

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

Do not use this space.

24086

1. PLACE OF DEATH  
 County St. Genevieve Registration District No. 783  
 Township Online Primary Registration District No. 6029  
 City (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward \_\_\_\_\_)

2. FULL NAME Sytha Ann Fezoz  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of Abode)  
 Length of residence in city or town where death occurred 7 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female  
 4. COLOR OR RACE white  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James M Fezoz  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 4 - 1850  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
79 7 26

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

9. BIRTHPLACE (CITY OR TOWN) Nashville Tenn.  
 (STATE OR COUNTRY)

PARENTS  
 10. NAME OF FATHER James C. Jones  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn.  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER Eliza Fare  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) England  
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Madam Miller  
 (Address) Farmington Mo

15. FILED 8/4 30 1930 Mrs H. M. Vaughn  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 30 1930  
 17. I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to July 30, 1930, that I last saw her alive on July 30, 1930, and that death occurred, on the date stated above, at 9-50 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
apoplexy -  
822

CONTRIBUTORY (SECONDARY) 1451  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED Home  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

(DID AN OPERATION PRECEDE DEATH?) No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
 (Signed) R. Applesby M. D.  
 (Address) Farmington Mo

\*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 LOT 101 Crematory DATE OF BURIAL July 31 1930

20. UNDERTAKER Farmington Mo  
 ADDRESS \_\_\_\_\_

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. AUG 26 1930

