

Y. S. 2 DEPARTMENT OF COMMERCE INDIANA STATE BOARD OF HEALTH
BUREAU OF THE CENSUS BUREAU OF VITAL STATISTICS
Local No. 21290
Registered No. _____

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County Delaware
City or town Muncie
(If outside city or town limits, write RURAL)
Street address, hospital, or institution 1927 East 17th Street
Stay in hospital or inst. (yrs. or mos. or days)
Stay in this community (yrs. or mos. or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Indiana County Delaware
City or town Muncie
(If outside city or town limits, write RURAL)
Street No. 1927 East 17th
(If rural give LOCATION)

3. (a) FULL NAME August Haas 3. (b) Social Security Number _____

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mabel Haas
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 29, 1894
8. AGE: Years 48 Months 10 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Defiance, Ohio
(Town, county and state)
10. Usual occupation Foreman
11. Industry or business Ball Brothers Company

12. Name Henry Haas
13. Birthplace Germany
14. Maiden name Caroline Whitestone
15. Birthplace Pennsylvania

16. Informant Mrs. Mabel Haas
Address 1927 E. 17th St., Muncie, Indiana

17. Burial Burial Date thereof July 19, 1943
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Calvin Ridge
Location Muncie, Ind.

18. Funeral director M.L. Weeks & Sons
Address Muncie, Indiana
Filed July 19, 1943 John A. Bowers, Jr. Health Officer

20. DATE OF DEATH July 17, 1943 at A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/17 1943 to 7/17 1943 and that I last saw him alive on _____ 19____
Immediate cause of death Left Bronchitis
Pneumonia
Due to Silicosis
Due to 107
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy Autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Injured at work? _____ Means of injury _____

23. SIGNATURE L.P. Mason M.D. M. D. or other _____
Address Muncie, Ind. Date signed 7/19/43

EMBALER'S NAME Clara E. Shaner
LICENSE No. 2194
FUNERAL DIRECTOR'S LICENSE No. 286

Given in every instance.