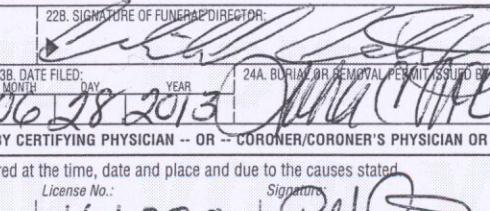
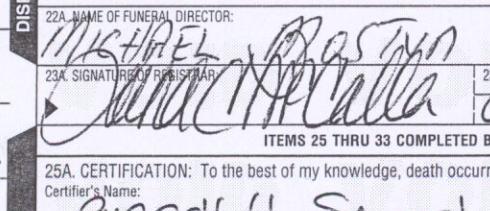
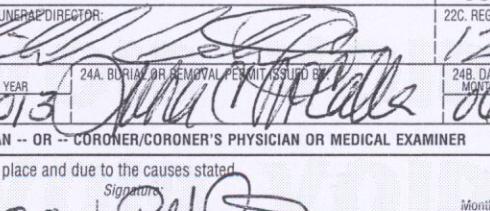
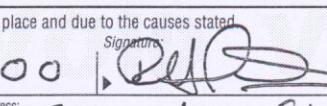
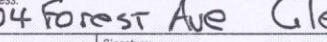


2901
229

NEW YORK STATE
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER

RESIDENCE		1. NAME: FIRST MIDDLE LAST						2. SEX: MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/> 3A. DATE OF DEATH: MONTH DAY YEAR	3B. HOUR: 6:30 AM	
NCHS		TODAY M. SIMON						6 27 2013		
4C		4A. PLACE OF DEATH: HOSPITAL DOA HOSPITAL OUTPATIENT HOSPITAL INPATIENT NURSING HOME PRIVATE RESIDENCE HOSPICE FACILITY OTHER (Specify):						4B. IF FACILITY, DATE ADMITTED: MONTH DAY YEAR		
4G		4C. NAME OF FACILITY: (If not facility, give address) 4D. LOCALITY: (Check one and specify) CITY VILLAGE TOWN						4E. COUNTY OF DEATH: Nassau		
		6 Edwards Lane Glen Cove, NY 11542 <input checked="" type="checkbox"/> <input type="checkbox"/> Glen Cove								
		4F. MEDICAL RECORD NO. 4G. WAS DECEASED TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state)								
		5. DATE OF BIRTH: 6A. AGE IN YEARS: 6B. IF UNDER 1 YEAR ENTER: months days 6C. IF UNDER 1 DAY ENTER: hours minutes 7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province)						7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:		
		04 25 1922	91 yrs.					New York, NY		
DECEDENT		8. SERVED IN U.S. ARMED FORCES? (Specify years) NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> 1942-45						9. DECEASED OF HISPANIC ORIGIN? Check the boxes that best describe whether the deceased is Spanish/Hispanic/Latino. A <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino B <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano C <input type="checkbox"/> Yes, Puerto Rican D <input type="checkbox"/> Yes, Cuban E <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino (Specify)		
								10. DECEASED'S RACE: Check one or more races to indicate what the deceased considered himself or herself to be. A <input checked="" type="checkbox"/> White/Caucasian B <input type="checkbox"/> Black or African American C <input type="checkbox"/> Asian Indian D <input type="checkbox"/> Chinese E <input type="checkbox"/> Filipino F <input type="checkbox"/> Japanese G <input type="checkbox"/> Korean H <input type="checkbox"/> Vietnamese J <input type="checkbox"/> Native Hawaiian K <input type="checkbox"/> Guamanian or Chamorro M <input type="checkbox"/> Samoan N <input type="checkbox"/> American Indian or Alaska Native (Specify) P <input type="checkbox"/> Other Asian (Specify) R <input type="checkbox"/> Other Pacific Islander (Specify) S <input type="checkbox"/> Other (Specify)		
		11. DECEASED'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death.								
		1 <input type="checkbox"/> ≤ 8th grade 2 <input type="checkbox"/> 9th-12th grade; no diploma 3 <input type="checkbox"/> High school graduate or GED 4 <input type="checkbox"/> Some college credit, but no degree 5 <input checked="" type="checkbox"/> Associate's degree 6 <input type="checkbox"/> Bachelor's degree 7 <input type="checkbox"/> Master's degree 8 <input type="checkbox"/> Doctorate/Professional degree								
		12. SOCIAL SECURITY NUMBER: 13. MARITAL STATUS: NEVER MARRIED MARRIED WIDOWED DIVORCED SEPARATED						14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated.		
		015-16-5808	<input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5					Vicki Claireaux		
		15A. USUAL OCCUPATION: (Do not enter retired)						15B. KIND OF BUSINESS OR INDUSTRY: Textiles	15C. NAME AND LOCALITY OF COMPANY OR FIRM: Veratex Inc, New York, NY	
		Chairman								
		16A. RESIDENCE: (State or Country if not USA) New York		16B. County or Region/Province if not USA: Nassau		16C. LOCALITY: (Check one and specify) CITY VILLAGE TOWN		16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> IF NO, SPECIFY TOWN: Glen Cove		
		16D. STREET AND NUMBER OF RESIDENCE: 6 Edwards Lane						16E. ZIP CODE: 11542	Glen Cove	
		17. BIRTH NAME OF FATHER / PARENT: FIRST MI LAST						18. BIRTH NAME OF MOTHER / PARENT: FIRST MI LAST		
		Samuel Simon						Lizzie Dichner (Duchman)		
		19A. NAME OF INFORMANT: Vicki Simon						19B. MAILING ADDRESS: (Include zip code) 6 Edwards Lane Glen Cove, NY 11542		
		20A. 1 <input type="checkbox"/> BURIAL 2 <input checked="" type="checkbox"/> CREMATION 3 <input type="checkbox"/> REMOVAL 4 <input type="checkbox"/> HOLD 5 <input type="checkbox"/> DONATION MONTH DAY YEAR						20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Nassau-Suffolk Crematory	20C. LOCATION: (City or town and state) Lake Ronkonkoma, NY	
		6 <input type="checkbox"/> ENTOMBMENT 06 28 2013								
DISPOSITION		21A. NAME AND ADDRESS OF FUNERAL HOME: 130 Carleton Avenue, Central Islip, NY 11722 Affordable Cremation Services of New York						21B. REGISTRATION NUMBER: 00029		
		22A. NAME OF FUNERAL DIRECTOR: MICHAEL RASTIN						22B. SIGNATURE OF FUNERAL DIRECTOR: 	22C. REGISTRATION NUMBER: 12550	
		23A. SIGNATURE OF REGISTRAR: 						23B. DATE FILED: MONTH DAY YEAR 06 28 2013	24A. BURIAL OR REMOVAL PERMIT ISSUED BY: 	24B. DATE ISSUED: MONTH DAY YEAR 06 28 2013
		ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER								
CERTIFIER		25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.								
		Certifier's Name: Russell H. Samuel						License No.: 161000	Signature: 	Month Day Year 6 27 13
		Certifier's Title: 0 <input checked="" type="checkbox"/> Attending Physician 0 <input type="checkbox"/> Physician acting on behalf of Attending Physician 1 <input type="checkbox"/> Coroner 2 <input type="checkbox"/> Medical Examiner / Deputy Medical Examiner						Address: 104 Forest Ave Glen Cove, NY 11542		
		25B. If coroner is not a physician, enter Coroner's Physician's name & title: License No.: Signature: 						Month Day Year		
		25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Address:						Month Day Year		
		26A. Attending physician attended deceased: FROM 6 1 1993 TO 6 13 2013						26B. Deceased last seen alive by attending physician: Month Day Year 06 13 2013	26C. Pronounced Dead ON 6 27 13 AT 6:30 AM	
		27. MANNER OF DEATH: NATURAL CAUSE ACCIDENT HOMICIDE SUICIDE UNDETERMINED CIRCUMSTANCES PENDING INVESTIGATION						28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 <input checked="" type="checkbox"/> NO 1 <input type="checkbox"/> YES	29A. AUTOPSY? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> REFUSED	29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES
								0 <input checked="" type="checkbox"/> NO 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> PROBABLY 3 <input type="checkbox"/> UNKNOWN		
		CONFIDENTIAL SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH CONFIDENTIAL								
		30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
		PART I. IMMEDIATE CAUSE: (A) Pancreatic Cancer						3 weeks		
		DUE TO OR AS A CONSEQUENCE OF: (B)								
		DUE TO OR AS A CONSEQUENCE OF: (C)								
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): Kidney Cancer						DID TOBACCO USE CONTRIBUTE TO DEATH? 0 <input checked="" type="checkbox"/> NO 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> PROBABLY 3 <input type="checkbox"/> UNKNOWN		
		31A. IF INJURY, DATE: MONTH DAY YEAR		HOUR: m		31B. INJURY LOCALITY: (City or town and county and state)		31C. DESCRIBE HOW INJURY OCCURRED:		31D. PLACE OF INJURY: 31E. INJURY AT WORK? NO <input type="checkbox"/> YES 0 <input type="checkbox"/> 1 <input type="checkbox"/>
		31F. IF TRANSPORTATION INJURY, SPECIFY: 1 <input type="checkbox"/> Driver/Operator 2 <input type="checkbox"/> Passenger 3 <input type="checkbox"/> Pedestrian 4 <input type="checkbox"/> OTHER (Specify)						32. WAS DECEASED HOSPITALIZED IN LAST 2 MONTHS? NO <input type="checkbox"/> YES 0 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> Not pregnant within last year 1 <input type="checkbox"/> Pregnant at time of death 2 <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death 4 <input type="checkbox"/> Unknown if pregnant within past year		33B. DATE OF DELIVERY: MONTH DAY YEAR

This is to certify this document is a true copy of a record on file in the office of the Registrar, City Hall, Glen Cove, New York. DO NOT ACCEPT a copy unless the raised seal of the City of Glen Cove is affixed.

John Simon
DATE OF DEATH: 6/30/13
TIME OF DEATH: 6:30 AM
NAME OF DECEASED: John Simon
CAUSE OF DEATH: Pancreatic Cancer

**Surrogate's Court of the State of New York
Nassau County**

File#: 2015-383818

Certificate of Appointment of Executor

IT IS HEREBY CERTIFIED that Letters for the Estate of the Decedent named below have been granted by this Court, and such Letters are unrevoked, are valid and are in full force as of this date.

Name of Decedent: **John Simon**
aka John M Simon

Date of Death: June 27, 2013

Domicile: Nassau County

Fiduciary Appointed: **Claude Simon**
71 Tonjes Road
Calicoon NY 12723

Letters Issued: LETTERS TESTAMENTARY

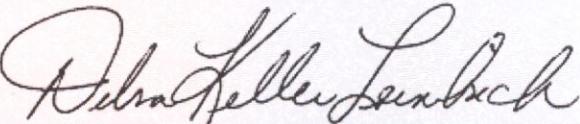
Letters Issued On: May 6, 2015

and such Letters are unrevoked and in full force as of this date.

Dated: November 12, 2019
Mineola, New York

IN TESTIMONY WHEREOF, the seal of the Nassau County Surrogate's Court has been affixed.

WITNESS, Honorable Margaret C. Reilly, Judge of the Nassau County Surrogate's Court.



Debra Keller Leimbach, Chief Clerk
Nassau County Surrogate's Court

*This Certificate is Not Valid Without the Raised Seal of the Nassau County Surrogate's Court
and expires 6 months from the issue date of this certificate, unless otherwise stated above.*