

2001 UNIFORM BUSINESS REPORT (UBR)

FILED
Jul 19, 2001 8:00 am
Secretary of State

07-19-2001 90001 021 ***150.00

005473 AV

DOCUMENT # 540822

1. Entity Name
PLANT RENTALS, INC.

Principal Place of Business
3245 VILLAGE GREEN DRIVE
MIAMI FL 33175

Mailing Address
3245 VILLAGE GREEN DRIVE
MIAMI FL 33175

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 **59-1771502**

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

ROXBORGH, THOMAS C.
3245 VILLAGE GREEN DR.
MIAMI FL 33175

Deceased 5/27/01

Name **PHILIPPA J. ROXBURGH**
 Street Address (P.O. Box Number is Not Acceptable)
3245 VILLAGE GREEN DR
MIAMI FL 33175
 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.

SIGNATURE *Philippa J. Roxburgh*
 Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

DATE

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. ☐ (See criteria on back)

FILE NOW!!! FEE IS \$550.00
After September 12, 2001 Fee will be \$750.00
Make Check Payable to Department of State

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

11. OFFICERS AND DIRECTORS

TITLE **PD** ☒ Delete
 NAME **ROXBURGH, THOMAS**
 STREET ADDRESS **3245 VILLAGE GREEN DR**
 CITY-ST-ZIP **MIAMI, FL 00000** *DECEASED 5-27-01*

TITLE **ST P** ☐ Delete
 NAME **ROXBURGH, PHILIPP A**
 STREET ADDRESS **3245 VILLAGE GREEN DR**
 CITY-ST-ZIP **MIAMI, FL 00000**

TITLE ☐ Delete
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

TITLE ☐ Delete
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

TITLE ☐ Delete
 NAME
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 CITY-ST-ZIP

TITLE ☐ Delete
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE ☐ Change ☐ Addition
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

TITLE ☐ Change ☐ Addition
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

TITLE ☐ Change ☐ Addition
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TITLE ☐ Change ☐ Addition
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

13. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), 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 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: *Philippa J. Roxburgh*
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

7/13/01 *305 298 4278*
 Date Daytime Phone

CR2E034 (5/01)

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

B0060180

CERTIFIED COPY
CERTIFICATE OF DEATH
FLORIDATYPE OR
PRINT IN
PERMANENT
BLACK INK

LOCAL FILE NO.		DECEDENT'S NAME		FIRST	MIDDLE	LAST	2 SEX
		THOMAS		CHRISTOPHER	ROXBURGH		Male
3 DATE OF DEATH (Month, Day, Year)		4 SOCIAL SECURITY NUMBER		5a AGE Last Birthday (years)		5b UNDER 1 YEAR	
May 27, 2001		264-81-3432		64		15c UNDER 1 Day	
6 DATE OF BIRTH (Month, Day, Year)		7 BIRTHPLACE (City and State or Foreign Country)		8 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)		9a INSIDE CITY LIMITS? (Yes or No)	
January 1, 1937		Kingston, Jamaica		No		Yes	
9b PLACE OF DEATH (Check only one - see instructions on other side)		9c FACILITY NAME (if not institution, give street and number)		9d CITY, TOWN, OR LOCATION OF DEATH		9e COUNTY OF DEATH	
HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ERO/Outpatient <input type="checkbox"/> DCA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		Mount Sinai Medical Center		Miami Beach		Miami-Dade	
10a DECEDENT'S USUAL OCCUPATION		10b KIND OF BUSINESS/INDUSTRY		11 MARITAL STATUS (If wife, give maiden name)		12 SURVIVING SPOUSE (If wife, give maiden name)	
Business Owner		Interior Plants		Married		Philipa Janet Dougall	
13a RESIDENCE - STATE		13b COUNTY		13c CITY, TOWN, OR LOCATION		13d STREET AND NUMBER	
Florida		Miami-Dade		Miami		3245 Village Green Drive	
13e INSIDE CITY LIMITS? (Yes or No)		13f ZIP CODE		14 WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes - If yes, specify Mexican, Cuban, Mexican/Puerto Rican, etc.)		15 RACE - American Indian, Black, White, etc. (Specify)	
No		33175		Specify		White	
17 FATHER'S NAME (First, Middle, Last)		18 MOTHER'S NAME (First, Middle, Maiden Surname)		19a MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		19b DECEDENT'S EDUCATION (Specify only highest grade completed)	
Walter Roxburgh		Nell Ridley		3245 Village Green Drive, Miami, Florida 33175		Elementary/Secondary/College 1	
20a METHOD OF DISPOSITION		20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)		20c LOCATION - City or Town, State			
Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Van Orsdel Crematory		Miami, Florida			
21a SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON AUTHORIZED TO SIGN		21b LICENSE NUMBER (If Licensee)		21c NAME AND ADDRESS OF FACILITY			
<i>[Signature]</i>		3611		Van Orsdel-Salgado Bird Road Funeral Chapel 9300 S.W. 40th Street, Miami, Florida 33165			
22a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated (Signature and Title)		22b DATE SIGNED (Mo., Day, Yr.)		22c HOUR OF DEATH		23a On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) and manner as stated (Signature and Title)	
<i>[Signature]</i>		May 30, 2001		11:15 P M		<i>[Signature]</i>	
22d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		23b MEDICAL EXAMINER'S CASE #					
24 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print)		25a SUBREGISTRAR - SIGNATURE AND DATE		25b LOCAL REGISTRAR - SIGNATURE		25c DATE REGISTERED	
Frances Glicksman, M.D., 4302 Alton Road #105, Miami Beach, Florida 33140		<i>[Signature]</i>		<i>[Signature]</i>		JUN 04 2001	
26 PART I Enter the diseases, injuries, or complications 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.		27a WAS AN AUTOPSY PERFORMED? (Yes or No)		27b WERE ANY OTHER PROCEDURES USED TO COMPLETE CAUSE OF DEATH? (Yes or No)		28 CASE REPORTED TO MEDICAL EXAMINER? (Yes or No)	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		No		No		Yes	
a. <i>Card Compression</i> DUE TO (OR AS A CONSEQUENCE OF)							
b. <i>Metastatic prostate cancer</i> DUE TO (OR AS A CONSEQUENCE OF)							
c. _____ DUE TO (OR AS A CONSEQUENCE OF)							
d. _____ DUE TO (OR AS A CONSEQUENCE OF)							
PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		29a IF SURGERY IS MENTIONED IN PART I OR II ENTER CONDITION FOR WHICH IT WAS PERFORMED		29b DATE OF SURGERY (Mo., Day, Year)			
29 IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? - YES - NO		30a DATE OF INJURY (Month, Day, Year)		30b TIME OF INJURY		30c INJURY AT WORK? (Yes or No)	
31 PROBABLE MANNER OF DEATH (Specify: Natural, accident, suicide, homicide, or undetermined)		32a PLACE OF INJURY - As home, farm, street, factory, etc. (Specify)		32b LOCATION (Street and Number or Rural Route Number, City or Town, State)		32c DESCRIBE HOW INJURY OCCURRED	
Natural							

DH 512, 7/96
(Replaces HRS
Form 512)

THIS IS A CERTIFIED TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

BY

Marino Darden

JUN 05 2001

State Registrar

WARNING:

12481240

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.

DOH FORM 1564 (10/98)

CERTIFICATION OF VITAL RECORD

FLORIDA DEPARTMENT OF
HEALTH

PLANT RENTALS, INC.

3245 VILLAGE GREEN DRIVE, MIAMI, FLORIDA 33175
PHONE (305) 554-4110 FAX (305) 229-1388

B0060180

July 13, 2001

Division of Corporations
Uniform Business Report Filings.
P.O. Box 1500,
Tallahassee, FL 32302-1500

Dear Sirs,

Re: Plant Rentals Inc 59-1771502

I am enclosing Document 540822 – 2001 UBR which I found amongst my late husband's papers. He passed away on 5-27-01 after battling cancer for these past 18 months.

I spoke with Scott at your office and he advised that I could send in \$150.00 with a letter of explanation.

Thank you for your consideration.

Yours truly,



Philippa J. Roxburgh

