


2007 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
May 14, 2007 8:00 am
Secretary of State

05-14-2007 90095 029 ***150.00

| | | | | | |
|---|--|---|--|--|--|
| DOCUMENT # 232417 1. Entity Name SUNQUEST, INC. | | | |  | |
| Principal Place of Business 1745 SIXTH AVE. #1 VERO BEACH, FL 32960 US | | | Mailing Address P.O. BOX 1634 VERO BEACH, FL 32961-1634 US | | |
| 2. Principal Place of Business - No P.O. Box # Suite, Apt. #, etc. | | 3. Mailing Address Suite, Apt. #, etc. | | | |
| City & State Zip Country | | City & State Zip Country | | 4. FEI Number 59-6071973 | |
| 5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required | | | | Applied For <input type="checkbox"/> Not Applicable | |
| 6. Name and Address of Current Registered Agent ROSCHACH, LORI D 1745 SIXTH AVE. #1 VERO BEACH, FL 32960 | | | | 7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code | |
| 8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent. | | | | | |
| SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating) _____ DATE _____ <small>Signature, typed or printed name of registered agent and title if applicable.</small> | | | | | |
| FILE NOW!!! FEE IS \$150.00 Due by September 14, 2007 | | 9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees | | In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice. | |
| 10. OFFICERS AND DIRECTORS | | | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 | | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | PD ROSCHACH, MARY S 1786 MOORINGLINE DR. VERO BEACH, FL 32963 | <input checked="" type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | VSD ROSCHACH, LORI D 335 18TH AVENUE VERO BEACH, FL 32962 | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY-ST-ZIP | SD ROSCHACH, LORI D 335 18TH AVE VERO BEACH, FL 32962 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | VTD ROSCHACH, VERNON S 3540 57TH AVENUE VERO BEACH, FL 32966 | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY-ST-ZIP | TD ROSCHACH, VERNON S. 4865 12TH PLACE VERO BEACH, FL 32966 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | VD THORNSBURY, JO ANN 2000 SHARON STREET BOCA RATON, FL 33486 | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY-ST-ZIP | PD THORNSBURY, JO ANN R. 2000 SHARON ST. BOCA RATON, FL 33486 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| 12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, Florida Statutes. I further certify that the information indicated on this report or supplemental 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 10 or Block 11 if changed, or on an attachment with an address with all other like empowered. | | | | | |
| SIGNATURE: <i>Lori D. Roschach</i> LORI D. ROSCHACH, SD 5/14/07 772-713-9288 <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #</small> | | | | | |

40113344



05072007 Chg-P CR2E034 (12/06)

OFFICE of VITAL STATISTICS

CERTIFIED COPY

FLORIDA CERTIFICATE OF DEATH

ATTACHMENT

40113322

#232417

| | | | |
|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last, Suffix) MARY STRONG | | 2. SEX FEMALE | |
| 3. DATE OF BIRTH (Month, Day, Year) OCTOBER 10, 1924 | | 4. AGE-Last Birthday (Years) 82 | |
| 5. DATE OF DEATH (Month, Day, Year) MARCH 9, 2007 | | 6. COUNTY OF DEATH INDIAN RIVER | |
| 7. BIRTHPLACE (City and State or Foreign Country) COUNCIL, IDAHO | | 8. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival <input type="checkbox"/> Non-Hospital <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long Term Care Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify) | |
| 9. SOCIAL SECURITY NUMBER 260-30-7207 | | 10. FACILITY NAME (If not institution, give street address) 1786 MOORINGLINE DRIVE | |
| 11. CITY, TOWN, OR LOCATION OF DEATH VERO BEACH | | 12. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 13. MARITAL STATUS (Specify) <input type="checkbox"/> Married <input type="checkbox"/> Married, but Separated <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married | | 14. SURVIVING SPOUSE'S NAME (If msa, give maiden name) | |
| 15. RESIDENCE - STATE FLORIDA | | 16. COUNTY INDIAN RIVER | |
| 17. CITY, TOWN, OR LOCATION VERO BEACH | | 18. APT. NO. 132963 | |
| 19. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 20. KIND OF BUSINESS/INDUSTRY REAL ESTATE | |
| 21. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) EXECUTIVE | | 22. DECEDENT'S RACE (Specify the race/ances to indicate what decedent considered himself/herself to be. More than one race may be specified.) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native (Specify tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Is. (Specify) <input type="checkbox"/> Other (Specify) | |
| 23. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin.) <input type="checkbox"/> Yes (If Yes, specify) <input checked="" type="checkbox"/> No | | 24. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.) <input type="checkbox"/> 8th or less <input type="checkbox"/> High school but no diploma <input checked="" type="checkbox"/> High school diploma or GED <input type="checkbox"/> College but no degree <input type="checkbox"/> College degree (Specify): <input type="checkbox"/> Associate <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate | | 26. FATHER'S NAME (First, Middle, Last, Suffix) ALFRED NAPIER STRONG | |
| 27. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIE REBECCA WADSWORTH | | 28. INFORMATION NAME JOANN R. THORNSBURY | |
| 29. RELATIONSHIP TO DECEDENT DAUGHTER | | 30. INFORMATION'S MAILING - STATE FLORIDA | |
| 31. CITY OR TOWN BOCA RATON | | 32. STREET ADDRESS 2000 SHARON STREET | |
| 33. ZIP CODE 33486 | | 34. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) CRESTLAWN CEMETERY | |
| 35. LOCATION - STATE FLORIDA | | 36. LOCATION - CITY OR TOWN VERO BEACH | |
| 37. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Reapproval from State <input type="checkbox"/> Other (Specify) | | 38. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL OBTAINED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 39. LICENSE NUMBER (of Licensee) 2423 | | 40. NAME OF FUNERAL FACILITY COX-GIFFORD-SEAWINDS FUNERAL HOME & CREMATORY | |
| 41. CITY OR TOWN VERO BEACH | | 42. STREET ADDRESS 1950 20TH STREET | |
| 43. ZIP CODE 32960 | | 44. CERTIFIER (Check one) <input checked="" type="checkbox"/> Certifying Physician - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, due to the cause(s) and manner stated. | |
| 45. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | 46. DATE SIGNED (mm/dd/yyyy) 03/09/2007 | |
| 47. MEDICAL EXAMINER'S CASE NUMBER 0920 | | 48. LICENSE NUMBER (of Certifier) ME70240 | |
| 49. CERTIFIER'S NAME JOSHUA B. SHIPLEY, M.D. | | 50. NAME OF ATTENDING PHYSICIAN (If other than Certifier) | |
| 51. CERTIFIER'S STATE FLORIDA | | 52. CITY OR TOWN VERO BEACH | |
| 53. STREET ADDRESS 1265 36TH STREET | | 54. ZIP CODE 32960 | |
| 55. SUBREGISTRAR - Signature and Date [Signature] | | 56. LOCAL REGISTRAR - Signature [Signature] | |
| 57. DATE FILED BY REGISTRAR (Mo., Day, Yr.) March 15, 2007 | | 58. PROBABLE MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined | |
| 59. CAUSE OF DEATH - PART I (See Instructions on back) Enter the chain of events - diseases, injuries, or complications - that directly caused the death. Enter only one cause on a line. DO NOT enter terminal event such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. Sudden Cardiac Death | | 60. REPORTED TO MEDICAL EXAMINER DUE TO CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 61. IMMEDIATE CAUSE (Final disease or condition resulting in death) Coronary Artery Disease | | 62. UNDERLYING CAUSE (Disease or injury that initiated the events resulting in death) LAST | |
| 63. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I. | | 64. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 65. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 66. IF SURGERY MENTIONED IN PART I OR II, ENTER REASON FOR SURGERY | |
| 67. DATE OF SURGERY (Mo., Day, Yr.) | | 68. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 69. IF FEMALE, WAS SHE PREGNANT WITHIN THE PAST YEAR? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 70. If Yes, specify timeframe: <input type="checkbox"/> at time of death <input type="checkbox"/> within 1 to 42 days of death <input type="checkbox"/> within 43 days to 1 year of death | |
| 71. DATE OF INJURY (Month, Day, Year) | | 72. TIME OF INJURY (24 hr.) | |
| 73. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 74. LOCATION OF INJURY - STATE | |
| 75. CITY OR TOWN | | 76. STREET ADDRESS | |
| 77. APT. NO. | | 78. ZIP CODE | |
| 79. DESCRIBE HOW INJURY OCCURRED | | 80. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) | |
| 81. IF TRANSPORTATION INJURY, 82a. Status of Decedent <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) | | 82b. Type of Vehicle <input type="checkbox"/> Car/Minivan <input type="checkbox"/> S.U.V. <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pickup Truck/Cargo Van <input type="checkbox"/> Bus <input type="checkbox"/> Heavy Transport <input type="checkbox"/> Other (Specify) | |

WARNING:

THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH A WATERMARK OF THE GREAT SEAL OF THE STATE OF FLORIDA. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK. THE DOCUMENT FACE CONTAINS A MULTI-COLORED BACKGROUND AND GOLD EMBOSSED SEAL. THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.

DH FORM 1947 (08/04)

FLORIDA DEPARTMENT OF
HEALTH