CITY OF NEW YORK — DEPARTMENT OF HEALTH

AUG 16 1984

Certificate of Death

FILED

Certificate No. 15[illegible]-53-107876

1. NAME OF DECEASED (Print or Typewrite): Samuel (First Name) Simon (Middle Name) [illegible] (Last Name)

PERSONAL PARTICULARS
(To be filled in by Funeral Director)

2 USUAL RESIDENCE: (a) State New York
(b) Co. New York (c) Post Office and Zone
(d) No. 396 Grand Street Ave. St.
(If in rural area, give location)
(e) Length of residence or stay in City of New York immediately prior to death Life

3 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

4 DATE OF BIRTH OF DECEDENT (Month) (Day) (Year)

5 AGE 65 yrs. | If under 1 year: mos. days | If LESS than 1 day: hrs. or min.

6 Occupation
a. Usual Occupation (Kind of work done during most of working life, even if retired) Ret. Longshoreman
b. Kind of Business or Industry in which this work was done

7 SOCIAL SECURITY NO.

8 BIRTHPLACE (State or Foreign Country) New York

9 OF WHAT COUNTRY WAS DECEASED A CITIZEN AT TIME OF DEATH? USA

10a. WAS DECEASED EVER IN UNITED STATES ARMED FORCES? No | 10b. IF YES, Give war or dates of service

11 NAME OF FATHER OF DECEDENT Louis Simon

12 MAIDEN NAME OF MOTHER OF DECEDENT Jennie Hart

MEDICAL CERTIFICATE OF DEATH
(To be filled in by the Physician)

15 PLACE OF DEATH:
(a) NEW YORK CITY: (b) Borough Manhattan
(c) Name of Hospital or Institution Roosevelt Hospital
(If not in hospital or institution, give street and number.)
(d) If in hospital, give Ward No. 4

16 DATE AND HOUR OF DEATH: (Month) April (Day) 3 (Year) 1953 (Hour) 9:30 P.M.

17 SEX: Male | 18 COLOR OR RACE: White | 19 Approximate Age: 64

20 I HEREBY CERTIFY that (I attended the deceased)* (a staff physician of this institution attended the deceased)*
from March 5 19 53, to April 3 19 53
and last saw h. [illegible] alive at 9:30 P.M. on April 3 19 53

I further certify that death † was not caused, directly or indirectly by accident, homicide, suicide, acute or chronic poisoning, or in any suspicious or unusual manner, and that it was due to NATURAL CAUSES more fully described in the confidential medical report filed with the Department of Health.

* Cross out words that do not apply.
† See first instruction on reverse of certificate.

Witness my hand this 3 day of April 19 53

Signature [illegible] M. D.

Address Roosevelt Hospital

13 NAME OF INFORMANT	RELATIONSHIP TO DECEASED	ADDRESS
Louis Simon	Son	90 Amsterdam Ave. NYC

14a. Name of Cemetery or Crematory	14b. Location (City, Town or County and State)	14c. Date of Burial or Cremation
Beth Moses Cemetery	Farmingdale, L.I. N.Y.	April 5, 1953

21 FUNERAL DIRECTOR	ADDRESS	PERMIT NUMBER
Weinstein Memorial Chapel, Inc.	202 Broome Street	4442

BUREAU OF RECORDS AND STATISTICS — DEPARTMENT OF HEALTH — CITY OF NEW YORK

This is to certify that the foregoing is a true copy of a record in my custody.

[illegible]
CITY REGISTRAR

The Department of Health does not certify to the truth of the statements made thereon, as no inquiry to the facts has been provided by law.

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