MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

21170 [redacted] 70
2

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. Bernard Skin & Cancer Hosp St. ..... Ward)

File No. .....

Registered No. 6030

2. FULL NAME Lucille Derwin

(a) Residence. No. ~~38~~ 4045 St Ferdnand St. 11 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Derwin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 19 1887

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
43	5	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

235

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER George Foster.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Catherine Ryan.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.

14. INFORMANT Mrs Margaret Derwin
(Address) 4045 St Ferdnand.

15. FILED JUN 21 1930 Saf C Hankey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 21 1930

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to June 21, 1930 that I last saw her alive on June 21, 1930 and that death occurred, on the date stated above, at 2:00 am

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Haemorrhage
Left Hemisphere

43
82A (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (SECONDARY) Carcinoma of Cervix (duration) ..... yrs. 6 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 46

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 6-2-30

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Clinical, Microscopically, Operative, Post Mortem

(Signed) Guy N. Magness, M.D.

6/21, 1930 (Address) 3427 Washington Ave.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvery	June 23 1930
20. UNDERTAKER	ADDRESS
Mullen Und. Co	5165 Delmar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.