2006 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Mar 14, 2006 8:00 am
Secretary of State
03-14-2006 90015 046 ***150.00

DOCUMENT # 532552

1. Entity Name

TOP VALUE AUTO SALES, INC.

Principal Place of Business	Mailing Address
4701 E. HILLSBOROUGH AVE. TAMPA FL 33610	4701 E. HILLSBOROUGH AVE. TAMPA FL 33610

1st MOORE CR2E034 (10/05)

2. Principal Place of Business	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. FEI Number 59-1734595 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ **$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent	7. Name and Address of New Registered Agent
ROBERT E. BARBER, SR. 6924 SPENCER CIRCLE TAMPA FL 33610	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 _____
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating) DATE

FILE NOW!!! FEE IS $150.00
After May 1, 2006 Fee Will Be $550.00
Make Check Payable to Florida Department of State

9. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	PD BARBER, ROBERT E. 6924 SPENCER CIRCLE TAMPA FL	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	Sec Treas Sandra S. Cribbs 512 East Morrell Drive PLant City FL 33563	☐ Change ☒ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D BARBER, CATHERINE S. 6924 SPENCER CIRCLE TAMPA FL	☒ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D BARBER, ROBERT E JR 3514 TACON STREET TAMPA FL 33629	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Section 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: Robert E. Barber 02-24-06 813-626-6304
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

ATTACHMENT 40030829
532552

OFFICE of VITAL STATISTICS

CERTIFIED COPY

FLORIDA CERTIFICATE OF DEATH

1. FILE NO.

2. DECEDENT'S NAME (First, Middle, Last, Suffix): Catherine S. Barber — 3. SEX: Female

4. DATE OF BIRTH (Month, Day, Year): April 29, 1924 — 4a. AGE-Last Birthday (Years): 81 — 4b. UNDER 1 YEAR: Months / Days — 4c. UNDER 1 DAY: Hours / Minutes — 5. DATE OF DEATH (Month, Day, Year): February 4, 2006

6. SOCIAL SECURITY NUMBER: 261-26-7208 — 7. BIRTHPLACE (City and State or Foreign Country): South Bend, Indiana — 8. COUNTY OF DEATH: Manatee

9. PLACE OF DEATH (Check only one) — HOSPITAL: ___ Inpatient ___ Emergency Room/Outpatient ___ Dead on Arrival — NON-HOSPITAL: ___ Hospice Facility ___ Nursing Home/Long Term Care Facility ___ Decedent's Home ✓ Other (Specify): Secondary residence

10a. FACILITY NAME (If not institution, give street address): 4521 Summer Cove Drive #515 — 10c. CITY, TOWN, OR LOCATION OF DEATH: Bradenton — 10b. INSIDE CITY LIMITS? ✓ Yes ___ No

12. MARITAL STATUS (Specify): X Married ___ Married, but Separated ___ Widowed ___ Divorced ___ Never Married — 13. SURVIVING SPOUSE'S NAME (If wife, give maiden name): Robert E. Barber

14a. RESIDENCE - STATE: Florida — 14b. COUNTY: Hillsborough — 14c. CITY, TOWN, OR LOCATION: Tampa

14d. STREET ADDRESS: 6924 Spencer Circle — 14e. APT. NO. — 14f. ZIP CODE: 33610 — 14g. INSIDE CITY LIMITS? ✓ Yes ___ No

15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) Do not use "Retired": Home Maker — 15b. KIND OF BUSINESS/INDUSTRY: Own Home

16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.)
X White ___ Black or African American ___ American Indian or Alaskan Native (Specify tribe) ___
___ Asian Indian ___ Chinese ___ Filipino ___ Japanese ___ Korean ___ Vietnamese ___ Other Asian (Specify) ___
___ Native Hawaiian ___ Guamanian or Chamorro ___ Samoan ___ Other Pacific Isl. (Specify) ___ Other (Specify) ___

17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin.) ___ Yes (If Yes, specify) X No ___ Mexican ___ Puerto Rican ___ Cuban ___ Central/South American ___ Other Hispanic (Specify) ___ Haitian

18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.)
___ 8th or less ___ High school but no diploma ___ High school diploma or GED
X College but no degree ___ College degree (Specify): ___ Associate ___ Bachelor's ___ Master's ___ Doctorate

19. WAS DECEDENT EVER IN U.S. ARMED FORCES? ___ Yes ✓ No

20. FATHER'S NAME (First, Middle, Last, Suffix): Peter Skelly — 21. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Shields

22a. INFORMANT'S NAME: Robert E. Barber — 22b. RELATIONSHIP TO DECEDENT: husband — 22c. INFORMANT'S MAILING - STATE: Florida

22b. CITY OR TOWN: Tampa — 22c. STREET ADDRESS: 6924 Spencer Circle — 22d. ZIP CODE: 33610

24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Manasota Memorial Crematory — 25a. LOCATION - STATE: Florida — 25b. LOCATION - CITY OR TOWN: Bradenton

26a. METHOD OF DISPOSITION: ___ Burial ___ Entombment X Cremation ___ Donation ___ Removal from State ___ Other (Specify)

26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? X Yes ___ No — 27a. LICENSE NUMBER (of Licensee): 2821 — 27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: [signature]

28a. NAME OF FUNERAL FACILITY: Manasota Memorial Funeral Home — 29a. FACILITY'S MAILING - STATE: Florida

29b. CITY OR TOWN: Bradenton — 29c. STREET ADDRESS: 1221 53rd Avenue East — 29d. ZIP CODE: 34203

30. CERTIFIER: X 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. ___ 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.

31a. (Signature and Title of Certifier): [signature] MD — 31b. DATE SIGNED (mm/dd/yyyy): 2/6/06 — 32. TIME OF DEATH (24 hr.): 1804 hrs — 33. MEDICAL EXAMINER'S CASE NUMBER

34a. LICENSE NUMBER (of Certifier): ME0042457 — 34b. CERTIFIER'S NAME: Dan Grice MD — 35. NAME OF ATTENDING PHYSICIAN (If other than Certifier)

36a. CERTIFIER'S - STATE: Florida — 36b. CITY OR TOWN: Bradenton — 36c. STREET ADDRESS: 2010 59th Street West — 36d. ZIP CODE: 34209

37. SUBREGISTRAR - Signature and Date — 38a. LOCAL REGISTRAR - Signature: Carolyn DeRuggiero — 38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.): Feb 9 2006

39. PROBABLE MANNER OF DEATH: ✓ Natural ___ Accident ___ Suicide ___ Homicide ___ Pending Investigation ___ Undetermined — 40. REPORTED TO MEDICAL EXAMINER (ME/CE)? ___ Yes ✓ No

41. 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cerebrovascular Accident — Due to (or as a consequence of):
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST: b. Alzheimers Dementia — Due to (or as a consequence of): c. — Due to (or as a consequence of):

Appproximate Interval: Onset to Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

42a. WAS AN AUTOPSY PERFORMED? ___ Yes ✓ No — 42b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ___ Yes ___ No

43a. IF SURGERY MENTIONED IN PART I OR II, ENTER REASON FOR SURGERY — 43b. DATE OF SURGERY (Mo., Day, Yr.) — 44. DID TOBACCO USE CONTRIBUTE TO DEATH? ___ Yes ✓ No ___ Probably ___ Unknown

45. IF FEMALE, WAS SHE PREGNANT WITHIN THE PAST YEAR: ___ Yes ✓ No ___ Unknown — If Yes, specify timeframe: ___ at time of death ___ within 1 to 42 days of death ___ within 43 days to 1 year of death

46. DATE OF INJURY (Month, Day, Year) — 47. TIME OF INJURY (24 hr.) — 48. INJURY AT WORK? ___ Yes ___ No — 49a. LOCATION OF INJURY - STATE

49b. CITY OR TOWN — 49c. STREET ADDRESS — 49d. APT. NO. — 49e. ZIP CODE

50. DESCRIBE HOW INJURY OCCURRED — 51. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)

If TRANSPORTATION INJURY, 52a. Status of Decedent: ___ Driver/Operator ___ Passenger ___ Pedestrian ___ Other (Specify)
52b. Type of Vehicle: ___ Car/Minivan ___ S.U.V. ___ Motorcycle ___ Pickup Truck/Cargo Van ___ Bus ___ Heavy Transport ___ Other (Specify)

February 9, 2006

Carolyn DeRuggiero

VOID IF ALTERED OR ERASED

I CERTIFY THAT THIS IS A TRUE AND EXACT COPY.
Sandra Mills
03:01:20

Sandra S. Cribbs
MY COMMISSION # DD247027 - EXPIRES
September 3, 2007
BONDED THRU TROY FAIN INSURANCE, INC

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

02081211

CERTIFICATION OF VITAL RECORD