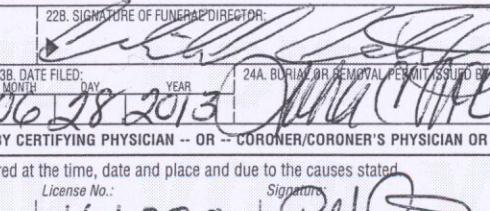
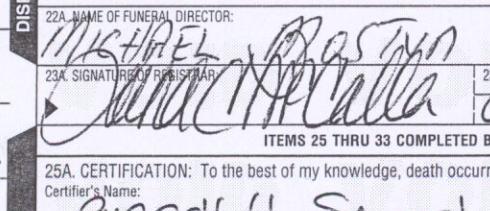
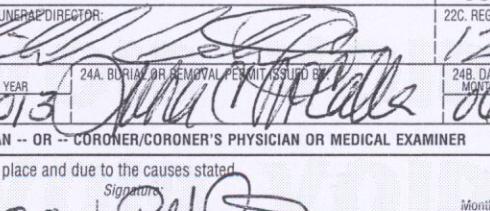
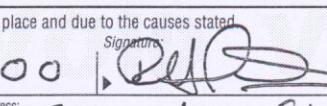
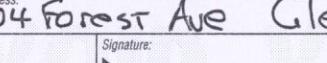


2901  
229

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 decedent 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 decedent 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"/> 1 <input type="checkbox"/> Not pregnant within last year 2 <input type="checkbox"/> Pregnant at time of death 3 <input type="checkbox"/> Not pregnant, but pregnant 42 days to 1 year before 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