DOH-1961 (05/2003)

RECORDED DISTRICT

REGISTER NUMBER

RESIDENCE

NCHS

4C

4G

7A

7B

SI

25

30

31

31B

QR

QS

QCOD

CANCER

NEW YORK STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

DECEDENT

1. NAME: FIRST: JOHN | MIDDLE: MILTON | LAST: SIMON

2. SEX: MALE ☐ 1 FEMALE ☐ 2 — X

3A. DATE OF DEATH: MONTH: 06 | DAY: 27 | YEAR: 2013

3B. HOUR: m

4A. PLACE OF DEATH: (Check one) HOSPITAL DOA ☐ ER ☐ | HOSPITAL OUTPATIENT ☐ | HOSPITAL INPATIENT ☐ | NURSING HOME ☐ | PRIVATE RESIDENCE ☐ X | HOSPICE FACILITY ☐ | OTHER (Specify): ☐

4B. IF FACILITY; DATE ADMITTED: MONTH | DAY | YEAR

4C. NAME OF FACILITY: (If not facility, give address): 6 Edwards Lane Glen Cove NY 11542

4D. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☐ X Glen Cove

4E. COUNTY OF DEATH: Nassau

4F. MEDICAL RECORD NO.:

4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO ☐ YES ☐

5. DATE OF BIRTH: MONTH: 04 | DAY: 25 | YEAR: 1922

6A. AGE IN YEARS: 91 yrs.

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): New York, NY

7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO ☐ 0 YES ☐ X 1

1942-1945

9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino.
A ☐ X No, not Spanish/Hispanic/Latino B ☐ Yes, Mexican, Mexican American, Chicano
C ☐ Yes, Puerto Rican D ☐ Yes, Cuban
E ☐ Yes, Other Spanish/Hispanic/Latino (Specify)

10. DECEDENT'S RACE Check one or more races to indicate what the decedent considered himself or herself to be:
A ☐ X White/Caucasian B ☐ Black or African American C ☐ Asian Indian D ☐ Chinese
E ☐ Filipino F ☐ Japanese G ☐ Korean H ☐ Vietnamese
J ☐ Native Hawaiian K ☐ Guamanian or Chamorro M ☐ Samoan
N ☐ American Indian or Alaska Native (specify)
P ☐ Other Asian (specify) R ☐ Other Pacific Islander (specify)
S ☐ Other (specify)

11. DECEDENTS EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death
1 ☐ ≤ 8th grade 2 ☐ 9th-12th grade; no diploma 3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree 5 ☐ X Associate's degree 6 ☐ Bachelor's degree
7 ☐ Master's degree 8 ☐ Doctorate/Professional degree

12. SOCIAL SECURITY NUMBER: 015-16-5808

13. MARITAL STATUS: NEVER MARRIED ☐ 1 MARRIED ☐ X 2 WIDOWED ☐ 3 DIVORCED ☐ 4 SEPARATED ☐ 5

14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is wife, enter maiden name.: Vicki Claireaux

15A. USUAL OCCUPATION: (Do not enter retired): Chairman

15B. KIND OF BUSINESS OR INDUSTRY: Textiles

15C. NAME AND LOCALITY OF COMPANY OR FIRM: Vertex Inc, New York NY

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 ☐ X TOWN ☐ Glen Cove

16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? YES ☐ NO ☐ X IF NO SPECIFY TOWN:

16D. STREET AND NUMBER OF RESIDENCE: 6 Edwards Lane

16E. ZIP CODE: 11542

PARENTS

17. NAME OF FATHER: FIRST: Samuel | MI: | LAST: Simon

18. MAIDEN NAME OF MOTHER: FIRST: Lizzie | MI: | LAST: Dichner (Duchman)

19A. NAME OF INFORMANT: Vicki Simon

19B. MAILING ADDRESS: (include zip code): 6 Edwards Lane, Glen Cove, NY 11542

DISPOSITION

20A. 1 ☐ BURIAL 2 ☐ CREMATION X 3 ☐ REMOVAL 4 ☐ HOLD 5 ☐ DONATION 6 ☐ ENTOMBMENT
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

21A. NAME AND ADDRESS OF FUNERAL HOME: Affordable Cremation Services Of New York, 130 Carleton Avenue, Central Islip, NY 11722

21B. REGISTRATION NUMBER: 00029

22A. NAME OF FUNERAL DIRECTOR: Peter G. Moloney

22B. SIGNATURE OF FUNERAL DIRECTOR: ▶

22C. REGISTRATION NUMBER: 12504

23A. SIGNATURE OF REGISTRAR: ▶

23B. DATE FILED: MONTH | DAY | YEAR

24A. BURIAL OR REMOVAL PERMIT ISSUED BY:

24B. DATE ISSUED: MONTH | DAY | YEAR

CERTIFIER

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN – OR – CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

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: | License No.: | Signature: ▶ | Month | Day | Year

Certifier's Title: 0 ☐ Attending Physician 0 ☐ Physician acting on behalf of Attending Physician 1 ☐ Coroner 2 ☐ Medical Examiner / Deputy Medical Examiner | Address

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

26A. Attending physician attended deceased: FROM Month Day Year TO Month Day Year

26B. Deceased last seen alive by attending physician: Month Day Year

26C. Pronounced Dead by M.E. or Coroner ☐ ON Month Day Year AT Time M

27. MANNER OF DEATH: NATURAL CASE ☐ 1 | ACCIDENT ☐ 2 | HOMICIDE ☐ 3 | SUICIDE ☐ 4 | UNDETERMINED CIRCUMSTANCES ☐ 5 | PENDING INVESTIGATION ☐ 6

28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 ☐ NO 1 ☐ YES

29A. AUTOPSY? NO ☐ 0 YES ☐ 1 REFUSED ☐ 2

29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEAT? 0 ☐ NO 1 ☐ YES

CONFIDENTIAL **SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH** **CONFIDENTIAL**

CAUSE OF DEATH

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)
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):

DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☐ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ 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 ☐ 0 YES ☐ 1

31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☐ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian 4 ☐ OTHER (specify)

32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☐ 0 YES ☐ 1

33A. IF FEMALE: 0 ☐ Not pregnant within last year 1 ☐ Pregnant at time of death 2 ☐ Not pregnant, but pregnant within 42 days of death 3 ☐ Not pregnant, but pregnant 43 days to 1 year before death 4 ☐ Unknown if pregnant within past year

33B. DATE OF DELIVERY: MONTH | DAY | YEAR

For use by physician or institution:
NAME OF DECEDENT: John Milton Simon
DATE OF DEATH: 6/27/2013
TIME OF DEATH: AM/PM