





**CERTIFICATE OF DEATH**

156 -00- 036072

NEW YORK CITY  
DEPARTMENT OF HEALTH

Certificate No.

2000 AUG -4 A 8:58  
DATE FILED

**1. NAME OF DECEASED** KENNETH SIMON  
(Type or Print) (First Name) (Middle Name) (Last Name)

**MEDICAL CERTIFICATE OF DEATH (To be filled in by the O.C.M.E.)**

2. PLACE OF DEATH <b>NEW YORK CITY</b> 2a. BOROUGH <b>Manhattan</b>	2b. Name of hospital or other facility if not facility, street address <b>72 GOUVENEUR STREET</b>	2c. If in Hospital or Other Facility 1 <input type="checkbox"/> DOA 3 <input type="checkbox"/> Outpatient 2 <input type="checkbox"/> Emerg. 4 <input type="checkbox"/> Inpatient	2d. If inpatient, date of current admission Month Day Year
3. DATE AND HOUR OF DEATH OR FOUND DEAD <b>June 17, 2000</b>	3a. (Month) (Day) (Year)	3b. HOUR <b>02:03</b>	4. SEX <b>MALE</b>
5. APPROXIMATE AGE <b>54 YEARS</b>			INTERVAL BETWEEN ONSET AND DEATH

**6. DEATH WAS CAUSED BY:** Enter only one cause per line

a. Immediate cause **PENDING FURTHER STUDIES**

b. Due to or as a result of

c. Due to or as a result of

d. Other significant conditions contributing to death but not resulting in the underlying cause given in part 1

**7a. INJURY: DATE** (Month) (Day) (Year) : **UNKNOWN**

**7b. TIME**  AM  PM

**7c. AT WORK** 1  YES 2  NO

**7d. PLACE OF INJURY** - At home, farm, street, etc.

**7e. LOCATION**

**8. Manner of Death**

Pending Further Study  Homicide  Suicide  Undetermined

Natural  Accident

**PENDING FURTHER STUDY**

**9. Autopsy**  Yes  No Autopsy Pursuant to Law  No Autopsy

**10. On the basis of examination and/or investigation, In my opinion, death occurred due to the causes and manner as stated:**

CERTIFIER SIGNATURE: *Mon. Smiddy* M.D.

DATE: **June 18, 2000**

CERTIFIER NAME (Print): **Monica Smiddy M.D.**

**11. M.E. Case No.** **100-03350**

**12a. Date Pronounced Dead** (Month, Day, Year) (If different from 3a)

**12b. TIME**  AM  PM

**PERSONAL PARTICULARS (To be filled in by Funeral Director, or in case of City Burial, by O.C.M.E.)**

13. Usual Residence a. State <b>N.Y.</b>	13b. County <b>N.Y.</b>	13c. City, Town, or Location <b>NEW YORK</b>	13d. Street & House No. <b>72 GOUVENEUR STREET.</b>	Zip <b>10016</b>	Apt. No.	13e. Inside City Limits of 7c <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
14. Served in U.S. Armed Forces No Yes Specify years 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> From To	15. Marital Status (Check One) 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Widowed 3 <input type="checkbox"/> Married or separated 4 <input type="checkbox"/> Divorced	16. Name of Surviving Spouse (If wife, give maiden name)		19. Social Security No. <b>058-36-5277</b>		
17. Date of birth of Decedent (Month) (Day) (Year) <b>MAY 31 1946</b>	18. Age at last birthday <b>54</b>	If under 1 Year mos. days		If less than 1 Day hours mins.		20b. Kind of business or industry <b>INVESTMENT CONSULTANT</b>
20a. Usual Occupation (Kind of work done during most of working lifetime. Do not enter retired)			21. Birthplace (City & State or Foreign Country)			
22. Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		23. Other name(s) by which decedent was known				
24. NAME OF FATHER OF DECEASED <b>LOUIS SIMON</b>			25. MAIDEN NAME OF MOTHER OF DECEASED <b>CATHERINE</b>			
26a. NAME OF INFORMANT <b>John Simon</b>	26b. RELATIONSHIP TO DECEASED <b>UNCLE</b>	26c. ADDRESS (CITY) (STATE) (ZIP) <b>160 MADISON AVENUE NY. C. NY 10016</b>				
27a. NAME OF CEMETERY OR CREMATORY <b>ROSEHILL CREMATORY</b>		27b. LOCATION (City, Town, State and Country) <b>LINDEN, N.J.</b>		27c. DATE OF BURIAL OR CREMATION <b>AUGUST 4, 2000</b>		
28a. FUNERAL ESTABLISHMENT <b>Direct Cremation Company</b>			28b. ADDRESS <b>152 EAST 20TH STREET, NYC, NY 10016</b>			

VR16 (1/94) VITAL RECORDS DEPARTMENT OF HEALTH THE CITY OF NEW YORK

This is to certify, that the foregoing is a true copy of a record on file in the Department of Health. The Department of Health does not certify to the truth of the statements made thereon, as no inquiry as to the facts has been provided by law.

*Stephen P. Schwartz*  
STEPHEN P. SCHWARTZ  
CITY REGISTRAR



Do not accept this transcript unless it bears the raised seal of the Department of Health. The reproduction or alteration of this transcript is prohibited by Section 3.21 of the New York City Health Code if the purpose is the evasion or violation of any provision of the Health Code or any other law.

VITAL RECORDS DEPARTMENT OF HEALTH THE CITY OF NEW YORK

DATE ISSUED **AUG 4, 2000**

DOCUMENT NO. **D 888600**

**CERTIFICATE OF DEATH**

156-00-036072

NEW YORK CITY  
DEPARTMENT OF HEALTH

Certificate No.

2000 AUG -4 A 8:58  
DATE FILED

**1. NAME OF DECEASED** KENNETH SIMON  
(Type or Print) (First Name) (Middle Name) (Last Name)

**MEDICAL CERTIFICATE OF DEATH** (To be filled in by the O.C.M.E.)

2. PLACE OF DEATH	NEW YORK CITY	2b. Name of hospital or other facility if not facility, street address <b>72 GOUVENEUR STREET</b>	2c. If in Hospital or Other Facility		2d. If inpatient, date of current admission		
	2a. BOROUGH <b>Manhattan</b>		1 <input type="checkbox"/> DOA 3 <input type="checkbox"/> Outpatient 2 <input type="checkbox"/> Emerg. 4 <input type="checkbox"/> Inpatient	Month	Day	Year	
3. DATE AND HOUR OF DEATH OR FOUND DEAD	3a. (Month) (Day) (Year) <b>June 17, 2000</b>	3b. HOUR <b>02:03</b>	<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	4. SEX <b>MALE</b>	5. APPROXIMATE AGE <b>54 YEARS</b>		

**6. DEATH WAS CAUSED BY:** Enter only one cause per line

a. Immediate cause **PENDING FURTHER STUDIES**

b. Due to or as a consequence of

c. Due to or as a result of

d. Other significant conditions contributing to death but not resulting in the underlying cause given in part 1

**7a. INJURY: DATE** (Month) (Day) (Year) : **UNKNOWN**

**7b. TIME**  AM  PM **UNKNOWN**

**7c. AT WORK** 1  YES 2  NO **UNKNOWN**

**7d. PLACE OF INJURY - At home, farm, street, etc.**

**7e. LOCATION**

**8. Manner of Death**

Pending Further Study  Homicide  Natural  Suicide  Accident  Undetermined

**PENDING FURTHER STUDY**

**9. Autopsy**

Yes  No Autopsy Pursuant to Law  No Autopsy

**10. On the basis of examination and/or investigation, In my opinion, death occurred due to the causes and manner as stated:**

CERTIFIER SIGNATURE: *Mon. Smiddy* M.D.  
DATE: **June 18, 2000**

CERTIFIER NAME (Print) **Monica Smiddy M.D.**  
~~XXXXXXXXXXXXXXXXXXXX~~ (Chief) (Medical Examiner)

**PERSONAL PARTICULARS** (To be filled in by Funeral Director, or in case of City Burial, by O.C.M.E.)

13. Usual Residence a. State <b>N.Y.</b>	13b. County <b>N.Y.</b>	13c. City, Town, or Location <b>NEW YORK</b>	13d. Street & House No. <b>72 GOUVENEUR STREET.</b>	Zip	Apt. No.	13e. Inside City Limits of 7c <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
14. Served in U.S. Armed Forces No Yes Specify years 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> From To	15. Marital Status (Check One) 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Widowed 3 <input type="checkbox"/> Married or separated 4 <input type="checkbox"/> Divorced	16. Name of Surviving Spouse (If wife, give maiden name)		19. Social Security No. <b>058-36-5277</b>		
17. Date of birth of Decedent (Month) (Day) (Year) <b>MAY 31 1946</b>	18. Age at last birthday <b>54</b>	If under 1 Year mos. days	If less than 1 Day hours mins.	20a. Usual Occupation (Kind of work done during most of working lifetime. Do not enter retired) <b>INVESTMENT CONSULTANT</b>		
21. Birthplace (City & State or Foreign Country)	22. Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	23. Other name(s) by which decedent was known				
24. NAME OF FATHER OF DECEDENT <b>LOUIS SIMON</b>			25. MAIDEN NAME OF MOTHER OF DECEDENT <b>CATHERINE</b>			
26a. NAME OF INFORMANT <b>John Simon</b>	26b. RELATIONSHIP TO DECEASED <b>UNKLE</b>	26c. ADDRESS (CITY) (STATE) (ZIP) <b>160 MADISON AVENUE NY, C NY 10016</b>				
27a. NAME OF CEMETERY OR CREMATORY <b>ROSEHILL CREMATORY</b>		27b. LOCATION (City, Town, State and Country) <b>LINDEN, N.J.</b>	27c. DATE OF BURIAL OR CREMATION <b>AUGUST 4, 2000</b>			
28a. FUNERAL ESTABLISHMENT <b>DIRECT CREMATION COMPANY</b>			28b. ADDRESS <b>152 EAST 20TH STREET, NY, NY 10016</b>			

VR16 (1/94) VITAL RECORDS DEPARTMENT OF HEALTH THE CITY OF NEW YORK

This is to certify, that the foregoing is a true copy of a record on file in the Department of Health. The Department of Health does not certify to the truth of the statements made thereon, as no inquiry as to the facts has been provided by law.

*Stephen P. Schwartz*  
STEPHEN P. SCHWARTZ  
CITY REGISTRAR



Do not accept this transcript unless it bears the raised seal of the Department of Health. The reproduction or alteration of this transcript is prohibited by Section 3.21 of the New York City Health Code if the purpose is the evasion or violation of any provision of the Health Code or any other law.

VITAL RECORDS DEPARTMENT OF HEALTH THE CITY OF NEW YORK

DATE ISSUED **AUG 4, 2000** DOCUMENT NO. **D 888599**

**CERTIFICATE OF DEATH**

156 -00-036072

NEW YORK CITY  
DEPARTMENT OF HEALTH

Certificate No.

2000 AUG -4 A 8:58  
DATE FILED

**1. NAME OF DECEASED** KENNETH SIMON  
(Type or Print) (First Name) (Middle Name) (Last Name)

**MEDICAL CERTIFICATE OF DEATH (To be filled in by the O.C.M.E.)**

2. PLACE OF DEATH	NEW YORK CITY	2b. Name of hospital or other facility if not facility, street address <b>72 GOUVENEUR STREET</b>	2c. If in Hospital or Other Facility		2d. If inpatient, date of current admission		
	2a. BOROUGH <b>Manhattan</b>		1 <input type="checkbox"/> DOA 3 <input type="checkbox"/> Outpatient 2 <input type="checkbox"/> Emerg. 4 <input type="checkbox"/> Inpatient	Month	Day	Year	
3. DATE AND HOUR OF DEATH OR FOUND DEAD	3a. (Month) (Day) (Year) <b>June 17, 2000</b>	3b. HOUR <b>02:03</b>	<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	4. SEX <b>MALE</b>	5. APPROXIMATE AGE <b>54 YEARS</b>		

**6. DEATH WAS CAUSED BY:** Enter only one cause per line

**PART 1**

a. Immediate cause **PENDING FURTHER STUDIES**

b. Due to or as a result of

c. Due to or as a result of

**PART 2**

d. Other significant conditions contributing to death but not resulting in the underlying cause given in part 1

7a. INJURY: DATE (Month) (Day) (Year) <b>UNKNOWN</b>	7b. TIME <input type="checkbox"/> AM <input checked="" type="checkbox"/> UNKN <input type="checkbox"/> PM	7c. AT WORK <input type="checkbox"/> YES <input checked="" type="checkbox"/> UNKN <input type="checkbox"/> NO	7d. PLACE OF INJURY - At home, farm, street, etc. 7e. LOCATION
---	---	---	---

7f. HOW INJURY OCCURRED

**8. Manner of Death**

Pending Further Study  Homicide  Natural  Suicide  Accident  Undetermined

**PENDING FURTHER STUDY**

**9. Autopsy**

Yes  No Autopsy Pursuant to Law  No Autopsy

**10. On the basis of examination and/or investigation, in my opinion, death occurred due to the causes and manner as stated:**

CERTIFIER SIGNATURE: *Mon. Smiddy* M.D.  
DATE: **June 18, 2000**

CERTIFIER NAME (Print) **Monica Smiddy M.D.**  
~~XXXXXXXXXXXXXXXXXXXX~~ (Chief) (Medical Examiner)

11. M.E. Case No. <b>100-03350</b>	12a. Date Pronounced Dead (Month, Day, Year) (If different from 3a)	12b. TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
---------------------------------------	---	---

**PERSONAL PARTICULARS (To be filled in by Funeral Director, or in case of City Burial, by O.C.M.E.)**

13. Usual Residence a. State <b>N.Y.</b>	13b. County <b>N.Y.</b>	13c. City, Town, or Location <b>NEW YORK</b>	13d. Street & House No. <b>72 GOUVENEUR STREET.</b>	Zip <b>10016</b>	Apt. No.	13e. Inside City Limits of 7c <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
14. Served in U.S. Armed Forces No Yes Specify years 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> From To	15. Marital Status (Check One) 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Widowed 3 <input type="checkbox"/> Married or separated 4 <input type="checkbox"/> Divorced	16. Name of Surviving Spouse (If wife, give maiden name)				
17. Date of birth (Month) (Day) (Year) <b>MAY 31 1946</b>	18. Age at last birthday <b>54</b>	If under 1 Year mos. days	If less than 1 Day hours mins.	19. Social Security No. <b>058-36-5277</b>		
20a. Usual Occupation (Kind of work done during most of working lifetime. Do not enter retired) <b>INVESTMENT CONSULTANT</b>			20b. Kind of business or industry			
21. Birthplace (City & State or Foreign Country)	22. Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	23. Other name(s) by which decedent was known				
24. NAME OF FATHER OF DECEASED <b>LOUIS SIMON</b>			25. MAIDEN NAME OF MOTHER OF DECEASED <b>CATHERINE</b>			
26a. NAME OF INFORMANT <b>John Simon</b>	26b. RELATIONSHIP TO DECEASED <b>UNCLE</b>	26c. ADDRESS (CITY) (STATE) (ZIP) <b>160 MADISON AVENUE NY, C. NY 10016</b>				
27a. NAME OF CEMETERY OR CREMATORY <b>Rosehill Crematory</b>		27b. LOCATION (City, Town, State and Country) <b>LINDEN, N.J.</b>	27c. DATE OF BURIAL OR CREMATION <b>AUGUST 4, 2000</b>			
28a. FUNERAL ESTABLISHMENT <b>Direct Cremation Company</b>		28b. ADDRESS <b>152 EAST 20TH STREET, NYC, NY 10016</b>				

VR16 (1/94) VITAL RECORDS DEPARTMENT OF HEALTH THE CITY OF NEW YORK

This is to certify, that the foregoing is a true copy of a record on file in the Department of Health. The Department of Health does not certify to the truth of the statements made thereon, as no inquiry as to the facts has been provided by law.

*Stephen P. Schwartz*  
STEPHEN P. SCHWARTZ  
CITY REGISTRAR



Do not accept this transcript unless it bears the raised seal of the Department of Health. The reproduction or alteration of this transcript is prohibited by Section 3.21 of the New York City Health Code if the purpose is the evasion or violation of any provision of the Health Code or any other law.

VITAL RECORDS DEPARTMENT OF HEALTH THE CITY OF NEW YORK

DATE ISSUED **AUG 4, 2000**

DOCUMENT NO. **D 888598**

**CERTIFICATE OF DEATH**

156-00-036072

Certificate No.

NEW YORK CITY  
DEPARTMENT OF HEALTH

2000 AUG -4 A 8: 58  
DATE FILED

**1. NAME OF DECEASED** KENNETH SIMON  
(Type or Print) (First Name) (Middle Name) (Last Name)

**MEDICAL CERTIFICATE OF DEATH** (To be filled in by the O.C.M.E.)

2. PLACE OF DEATH <b>NEW YORK CITY</b> 2a. BOROUGH <b>Manhattan</b>	2b. Name of hospital or other facility if not facility, street address <b>72 GOUVENEUR STREET</b>	2c. If in Hospital or Other Facility 1 <input type="checkbox"/> DOA 3 <input type="checkbox"/> Outpatient 2 <input type="checkbox"/> Emerg. 4 <input type="checkbox"/> Inpatient	2d. If inpatient, date of current admission Month Day Year
3. DATE AND HOUR OF DEATH OR FOUND DEAD <b>June 17, 2000</b>	3a. (Month) (Day) (Year)	3b. HOUR <b>02:03</b>	3c. AM <input type="checkbox"/> PM <input checked="" type="checkbox"/>
		4. SEX <b>MALE</b>	5. APPROXIMATE AGE <b>54 YEARS</b>

**6. DEATH WAS CAUSED BY:** Enter only one cause per line

a. Immediate cause **PENDING FURTHER STUDIES**

b. Due to as a consequence of

c. Due to as a consequence of

d. Other significant conditions contributing to death but not resulting in the underlying cause given in part 1

**PART 2**

7a. INJURY: DATE (Month) (Day) (Year) <b>UNKNOWN</b>	7b. TIME <input type="checkbox"/> AM <input checked="" type="checkbox"/> UNKN <input type="checkbox"/> PM	7c. AT WORK <input type="checkbox"/> YES <input checked="" type="checkbox"/> UNKN <input type="checkbox"/> NO	7d. PLACE OF INJURY - At home, farm, street, etc.
7e. LOCATION			7f. HOW INJURY OCCURRED

8. Manner of Death  
 Pending Further Study  Homicide  
 Natural  Suicide  
 Accident  Undetermined  
**PENDING FURTHER STUDY**

9. Autopsy  
 Yes  No Autopsy Pursuant to Law  No Autopsy

10. On the basis of examination and/or investigation, In my opinion, death occurred due to the causes and manner as stated:  
CERTIFIER SIGNATURE: *Mon. Smiddy M.D.*  
DATE: **June 18, 2000** M.D.  
CERTIFIER NAME (Print): **Monica Smiddy M.D.**  
Chief (Medical Examiner)

11. M.E. Case No. <b>100-03350</b>	12a. Date Pronounced Dead (Month, Day, Year) (If different from 3a)	12b. TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
---------------------------------------	---	---

**PERSONAL PARTICULARS** (To be filled in by Funeral Director, or in case of City Burial, by O.C.M.E.)

13. Usual Residence a. State <b>N.Y.</b>	13b. County <b>N.Y.</b>	13c. City, Town, or Location <b>NEW YORK</b>	13d. Street & House No. <b>72 GOUVENEUR STREET.</b>	Zip <b>10016</b>	Apt. No.	13e. Inside City Limits of 7c <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
14. Served in U.S. Armed Forces No Yes Specify years 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> From To	15. Marital Status (Check One) 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Widowed 3 <input type="checkbox"/> Married or separated 4 <input type="checkbox"/> Divorced	16. Name of Surviving Spouse (If wife, give maiden name)				
17. Date of birth of Decedent <b>MAY 31 1946</b>	18. Age at last birthday <b>54</b>	If under 1 Year mos. days	If less than 1 Day hours mins.	19. Social Security No. <b>058-36-5277</b>		
20a. Usual Occupation (Kind of work done during most of working lifetime. Do not enter retired) <b>INVESTMENT CONSULTANT</b>			20b. Kind of business or industry			
21. Birthplace (City & State or Foreign Country)	22. Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	23. Other name(s) by which decedent was known				
24. NAME OF FATHER OF DECEDENT <b>LOUIS SIMON</b>		25. MAIDEN NAME OF MOTHER OF DECEDENT <b>CATHERINE</b>				
26a. NAME OF INFORMANT <b>John Simon</b>	26b. RELATIONSHIP TO DECEASED <b>UNCLE</b>	26c. ADDRESS (CITY) (STATE) (ZIP) <b>160 MADISON AVENUE NY. C. NY 10016</b>				
27a. NAME OF CEMETERY OR CREMATORY <b>Rosehill Crematory</b>	27b. LOCATION (City, Town, State and Country) <b>LINDEN, N.J.</b>	27c. DATE OF BURIAL OR CREMATION <b>AUGUST 4, 2000</b>				
28a. FUNERAL ESTABLISHMENT <b>Direct Cremation Company</b>		28b. ADDRESS <b>152 EAST 20TH STREET, NY, NY 10016</b>				

VR16 (1/94)

VITAL RECORDS

DEPARTMENT OF HEALTH

THE CITY OF NEW YORK

This is to certify, that the foregoing is a true copy of a record on file in the Department of Health. The Department of Health does not certify to the truth of the statements made thereon, as no inquiry as to the facts has been provided by law.

*Stephen P. Schwartz*  
STEPHEN P. SCHWARTZ  
CITY REGISTRAR



Do not accept this transcript unless it bears the raised seal of the Department of Health. The reproduction or alteration of this transcript is prohibited by Section 3.21 of the New York City Health Code if the purpose is the evasion or violation of any provision of the Health Code or any other law.

VITAL RECORDS

DEPARTMENT OF HEALTH

THE CITY OF NEW YORK

DATE ISSUED

**AUG 4, 2000**

DOCUMENT NO.

**D 888597**