

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

Do not use this space.

31821

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis, Mo.** (No. **Mo. Baptist Sanitarium**) St. _____ Ward _____
 Registered No. **9179**

2. FULL NAME

Douglas K. Chamblin
 (a) Residence. No. **3619** **Cora** av. St. **6** 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 Agnes Chamblin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 25 - 1890

7. AGE
 YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
 37 | 4 | 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Detective**
 (b) General nature of industry, business, or establishment in which employed (or employer) **St. Louis Metropolitan Police Department**
 (c) Name of employer

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

10. NAME OF FATHER Leroy Chamblin

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

12. MAIDEN NAME OF MOTHER Katherine Hickey

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

14. INFORMANT Mrs. Agnes Chamblin
 (Address) 3619 Cora av.

15. DIED OCT 15 1927
 (Date) (Time) May 6 Starkoff REGISTER

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 14 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 9:05A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Staphylo - Cocci (Septicemia)
 following Shock & Injuries
 Caused by being struck with
 falling **Cyclopedic** **Storm**
CONTRIBUTORY (SECONDARY) (Specify) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED Accident
 (Specify) (Date) (Time)
NOT AT PLACE OF DEATH? _____
Did AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? P. S. Vitt
 (Signed) _____, M. D.
 10/15, 19 27 (Address) **Coroner 90.**

*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 Calvary Cemetery
DATE OF BURIAL Oct 17 1927

20. UNDERTAKER E. J. Schurz
 ADDRESS 3125 Lafayette av.

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 PERMANENT RECORD

