

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Jun 25, 2002 8:00 am
Secretary of State

06-25-2002 90437 007 ***563.75

DOCUMENT # 668105

1. Entity Name
MISSIE ANN, INC.

Principal Place of Business
17350 SW 46TH STREET
SOUTHWEST RANCHES FL 33331

Mailing Address
17350 SW 46TH STREET
SOUTHWEST RANCHES FL 33331
US

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number
59-2009508

Applied For
 Not Applicable

Zip

Country

Zip

Country

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

DOLLAR, JOHN T.
17350 S.W. 46 STREET
SOUTHWEST RANCHES FL 33331

*Deceased on June 05, 02
 (See enclosed death certificate)*

Name **TAMARA SHANNON-DOLLAR**
 Street Address (P.O. Box Number is Not Acceptable)
17350 S.W. 46 Street

City **Southwest Ranches** FL Zip Code **33331**

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 *Tamara Shannon-Dollar* **TAMARA SHANNON-DOLLAR, Sec.** *June 21, 2002*
 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 \$150.00
After May 1, 2002 Fee will be \$550.00
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

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE **PD** ☒ Delete
 NAME **DOLLAR, JOHN T.**
 STREET ADDRESS **17350 SW 46TH STREET**
 CITY-ST-ZIP **SOUTHWEST RANCHES FL 33331**
Deceased - (See Above)

TITLE ☒ Change ☐ Addition
 NAME **Deceased - see above and enclosed death cert.**
 STREET ADDRESS
 CITY-ST-ZIP

TITLE **ST** ☐ Delete
 NAME **SHANNON-DOLLAR, TAMARA**
 STREET ADDRESS **17350 SW 46 STREET**
 CITY-ST-ZIP **SOUTHWEST RANCHES FL 33331**

TITLE **President** ☒ Change ☐ Addition
 NAME **TAMARA SHANNON-DOLLAR**
 STREET ADDRESS **17350 S.W. 46 Street**
 CITY-ST-ZIP **Southwest Ranches, FL 33331**

TITLE ☐ Delete
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

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

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 CITY-ST-ZIP

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: *Tamara Shannon-Dollar*
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

6-21-02 **854-680-9830**
 Date Daytime Phone #

CR2E034 (9/01)

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

Attest
Doc 14
668105
1/8390

TYPE OR
PRINT IN
PERMANENT
BLACK INKCERTIFICATE OF DEATH
FLORIDA

1. DECEDENT'S NAME		2. SEX	
FIRST MIDDLE LAST Johnny T. Dollar		Male	
3. DATE OF DEATH (Month, Day, Year) June 5, 2002		4. SOCIAL SECURITY NUMBER 267-98-8856	
5a. AGE Last Birthday (years) 48		5b. UNDER 1 YEAR Months Days Hours Minutes	
6. DATE OF BIRTH (Month, Day, Year) January 18, 1954		7. BIRTHPLACE (City and State or Foreign Country) Jacksonville Florida	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) No		9. INSIDE CITY LIMITS? (Yes or No) Yes	
10a. PLACE OF DEATH (Check only one; see instructions on other side) HOSPITAL <input checked="" type="checkbox"/> Incident <input type="checkbox"/> EXCULPATORY <input type="checkbox"/> DCA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		10b. CITY, TOWN, OR LOCATION OF DEATH Weston	
10c. FACILITY NAME (If not institution, give street and number) Cleveland Clinic		10d. COUNTY OF DEATH Broward	
11a. DECEDENT'S USUAL OCCUPATION Owner/Operator		11b. KIND OF BUSINESS/INDUSTRY Vehicle Towing	
11c. MARITAL STATUS — Married, Never Married, Widowed, Divorced (Specify) Married		11d. SURVIVING SPOUSE (If wife, give maiden name) Tami Shannon	
12a. RESIDENCE — STATE Florida		12b. COUNTY Broward	
12c. CITY, TOWN, OR LOCATION Southwest Ranches		12d. STREET AND NUMBER 17350 SW 46th Street	
13a. INSIDE CITY LIMITS? (Yes or No) Yes		13b. ZIP CODE 33331	
14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes. If yes, specify Mexican, Cuban, Salvadoran, Puerto Rican, etc.) No		15. RACE — American Indian, Black, White, etc. (Specify) White	
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary: 10 College: 1		17. FATHER'S NAME (First, Middle, Last) Frank W. Dollar	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Wingate		19a. INFORMANT'S NAME (Type/Print) Tami Dollar	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17350 SW 46th Street, Southwest Ranches, FL 33331		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)	
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Keen Cemetery		20c. LOCATION — City or Town, State Callahan FL	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>[Signature]</i>		21b. LICENSE NUMBER (of Licensee) FE3382	
21c. NAME AND ADDRESS OF FACILITY T.M. Ralph Funeral Home 371 NW 136 Avenue, Sunrise, FL 33325		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) <i>[Signature]</i>	
22b. DATE SIGNED (Mo., Day, Yr.) 6/11/02		22c. HOUR OF DEATH 02:35 AM	
23a. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) Kenneth Fromkin MD		23b. MEDICAL EXAMINER'S CASE # 2950 Cleveland Clinic Boulevard, Weston, FL 33331	
24a. REGISTRAR — SIGNATURE AND DATE <i>[Signature]</i> JUNE 13, 2002		24b. REGISTRAR — SIGNATURE <i>[Signature]</i>	
24c. DATE REGISTERED JUN 14 2002		25. 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 disease on each line.	

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

BY

Doris Owens
 Deputy Chief Registrar

State Registrar

JUN 14 2002

WARNING:

13713314

THIS DOCUMENT IS PRINTED ON PHOTOGRAPHIC COPY 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 1584 (10-98)

CERTIFICATION OF VITAL RECORD

FLORIDA DEPARTMENT OF
HEALTH