

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully completed. 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.

Has decedent ever served in military or naval service of U. S.?

V. S. No. 5
73M—10-26-17

2 871

1. PLACE OF DEATH

County Lake

Township or Road/Dist. or Inland Town or Village or City Naval Hospital
Dear Lake

Registration Dist. No. 479
Primary Dist. No. 6956

STATE OF ILLINOIS
Department of Public Health - Division of Vital Statistics

RECORD

STANDARD
CERTIFICATE OF DEATH

160

Registered No. 2-135

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St.; Ward

2. FULL NAME

Halliday, Newton Schury Seaside

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH June 18, 1896
(Month) (Day) (Year)

7. AGE 71 yrs. 9 mos. 19 da.
OR 91 yrs. 9 mos. 19 da.

8. OCCUPATION
(a) Trade, profession, or particular kind of work U.S. Army
(b) General nature of industry, business, or establishment in which employed (for employer) do

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or country) Illinois

12. MAIDEN NAME OF MOTHER Illinois

13. BIRTHPLACE OF MOTHER (State or country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Naval Hospital
(Address) Dear Lake Ill

15. Filed 4/4/18 by N. J. Seel Registrar
(Address of Registrar) Chicago Ill

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 6, 1918
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4, 1918 to April 6, 1918
that I last saw him alive on April 6, 1918
and that death occurred, on the date stated above, at 1:25 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
Acute bacilliformis

Contributory (Secondary) Renal
(Duration) yrs. mos. da.

(Signed) Joseph Zalkow M. D.

(Address) Dear Lake Ill

Date . 191. Telephone .

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. da. In the State yrs. mos. da.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Chicago Ill
20. UNDERTAKER White & Son
ADDRESS Manicor

DATE OF BURIAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLATED LAWS, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL