

**FILE NOW: FILING FEE AFTER MAY 1 IS \$225.00**

PROFIT CORPORATION ANNUAL REPORT 1996



FLORIDA DEPARTMENT OF STATE  
Sandra B. Montiam  
Secretary of State  
DIVISION OF CORPORATIONS

DOCUMENT # **G24993** (9)

1. Corporation Name  
**YOVAL CONSTRUCTION, INC.**



Principal Place of Business Mailing Address  
**% VALENTIN SANCHEZ**  
13640 S.W. 102ND CT.  
MIAMI FL 33176

3. Date Incorporated or Qualified **02/14/1983** 3a. Date of Last Report **03/15/1995**  
4. FEI Number **59-2269915** Applied For Not Applicable  
5. Certificate of Status Desired  **\$8.75 Additional Fee Required**  
6. Election Campaign Financing Trust Fund Contribution  **\$5.00 May Be Added to Fees**  
8. This corporation has liability for intangible tax under s 199.032, Florida Statutes  Yes  No

2. Principal Place of Business 2a. Mailing Address  
21 Suite, Apt. #, etc. 26 Suite, Apt. #, etc.  
22 City & State 27 City & State  
23 Zip Country 28 Zip Country  
24 25 29 30

9. Name and Address of Current Registered Agent  
**SANCHEZ, YOLANDA**  
13840 S.W. 102 CT  
MIAMI FL 33176

10. Name and Address of New Registered Agent  
81 Name  
82 Street Address (P.O. Box Number is Not Acceptable)  
83  
84 City FL 85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE (NOTE: Registered Agent signature required when reinstating) DATE

| 12. OFFICERS AND DIRECTORS |  | 13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12 |   |
|----------------------------|--|---|---|
| TITLE                      | <b>P</b> <input type="checkbox"/> DELETE | 1.1 TITLE   | <b>P</b> <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME                       | <b>SANCHEZ, VALENTIN</b>                 | 1.2 NAME  | <b>VALENTIN SANCHEZ</b>   |
| STREET ADDRESS             | <b>13640 S.W. 102ND CT.</b>              | 1.3 STREET ADDRESS                                    | <b>DECEASED</b>   |
| CITY - ST - ZIP            | <b>MIAMI FL</b>                          | 1.4 CITY - ST - ZIP                                   |   |
| TITLE                      | <b>P</b> <input type="checkbox"/> DELETE | 2.1 TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition                     |
| NAME                       | <b>SANCHEZ, YOLANDA</b>                  | 2.2 NAME  |   |
| STREET ADDRESS             | <b>13640 S.W. 102 CURT</b>               | 2.3 STREET ADDRESS                                    |   |
| CITY - ST - ZIP            | <b>MIAMI FL</b>                          | 2.4 CITY - ST - ZIP                                   |   |
| TITLE                      | <input type="checkbox"/> DELETE          | 3.1 TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition                     |
| NAME                       |  | 3.2 NAME  |   |
| STREET ADDRESS             |  | 3.3 STREET ADDRESS                                    |   |
| CITY - ST - ZIP            |  | 3.4 CITY - ST - ZIP                                   |   |
| TITLE                      | <input type="checkbox"/> DELETE          | 4.1 TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition                     |
| NAME                       |  | 4.2 NAME  |   |
| STREET ADDRESS             |  | 4.3 STREET ADDRESS                                    |   |
| CITY - ST - ZIP            |  | 4.4 CITY - ST - ZIP                                   |   |
| TITLE                      | <input type="checkbox"/> DELETE          | 5.1 TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition                     |
| NAME                       |  | 5.2 NAME  |   |
| STREET ADDRESS             |  | 5.3 STREET ADDRESS                                    |   |
| CITY - ST - ZIP            |  | 5.4 CITY - ST - ZIP                                   |   |
| TITLE                      | <input type="checkbox"/> DELETE          | 6.1 TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition                     |
| NAME                       |  | 6.2 NAME  |   |
| STREET ADDRESS             |  | 6.3 STREET ADDRESS                                    |   |
| CITY - ST - ZIP            |  | 6.4 CITY - ST - ZIP                                   |   |

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(k), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 12 or Block 13, changed, or on an attachment with an address.

SIGNATURE: *Yolanda Sanchez* Date: **2/2/96** Daytime Phone #: **305-251-9009**

CR2E034 (12/95)

**OFFICE of VITAL STATISTICS**  
**CERTIFIED COPY**

**CERTIFICATE OF DEATH**  
**FLORIDA**

|  |   |  |  |                                      |  |  |   |  |
|--|---|--|--|--------------------------------------|--|--|---|--|
| LOCAL FILE NO.   |   | FIRST<br><b>VALENTIN</b>   |  | MIDDLE                               | LAST<br><b>SANCHEZ</b>   |  | 2 SEX<br><b>Male</b>  |  |
| DECEDENT   | 3 DATE OF DEATH (Month, Day, Year)<br><b>October 10, 1993</b>   |  | 4 SOCIAL SECURITY NUMBER<br><b>057-32-7145</b>   |                                      | 5a AGE Last Birthday (years)<br><b>63</b>  |  | 5b UNDER 1 YEAR<br>Months: Days:  |  |
|  | 6 DATE OF BIRTH (Month, Day, Year)<br><b>February 22, 1930</b>  |  | 7 BIRTHPLACE (City and State or Foreign Country)<br><b>Cuba</b>                                      |                                      | 8 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)<br><b>NO</b>   |  | 8b INSIDE CITY LIMITS? (Yes or No)<br><b>No</b>                           |  |
|  | 9a PLACE OF DEATH (Check only one - see instructions on other side)<br>HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                         |  | 9c FACILITY NAME (If not mentioned, give street and number)<br><b>Baptist Hospital Of Miami</b>      |                                      | 9d CITY, TOWN, OR LOCATION OF DEATH<br><b>Miami</b>  |  | 9e COUNTY OF DEATH<br><b>Dade</b>   |  |
| PARENTS  | 10a DECEDENT'S USUAL OCCUPATION<br><b>Owner</b>   |  | 10b KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>   |                                      | 11 MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)<br><b>Married</b>  |  | 12 SURVIVING SPOUSE (If wife, give maiden name)<br><b>Yolanda Ramirez</b> |  |
|  | 13a RESIDENCE - STATE<br><b>Florida</b>   |  | 13b COUNTY<br><b>Dade</b>  |                                      | 13c CITY, TOWN, OR LOCATION<br><b>Miami</b>  |  | 13d STREET AND NUMBER<br><b>13640 S.W. 102 Court</b>                      |  |
|  | 13e INSIDE CITY LIMITS? (Yes or No)<br><b>No</b>  |  | 13f ZIP CODE<br><b>33176</b>   |                                      | 14 WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes - If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes<br><b>Cuban</b> |  | 15 RACE - American Indian, Black, White, etc. Specify<br><b>White</b>     |  |
| DISPOSITION  | 17 FATHER'S NAME (First, Middle, Last)<br><b>Valentin Sanchez</b>   |  | 18 MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carmelina Hernandez Ayala</b>                 |                                      | 19a MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12705 S.W. 112 Court Miami FL 33176</b>   |  | 19b COUNTY OF DEATH<br><b>Dade</b>  |  |
|  | 20a MANNER OF INTERMENT<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)  |  | 20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Woodlawn Park South</b> |                                      | 20c LOCATION - City or Town, State<br><b>Miami, Florida</b>  |  | 21a LICENSING AGENCY<br><b>1047</b>                                       |  |
|  | 21a SIGNATURE OF PHYSICIAN OR PHYSICIAN ASSISTANT<br><i>Jonathan S. Roberts, MD</i>   |  | 21b LICENSE NUMBER (of Licensee)<br><b>1047</b>  |                                      | 21c NAME AND ADDRESS OF FACILITY<br><b>Caballero-Woodlawn Funeral Home<br/>11655 S.W. 117th Avenue Miami FL 33186</b>  |  | 23a HOUR OF DEATH<br><b>5:30 P.</b>                                       |  |
| CERTIFIER  | 22a DATE OF DEATH<br><b>10/10/93</b>  |  | 22b HOUR OF DEATH<br><b>5:30 P.</b>  |                                      | 22c NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)<br><b>Jonathan S. Roberts, MD</b>  |  | 23b DATE SIGNED (Mo., Day, Yr.)<br><b>OCT 25 1993</b>                     |  |
|  | 24 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print)<br><b>Jonathan Roberts M.D. 8950 North Kendall Drive #606 Miami, Florida 33176</b>   |  | 25a SIGNATURE AND DATE<br><i>Jonathan S. Roberts</i> <b>10-21-93</b>                                 |                                      | 25b LOCAL REGISTRAR - SIGNATURE<br><i>Maurice Darden</i>   |  | 25c DATE REGISTERED<br><b>OCT 25 1993</b>                                 |  |
|  | 26 PART I - List the disease, injury, or simple events that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CEREBRAL EDEMA/HERNIATION</b><br>DUE TO (OR AS A CONSEQUENCE OF)<br><b>CEREBRAL VASCULAR ACCIDENT (STROKE)</b><br>DUE TO (OR AS A CONSEQUENCE OF) |  | 27a WAS AN AUTOPSY PERFORMED? (Yes or No)<br><b>No</b>   |                                      | 27b WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? (Yes or No)<br><b>No</b>  |  | 28 CASE REPORTED TO MEDICAL EXAMINER? (Yes or No)<br><b>No</b>            |  |
| 29 IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? YES ... NO |   | 30a IF SURGERY IS MENTIONED IN PART I OR II ENTER CONDITION FOR WHICH IT WAS PERFORMED |  | 30b DATE OF SURGERY (Mo., Day, Year) |  | 31 PROBABLE MANNER OF DEATH (Specify)<br>Natural, accident, suicide, homicide, or undetermined |   |  |
| 32a DATE OF INJURY (Month, Day, Year)                                |   | 32b TIME OF INJURY<br><b>M</b>   |  | 32c INJURY AT WORK? (Yes or No)      |  | 32d DESCRIBE HOW INJURY OCCURRED   |   |  |
| 32e PLACE OF INJURY - At home, farm, street, factory, etc. (Specify) |   | 32f LOCATION (Street and Number or Rural Route Number, City or Town, State)            |  | 33                                   |  |  |   |  |

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399

GIVE KIND OF WORKING MOST DO NOT RETIRE

PARENTS

DISPOSITION

CERTIFIER

CAUSE OF DEATH BY CERTIFIER

FILE Form 512, (Previous)