

S. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
2000

State File No. 30901
Registrar's No. 857

Registration District No. 12A Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hours
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Nebraska (b) County 999
(c) City or town Orleans (If outside city or town limits, write "RURAL") 25
(d) Street No. _____ (If rural, give location) 11
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country _____

3. (a) PRINT FULL NAME Virgil C. Christenson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Male 5. Color or race WHITE
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 12 1927
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 9 day 28 year 1947 hour 1:35 minute 35 P.M.
21. I hereby certify that I attended the deceased from 9-28, 1947 to 9-28, 1947
that I last saw him alive on 9-28, 1947 and that death occurred on the date and hour stated above.
Immediate cause of death Acute Pneumonia Duration 2 da

8. AGE: Years Months Days If less than one day
20 4 16 hr. min.
9. Birthplace Orleans Nebr.
(City, town, or county) (State or foreign country)
10. Usual occupation Student
11. Industry or business Central Bible Institute
12. Name Holger Christenson
13. Birthplace Denmark
(City, town, or county) (State or foreign country)
14. Maiden name Emma Noren
15. Birthplace Orleans Nebraska
(City, town, or county) (State or foreign country)
16. (a) Informant Holger Christenson
(b) Address Orleans Nebraska
17. (a) Removal (b) Date thereof 9/29/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Orleans, Nebr.
18. (a) Signature of funeral director Gorman-Scharpf Funeral
(b) Address Springfield, Missouri Home
19. (a) 9-27-47 (b) W. Z. Handley M.D.
(Date received local registrar) (Registrar's signature)

Due to Epilepsy - Grand mal
unknown 8905
Due to unknown
Other conditions Gen Convulsion
(Include pregnancy within 6 months of death) Continues for 12 hrs.
Major findings: no
Of operations no
Of autopsy no

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury OV
23. Signature W. Z. Handley (M. D. or other) no
Address Springfield Date signed 9/28/47

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

9
2
6

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Lewis G. Scharpf

Licensed Embalmer No.

3802

P. O. Address.....

Springfield, Ma.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.