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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 27967

Township ..... Primary Registration District No. 1003 Registered No. 7793

City St. Louis, Mo. (No. 3173 Alfred Avenue St. ..... Ward)

2. FULL NAME John Lever

(a) Residence. No. 3173 Alfred Avenue St., 16 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)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Lever

6. DATE OF BIRTH (MONTH, DAY AND YEAR) September 15, 1864

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	65	10	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bank Messenger

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Guaranteed Service

9. BIRTHPLACE (CITY OR TOWN) Kimswick,
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Anna Lever
(Address) 3173 Alfred Avenue

15. FILED AUG -4 1930, 19 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 2nd, 1930.

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Aug 2, 1930 that I last saw him alive on Aug 2, 1930, and that death occurred, on the date stated above, at 4:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastric Carcinoma

46B (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? X Ray

(Signed) Adam E Youngman M. D.

8/4, 1930 (Address) 5439 Gravois

*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
Sunset Burial Park	Aug. 5, 1930
20. UNDERTAKER Wacker-Heldrich	ADDRESS 2331 S. Brdwy.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A [illegible]