## PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

## NDA DEPARTMENT OF STATE PPLICATION Jim Smith Secretary of State DIVISION OF CORPORATIONS

**DOCUMENT #** 

S86140

1. Corporation Name

THOMAS FARMS OF LACROSSE, INC.

Principal Place of Business

20915 N ST RD 121

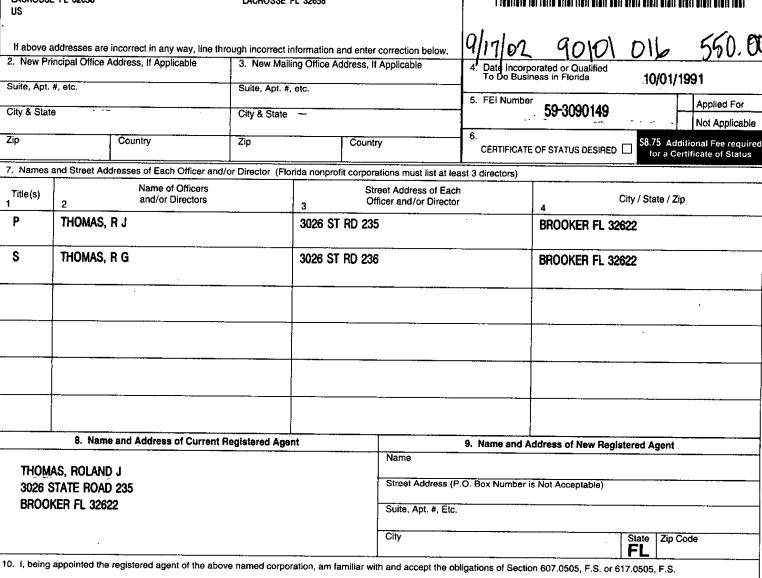
LACROSSE FL 32658

Mailing Address

PO BOX 404

LACROSSE FL 32658

FILED 02 OCT 28 AM 9: 02 GECRETARY OF STATE TALLAHASSEE, FLORIDA



11. I certify that I am an officer or director or the receiver or trustee empowered to execute this application as provided for in chapter 607 or 617, F.S. I further certify that when filling this reinstatement application, the reason for dissolution has been eliminated, the corporate name satisfies the requirements of section 607.0401 or 617.0401, F.S., that all fees owed by the corporation have been paid and the names of individuals listed on this form do not qualify for an exemption under section 119.07(3)(i), F.S. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.

Signature of Registered Agent

9/13/02 3523394768
Daytime Phone #

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