

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

Do not use this space.

12739

1. PLACE OF DEATH

County Jackson
Township KAW
City Kansas City

Registration District No. 399

Primary Registration District No. 1002

(No. President Hotel)

File No. 1666

Registered No. 1666

St. _____ Ward _____

2. FULL NAME

James Zadeck

(a) Residence, No. Los Angeles, Calif. St. _____ 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 Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) MARRIED
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Not known**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Not known**

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
About 35			

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not Known**

10. NAME OF FATHER **Not Known**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Not Known**

12. MAIDEN NAME OF MOTHER **Not Known**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Not Known**

14. INFORMANT **Identifacation Card**
(Address) Prison

15. FILED 4/15 19 30 M. M. Corne REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Relapsing
92A 2 Heart
95B

CONTRIBUTORY (SECONDARY) Chronic Endocarditis
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Chas. E. Gough, M.D.
4/15 1930 (Address) Prison

*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 **Los Angeles, Calif.** DATE OF BURIAL. **4-15-30**

20. UNDERTAKER **J.P. Louis, Funeral Director, K?C., Mo.** ADDRESS _____

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

