts of the country. Under this system, parish registers documented the reported causes, which were then formally certified through collaboration between parish ministers and attending physicians (Svensk författningssamling, 1910, 1911).

Thus, three key milestones mark the evolution of cause of death reporting in Sweden between 1749 and 1950. The first, in 1749, introduced cause of death reporting nationwide. The second, in 1860, saw the shift to mandatory reporting in towns and cities. The final milestone, in 1911, required complete nationwide reporting. These developments reflect the growing importance of standardised health data, which would later become integral to the work of medical scientists and governmental officials.

3 OFFICIALS IN GOVERNMENTAL AGENCIES (INCLUDING MEDICAL SCIENTISTS)

The development of a systematic approach to health data in Sweden coincided with broader advancements in medical research and governance. However, the integration of cause of death reporting into public health policy was not without challenges. Despite Sweden's slower progress in formal medical education and research infrastructure compared to much of Europe, medical scientists and officials within governmental agencies played a crucial role in shaping the healthcare system.

In 1613, the establishment of a Faculty of Medicine at Uppsala University marked the beginning of medical research and education in Sweden. To enhance their expertise, Swedish medical students often studied abroad at leading European institutions such as those in Leiden and Paris. This international exposure ensured that Swedish physicians were well-versed in the latest medical knowledge, directly benefiting from the research of prominent figures like Boerhaave and Sydenham. As a result, Swedish medical professionals were early participants in a larger European research network, where new medical discoveries were shared and applied in practice (see Lindroth 1975, 1978).

In the 18th century, medical education and scientific progress took significant steps forward in Sweden, particularly at Uppsala and Lund. The era's leading scientist, Carl Linnaeus, became a professor of medicine after studying at European institutions like Leiden. Linnaeus' work in biological classification had a profound influence, and he also developed a disease classification system (Nyström, 1988; Uddenberg, 2015). His contributions extended beyond the academic realm; he was approached to help categorise causes of death for the "Tabellverket system", though he was sceptical about the competence of the clergy to accurately report causes of death. While Linnaeus did not take on this task, another prominent physician, Abraham Bäck, took on the challenge, assuming that the clergy were familiar with the diseases listed in the reports (Nyström, 1988). These early efforts led to varying lists of causes of death, used from 1749 to 1830, which ranged from 30 to 45 categories.

During the 18th century, the spread of new medical knowledge was accelerated through the publications from the Swedish Royal Academy of Science and the earliest medical journals such as *Veckoskrift för Läkaren och Naturforskaren* (Weekly magazine for doctors and natural scientists). For example, Jenner's findings on smallpox vaccination were quickly introduced to Swedish physicians within a few years of their publication (Sköld, 1996).

The establishment of governmental agencies responsible for medicine and healthcare, for example the *Collegium Medicum*, assumed a significant role in integrating medical science into public policy.

Several physicians became involved in government work, further strengthening the connection between medical science and governance.

The role of medical science in the development of cause of death reporting became increasingly important. In the early stages, there were debates about whether the clergy, tasked with reporting causes of death, had the necessary expertise. Some suggested that a more general, popularly understood terminology might suffice. In an effort to address this, the government published books to improve the medical knowledge of clergy (Brändström, 1984; Hjelt, 1892). For instance, Hedin's (1796) publication aimed to enhance the therapeutic and diagnostic abilities of the clergy. Similarly, Nils Rosén von Rosenstein's (1764) work on childcare, a pioneering text in paediatrics, was first published as chapters in the widely distributed annual almanacs of the Academy of Sciences.

By the 19th century, Swedish medical education had become more established, with most physicians receiving their training in Sweden. Despite this, many physicians continued to travel to prominent European medical faculties to stay abreast of new developments. These insights were subsequently disseminated in prominent Swedish medical journals, such as *Hygiea* and *Svenska Läkare-Sällskapets Handlingar* (Acts from the Swedish Medical Society). Particular attention was paid to emerging threats, notably the cholera epidemics, which prompted extensive debate over competing medical theories, including miasmatic versus contagious origins. As the century progressed, significant breakthroughs — most notably in bacteriology through the pioneering work of Pasteur and Koch — were rapidly communicated within the Swedish medical community. This ongoing exchange of knowledge illustrates the continued integration of Swedish medical practice into the broader European medical community.

A major shift occurred in 1860, when a standardised nosology (disease classification) was introduced in Sweden following discussions within medical societies. This new system was more structured than the previous lists used in the *Tabellverket* forms and was influenced by international developments, particularly the work of William Farr in England (Janssens & Devos, 2022). The aim of this new nosology was to bring uniformity to cause of death reporting, ensuring consistency in terminology. Despite having aligned itself with international nosological developments — introducing new classification systems in 1874, 1891, 1911, and 1931 — Sweden refrained from adopting the International Classification of Diseases (ICD) upon its initial publication in 1893 and did not formally accede to the ICD until 1951.

As Sweden's medical sciences matured under governmental and academic guidance, the role of physicians in public health initiatives and cause of death reporting steadily gained prominence. In the following section, we examine how physicians in both urban centres and outlying districts shaped the evolution and maturation of Sweden's death reporting system between 1749 and 1950.

4 PHYSICIANS

Physicians played a crucial role in advancing healthcare accessibility and medical practice throughout Sweden, particularly as the country transitioned from limited medical access in the 18th century to a more robust healthcare system in the 20th century. Their education, professional expertise, and their growing involvement in governmental duties significantly contributed to the evolution of cause of death reporting. This section explores how physicians were integral in the development of medical records and death certificates, while also examining the challenges posed by their limited presence, especially in rural areas.

Throughout the 18th century, and to a significant extent well into the 19th century, physicians remained scarce in Sweden. In 1805, the country had fewer than 300 practising physicians, although this number had risen to over 1,300 by 1900 (Edvinsson, 1992). Accessibility to medical care in Sweden was largely confined to urban centres, with most physicians residing in towns and cities, while the majority of the population lived in rural areas. As a result, many people had limited contact with doctors for health issues.

To address the gap in healthcare provision, the government established the position of *provinsialläkare* i.e. district medical officers, in 1773 (Hjelt, 1892). These officers combined governmental duties with private practice, aiming to make medical services more accessible across Sweden.

Due to the scarcity of physicians, they were seldom involved in diagnosing causes of death, particularly in rural areas. However, with the reorganization of Swedish population statistics in 1860, it became mandatory for every death in towns and cities to be accompanied by a death certificate, which was sent to the parish minister for recording in the Death and Burial book. This practice was largely adhered to in urban areas, such as Sundsvall and Linköping. In contrast, rural parishes saw only a small proportion of deaths diagnosed by physicians. In three rural parishes outside Sundsvall, for instance, only 0.8% of the deaths were officially recorded by a physician between 1860 and 1894 (Demographic Data Base, 2025).

By 1911, Sweden had implemented nationwide reporting of causes of death (Svensk författningssamling, 1910), though this did not necessarily mean physicians were physically present at every death. In rural areas, district medical officers were tasked with reviewing the death records in the Death and Burial books monthly and requesting clarifications when needed. However, the proportion of deaths certified directly by physicians remained low. For example, in four rural parishes outside Skellefteå, only 7% of deaths between 1911 and 1950 were certified by a physician (Demographic Data Base, 2025).

Despite this, physicians were still indirectly involved in many cases. If a person had been under a physician's care in the year leading up to their death, the parish minister would often consult the physician for an assessment of the cause of death. This was not always recorded, but in some parishes these physician consultations were noted in the death records, indicating that physicians were, in many instances, consulted posthumously.

In Sweden, licensed midwives, who were more numerous than physicians, played a significant role in diagnosing perinatal and neonatal deaths. They had the closest contact with local populations, particularly in rural areas. While their role in other health matters is harder to quantify, midwives' medical expertise contributed significantly to the local medical knowledge within their communities.

To summarise, while physicians were rarely involved in cause of death reporting during the 18th century, their role in this area grew substantially in the 19th and 20th centuries, as their numbers and responsibilities expanded, particularly in urban and later rural settings.

5 THE CLERGY

The clergy in Sweden played an integral role in the administration and operation of the cause of death reporting system, making them one of the most significant agents in ensuring the machinery of death reporting functioned effectively. Their close relationships with parishioners and their frequent interactions in religious and administrative capacities positioned them as the key individuals responsible for recording and reporting causes of death throughout the studied period.

Throughout the entire period from 1749 to 1950, the clergy maintained a central role in documenting and reporting causes of death. As the primary point of contact for parishioners, ministers were involved in many aspects of their lives — meeting them during sermons, catechetical examinations, and other church-related activities. Through these interactions, ministers kept track of the population in each household, making them uniquely positioned to carry out government tasks, such as contributing to national statistics beginning in 1749. One of their primary responsibilities in this context was to record causes of death in the Death and Burial book, a task that was essential for compiling vital statistics on mortality.

However, the task of compiling cause of death statistics was not without its challenges. Rogers (1999) compared cause of death entries in the Death and Burial Books with the figures reported to *Tabellverket*. Although the discrepancies were generally small, the comparison reveals that parish ministers at times struggled to align locally reported causes of death with the standardised categories prescribed in the official statistical forms (see also Hedenborg, 2004).

These classification challenges were not the only source of difficulty for the clergy. Many ministers complained about the burden of this duty, and in 1831, they were no longer required to report the cause of death for every individual. Despite this change, some ministers continued the practice, though coverage significantly declined. With the introduction of new regulations in 1911, the requirement for complete nationwide cause of death reporting was reinstated. At this point, clergy once again had the responsibility to document the cause of death, though this information was often reviewed by district

medical officers. In cases where no death certificate was presented, causes were either determined through consultation with a physician or based on information from relatives.

The clergy's influence on cause of death reporting remained strong for a significant portion of this period, but the quality and accuracy of their reports were often a point of contention. In the beginning of *Tabellverket*, they even lacked instructions on how to fill in the forms (Rogers, 1999). While some physicians doubted the clergy's ability to provide accurate diagnoses, others recognised the valuable contributions the clergy made to local health knowledge, particularly in rural areas where medical professionals were scarce.

Although parish ministers lacked formal medical training, their knowledge was not without merit. Many 18th-century theological students were deeply interested in science, and medical literature on health and diseases was distributed to all parishes to support the clergy in their reporting duties (Hjelt, 1892). This resource aimed to enhance their ability to accurately record causes of death, even though it did not equip them with the depth of medical expertise. Additionally, due to the shortage of physicians across large parts of Sweden, prominent figures in the medical field, such as Carl Trafvenfelt, advocated for a greater role for the clergy in disseminating medical knowledge (Hjelt, 1892).

From 1811 onward, grants were offered to theological students who wished to take medical courses, a program known as "prästmedicin" (clerical medicine), though interest among students was low. Nevertheless, the clergy's involvement in health-related matters extended beyond death reporting. Ministers were responsible for the "sockenapotek" (parish pharmacy), which provided basic medicines to parishioners in need, further embedding medical knowledge into their duties (Darelius, 1760).

Some parish ministers, such as Gustaf Hjortberg (1724–1776), were particularly passionate about health and medicine. Hjortberg, influenced by Carl Linnaeus, collected natural history specimens during his voyages with the Swedish East India Company and actively promoted medical knowledge in his parish. His contributions to the spread of health information demonstrate how some clergy members went beyond the basic requirements of their roles to engage with contemporary medical practices (Lindroth, 1975). Despite his expertise, however, even Hjortberg's family was not immune to the health challenges of the time, as evidenced by the early deaths of many of his children.

In summary, the clergy played a crucial role in the reporting of causes of death throughout the entire study period. Their involvement in identifying causes of death was most prominent in the 18th and early 19th centuries, but even as their direct role in cause identification diminished, they remained central to the reporting system well into the 20th century.

While the clergy's role in the reporting system was indispensable, their work often relied on the information provided by those closest to the deceased. In many instances, the immediate family or local community members were the first to identify the cause of death, especially in situations where physicians or clergy were unavailable. Their observations and knowledge were instrumental in forming the basis of the death records. The following section will explore the role of this “closest network” in the reporting and identification of causes of death, illustrating how their input contributed to the broader system of cause of death reporting.

6 THE CLOSEST NETWORK OF THE DECEASED

The immediate family and close community members of the deceased played a significant role in identifying and reporting the cause of death. Before the rise of institutionalised healthcare, deaths typically occurred at home, where the family became the initial source of information on the circumstances leading to the death. This information was then reported to the local parish minister, who would record it in the Death and Burial book.

While most individuals had limited medical knowledge, it is important to note that by the 18th century, many Swedes were literate. However, medical literature was rarely found in private homes as presented in estate inventories (Carlsson, 1972), which suggests that the family's understanding of

medical conditions was rudimentary. That said, information about health and diseases was occasionally distributed through literature sent to parishes.

Many families held traditional beliefs about diseases and their causes, often using local or colloquial terms to describe conditions. In the absence of physicians, alternative medicine was frequently sought, with people relying on home remedies and local healers (Tillhagen, 1958). When reporting a death to the parish minister, families could only describe the symptoms leading up to the death as they understood them, and the final cause.

By the late 19th and early 20th centuries, however, the increasing publication of books on popular medicine (a preliminary categorisation from book titles in Swedish Book catalog (*Svensk Bok-katalog*) of medical literature directed to the public shows a fourfold increase 1865–1874 to 1886–1894) began to reach a wider audience, even in private homes (Kristenson, 1987). This trend helped broaden the medical knowledge of the general population, gradually diminishing the reliance on traditional and alternative methods.

The challenges of reconciling local understandings of diseases with the official medical terms used in the death reporting system can be seen in death records from two parishes in northern Sweden — Nora and Skog. In these parishes, the statistical records reveal a sharp rise in the reporting of *engelska sjukan* (rickets) in the 1820s, which coincided with a decrease in the reporting of diarrhoea cases. This shift aligned with the introduction of a new statistical form, which included some changes to the preprinted causes of death, as noted in Table 1 (see also Demographic Data Base, CEDAR, online database TABVERK). A comment from the local district medical officer suggested that what the locals referred to as *ris* (a popular term for rickets) actually encompassed a broader range of childhood ailments, including symptoms of weakness and diarrhoea (Medén, 1804). This example highlights a specific instance in which the local population's terminology diverged from official medical language, illustrating the potential for challenges in accurate reporting.

Another important aspect to consider is the lived experience of individuals in a high-mortality society. People were constantly exposed to illness, which led to a more direct, empirical knowledge of disease symptoms and progression. Epidemic diseases were frequent, and the population was often well-versed in identifying them, even if their terms differed from those used by medical professionals. As contact with professional medicine increased, however, the language of disease began to converge, reducing the discrepancies between popular and medical terminology.

The relationship between local knowledge and official medical classifications highlights the importance of understanding the broader context in which cause of death reporting evolved. As discussed, while the clergy and medical professionals played central roles, the immediate network surrounding the deceased — typically family and community members — was essential in shaping the data recorded.

The final section will discuss the implications of this relationship, focusing on how the evolving medical landscape and public health systems gradually improved the accuracy and reliability of cause of death reporting in Sweden.

7 CONCLUDING REFLECTIONS

In this final section we reflect on how local observers — family, community members, and clergy — interacted with official medical authorities to shape Sweden's cause of death records and how the subsequent developments in medical practice and public-health infrastructure progressively enhanced the precision and dependability of these statistics.

Over the course of the 18th and 19th century, institutional efforts to standardise medical terminology laid the groundwork for more uniform reporting. Central authorities promulgated officially sanctioned nosologies, which the clergy adopted through formal training and circulars. Consequently, local descriptions of disease events were increasingly "translated" into a coherent, shared lexicon — thereby reducing terminological variability across parishes.

Moreover, from 1860 in urban areas, the introduction of death certificates assigned by physicians and the structured lines of communication between physicians and parish ministers introduced a crucial layer of professional validation.

A further milestone arrived in 1911, when legislation mandated reporting of causes of death for all deaths nationwide. When a minister sought clarification, a formally trained physician could confirm — or correct — the provisional cause supplied by lay informants, thereby verifying the cause of death. This reform improved geographic coverage, representativeness and accuracy. Simultaneously, the 20th-century expansion of the physician workforce amplified this effect: as more medically qualified practitioners became available, their direct involvement in death certification grew, further reinforcing data quality.

Taken together, these iterative reforms did more than harmonise local and official medical lexicons — they established a robust methodological framework that underpins modern Swedish mortality statistics. By combining standardised nosologies, professional validation, and comprehensive coverage, the system delivered increasingly accurate and reliable data. Such high-quality cause of death statistics have been indispensable for evidence-based public-health planning — informing interventions against smallpox, tuberculosis, measles, and other historically significant diseases.

In conclusion, the ambition to establish a national cause of death reporting system in Sweden involved a range of agents, each with their own knowledge and perspectives. Understanding these roles and the context in which they operated is essential. Despite the limitations of the early reporting system, the preserved cause of death data offers invaluable insights into the profound changes in public health, disease, and mortality over the last few centuries.

Tracing the interplay between lay observers and medical authorities illuminates how Sweden's cause of death reporting evolved from a locally driven practice towards a nationally consistent, scientifically grounded enterprise. The preserved data not only chart centuries of demographic and epidemiological change but also continue to guide health decision-making, demonstrating the enduring value of meticulously collected mortality statistics.

REFERENCES

Brändström, A. (1984). *"De kärlekslösa mödrarna". Spädbarnsdödlighet i Sverige under 1800-talet med särskild hänsyn till Nedertorneå* ["The loveless mothers": Infant mortality in Sweden during the 19th century with special attention to the parish of Nedertorneå] [Doctoral dissertation, Umeå University]. Almqvist & Wiksell international.

Carlsson, A. (1972). *Böcker i Bohusländska boupptecknin*gar *1752–1808* [Books in the Bohus county's estate inventories 1752–1808] [Unpublished doctoral dissertation]. Göteborg University.

Church Law 1686. (1885). *Kyrkolagen af den 3 september 1686 med hithörande författningar* [The Church Act of 3 September 1686 with associated constitutions]. Norstedt.

Darelius, J. A. af. (1760). *Socken-apothek och några hus-curer, utgifne under kongl. collegii medici öfwerseende och besörjande* [Parish pharmacy and some home remedies, published under the supervision and care of the Royal College of Physicians]. Nyström och Stolpe.

Demographic Data Base, CEDAR, Umeå University. (2025). *U25006* [Dataset]. https://doi.org/10.17197/U25006

Edvinsson, S. (1992). *Den osunda staden: Sociala skillnader i dödlighet in 1800-talets Sundsvall* [The unhealthy town: Social inequality regarding mortality in 19th century Sundsvall] [Doctoral dissertation, Umeå University]. http://urn.kb.se/resolve?urn=urn:nbn:se:umu:diva-45897

Hedenborg, S. (2004). *Reproduktionens resurser. Spädbarnsvård i Stockholm 1750–1850* [Resources of reproduction. Infant care in Stockholm 1750–1850]. Studentlitteratur.

Hedin, S. A. (1796). *Handbok för practiska läkare-vetenskapen, utgifven af Sven A. Hedin* [Handbook for practical medical science, published by Sven A. Hedin]. J. A. Carlbohm.

Hjelt, O. E. A. (1892). *Svenska och finska medicinalverkets historia, 1663–1812* [The history of the Swedish and Finnish Medicines Agency, 1663–1812] (Vol. 2). Central-tryckeri.

Janssens, A., & Devos, I. (2022). The limits and possibilities of cause of death categorisation for understanding late nineteenth century mortality. *Social History of Medicine, 35*(4), 1053–1063. https://doi.org/10.1093/shm/hkac040

Kristenson, M. (1987). *Böcker i svenska hem. Carl Cederblads litteratursociologiska undersökning 1928–1931* [Books in Swedish homes. Carl Cederblad's literary sociological study 1928–1931]. Litteratur och samhälle.

Lindroth, S. (1975). *Svensk lärdomshistoria: Del 2, Stormaktstiden* [Swedish scholarly history: Part 2, The Great Power Era]. Norstedt.

Lindroth, S. (1978). *Svensk lärdomshistoria: Del 3, Frihetstiden* [Swedish scholarly history: Part 3, The Age of Freedom]. Norstedt.

Medén (1804). *Veckoskrift för läkare och naturforskare* [Weekly magazine for doctors and natural scientists], *13*, 118–119. http://urn.kb.se/resolve?urn=urn:nbn:se:alvin:portal:record-511193

Nyström, E. (1988). The development of cause-of-death classification in eighteenth century Sweden: A survey of problems, sources, and possibilities. In A. Brändström & L.-G. Tedebrand (Eds.), *Society, health, and population during the demographic transition* (pp. 109–129). Almqvist & Wiksell International.

Omran, A. R. (1971). The epidemiologic transition: A theory of the epidemiology of population change. *Millbank Memorial Quarterly, 49*(4), 509–538. https://doi.org/10.2307/3349375

Rogers, J. (1999). Reporting causes of death in Sweden, 1750–1950. *Journal of the history of medicine and allied sciences, 54*(2), 190–209. https://doi.org/10.1093/jhmas/54.2.190

Rosén von Rosenstein, N. (1764). *Underrättelser om Barn-Sjukdomar och deras Bote-Medel: tillförene styckewis utgifne uti de små Almanachorna, nu samlade, tilökte och förbättrade* [Information on children's diseases and their remedies: Previously published piecemeal in the small almanacs, now collected, supplemented and improved]. På Kongl. Wet. Acad. kostnad, tryckt hos Lars Salvius.

Sköld, P. (1996). *The two faces of smallpox: A disease and its prevention in eighteenth- and nineteenth-century Sweden* [Unpublished doctoral dissertation]. Umeå University.

Sköld, P. (2001). *Kunskap och kontroll: Den svenska befolkningsstatistikens historia* [Knowledge and control: The history of Swedish population statistics]. Umeå University.

Sköld, P. (2004). The birth of population statistics in Sweden. *The History of the Family*, *9*(1), 5–21. https://doi.org/10.1016/j.hisfam.2001.10.001

Svensk bok-katalog. (1866–1875, 1886–1895). *Svensk bok-katalog 1866–1875, 1886–1895* [Swedish book catalogue 1866–1875, 1886–1895]. Stockholm.

Svensk Författningssamling. (1860). Kungliga Sundhets-Collegii cirkulär till samtlige läkare i Riket, angående vissa formulärs begagnande vid anbefallna uppgifter rörande dödsorsaker. Bilaga 2. Nomenklatur till ledning vid dödsattesters afgifvande [Circular from the Royal Swedish Academy of Health to all doctors in the Kingdom, regarding the use of certain forms in the prescribed information concerning causes of death. Appendix 2. Nosology for guidance in issuing death certificates]. *Svensk författningssamling,13*, 1–8. P. A. Norstedt & söner.

Svensk författningssamling. (1910). Om ändring af de i kungörelsen den 4 november 1859 angående meddelande af uppgifter till rikets officiella statistik gifna föreskrifter rörande statistik öfver dödsorsakerna [On amendment of the regulations given in the proclamation of November 4, 1859 concerning the submission of data to the official statistics of the kingdom concerning statistics on the causes of death]. *Svensk författningssamling, 139*, 1–2. P. A. Norstedt & söner.

Svensk författningssamling. (1911). Kungliga Medicinalstyrelsens cirkulär till samtliga läkare i Riket angående uppgifter om dödsorsaker, Bilaga 1. Dödsorsaksnomenklatur för ordnande och statistisk bearbetning av dödsbevisen [Circular from the Royal Swedish Medical Board to all physicians in the Kingdom regarding information on causes of death. Appendix 1. Cause of death nomenclature for the organization and statistical processing of death certificates]. Stockholm. *Svensk författningssamling, 58*,1–14. P. A. Norstedt & söner.

Swedish National Archives. (n.d.). *Search archives over Tabellverket (f.d. Tabellkommissionen 1749–1859)*. https://sok.riksarkivet.se/nad/ and original sources of Tabellverket stored at Swedish National Archives in Härnösand.

SwedPop. (n.d.). A Swedish national research infrastructure with historical population databases. https://swedpop.se/databases/

Tillhagen, C. H. (1958). *Folklig läkekonst* [Folk medicine]. Nordiska museet.

Uddenberg, N. (2015). *Lidande och läkedom, part 1* [Suffering and healing, part 1]. (pp. 230–232). Fri Tanke förlag.