

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

Do not use this space.

6242

**1. PLACE OF DEATH**

County St. Louis  
 Township Central  
 City Oreland (No. 621) Chaucer

Registration District No. 789  
 Primary Registration District No. 6033B

File No. ....  
 Registered No. 46 (Ward) .....

**2. FULL NAME**

Robert Wallace Ayres  
 (a) Residence. No. 621 Chaucer 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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sophia Shaffer Ayres

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 30 - 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
77 1 10 #

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired  
 (b) General nature of industry, business, or establishment in which employed (or employer) Florist  
 (c) Name of employer .....

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) St. Louis County

10. NAME OF FATHER William Ayres

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

12. MAIDEN NAME OF MOTHER Edna Maria Daggott

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

14. INFORMANT (Address) Mrs. Sophia Ayres 621 Chaucer

15. FILED 2/11 19 30 Orelant, Missouri Gella Bray, M.D. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 10<sup>th</sup> - 1930

17. I HEREBY CERTIFY, That I attended deceased from several years to Feb 7/30, 19... that I last saw him alive on 2/9/30, 19... and that death occurred, on the date stated above, at 2 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Parasitism of maxillary molar  
51B  
51C (duration) 2 yrs. .... mos. .... ds.

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

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPT? No

WHAT TEST CONFIRMED DIAGNOSIS .....

(Signed) Sam Bassett, M. D.

2/10, 1930 (Address) 5427 Delmar

\*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

Bellefontaine Cemetery Feb 12, 1930

20. UNDERTAKER ADDRESS

E. R. Lupton 4449  
Ohio St.

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.

MAR 28 1930

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