

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 RTI

1. PLACE OF DEATH
 County Lake
 Township or Road, District or Inland Town or Village, or City Naval Hospital
Dear Lakes
 No. 160

STATE OF ILLINOIS
 Department of Public Health - Division of Vital Statistics
STANDARD
CERTIFICATE OF DEATH

Registered No. 2-135
 St.; Ward _____

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

2. FULL NAME Halliday, Newton Schury Seaman

PERSONAL AND STATISTICAL PARTICULARS

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

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

PARENTS

10. NAME OF FATHER Unknown
 11. BIRTHPLACE OF FATHER (State or country) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (State or country) _____

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 Lakes Ill
 Date _____ 1918 Telephone _____

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

(Informant) Naval Hospital
 (Address) Dear Lakes Ill

15. Filed 4/4/18 at W. F. Hall Registrar
 (Address of Registrar) Chicago

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
 DATE OF BURIAL _____

20. UNDERTAKER White & Robin
 ADDRESS Dear Lakes Ill

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