2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Mar 20, 2002 8:00 am
Secretary of State
03-20-2002 90010 017 ***150.00

DOCUMENT # 695068

1. Entity Name
MDM STUDIOS, INC.

Principal Place of Business	Mailing Address
MDM STUDIOS, INC 968 PINETREE DR INDIAN HARBOUR BCH FL 32937 US	% SARA L HEIM 209 SE FIRST STREET SATELLITE BEACH FL 32937

DO NOT WRITE IN THIS SPACE

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 59-2109676 ☐ 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
HEIM, SARA L 209 SE FIRST STREET SATELLITE BEACH FL 32937	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.

SIGNATURE ______________________
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 / NAME / STREET ADDRESS / CITY-ST-ZIP	V HEIM, EDISON L 209 SE FIRST ST SATELLITE BCH, FL 00000 ☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	PD HEIM, SARA L 209 SE FIRST ST SATELLITE BCH, FL 00000 ☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
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TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition

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: SIGNATURE REQUIRED Sara L Heim March 7, 2002 321-777-1344
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

CR2E034 (9/01)

STATE OF FLORIDA

Copy

Attachment #695068 747634

OFFICE of VITAL STATISTICS

CONFIDENTIAL VERIFICATION OFFICIAL PURPOSES ONLY

CERTIFIED COPY CERTIFICATE OF DEATH FLORIDA

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NO. 01-3257

DECEDENT

1. DECEDENT'S NAME (First / Middle / Last)			2. SEX
EDISON		HEIM	Male

3. DATE OF DEATH (Month, Day, Year)	4. SOCIAL SECURITY NUMBER	5a. AGE-Last Birthday (years)	5b. UNDER 1 YEAR Months	Days	5c. UNDER 1 Day Hours	Minutes
August 14, 2001	424-30-7716	69				

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)
September 27, 1931	Mobile, Alabama	Yes

9a. PLACE OF DEATH (Check only one; see instructions on other side)
HOSPITAL: ___ Inpatient ___ ER/Outpatient ___ DOA OTHER: X Nursing Home ___ Residence ___ Other (Specify)

9b. INSIDE CITY LIMITS? (Yes or No): No

9c. FACILITY NAME (If not institution, give street and number)	9d. CITY, TOWN, OR LOCATION OF DEATH	9e. COUNTY OF DEATH
Tandem Health Care of Melbourne	Melbourne	Brevard

10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use Retired.)	10b. KIND OF BUSINESS/INDUSTRY	11. MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify)	12. SURVIVING SPOUSE (If wife, give maiden name)
Engineer	Electrical	Married	Sara Martin

PARENTS

13a. RESIDENCE – STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Florida	Brevard	Satellite Beach	209 S.E. 1st Street

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 Haitian, Cuban, Mexican, Puerto Rican, etc.) X No ___ Yes Specify:	15. RACE – American Indian, Black, White, etc. Specify:	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0 - 12)	College (1-4 or 5 +)
No	32937		White		4

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
George Heim	Ruby E. Sumerlin

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sara L. Heim	209 S.E. 1st Street, Satellite Beach, Florida 32937

DISPOSITION

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION – City or Town, State
___ Burial X Cremation ___ Removal from State ___ Donation ___ Other (Specify)	Atlas Crematory	Rockledge, Florida

CERTIFIER (To be Completed by CERTIFYING PHYSICIAN Only)

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (of Licensee)	21c. NAME AND ADDRESS OF FACILITY
	1929	Beach Funeral Home, 1689 S. Patrick Drive Indian Harbour Beach, Florida 32937

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) ▶ Bakshi MD

22b. DATE SIGNED (Mo., Day, Yr)	22c. HOUR OF DEATH
8/16/01	6:00p M

22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

MEDICAL EXAMINER (To be Completed by)

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) ▶

23b. DATE SIGNED (Mo., Day, Yr)	23c. HOUR OF DEATH
	M

23d. MEDICAL EXAMINER'S CASE #

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print)
Shakti Bakshi, M.D. 6550 N. Wickham Road, Melbourne, Florida 32940

25a. SUBREGISTRAR – SIGNATURE AND DATE	25b. LOCAL REGISTRAR – SIGNATURE	25c. DATE REGISTERED
Nancy L Molinemix 8.17.01	Irene H Stevens	AUG 17 2001

CAUSE OF DEATH BY CERTIFIER (Part II)

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hepatic Failure	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Cirrhosis of Liver	
	DUE TO (OR AS A CONSEQUENCE OF): c. Chronic alcohol abuse	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	27a. WAS AN AUTOPSY PERFORMED? (Yes or No)	27b. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? (Yes or No)	28. CASE REPORTED TO MEDICAL EXAMINER? (Yes or No)
	No		Yes

29. IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? ___ Yes ___ No	30a. IF SURGERY IS MENTIONED IN PART I or II, ENTER CONDITION FOR WHICH IT WAS PERFORMED	30b. DATE OF SURGERY (Mo., Day, Year)

31. PROBABLE MANNER OF DEATH (Specify) (Natural, Accident, Suicide, Homicide, or Undetermined)	32a. DATE OF INJURY (Month, Day, Year)	32b. TIME OF INJURY M	32c. INJURY AT WORK? (Yes or No)	32d. DESCRIBE HOW INJURY OCCURRED

32a. PLACE OF INJURY – At home, farm, street, factory, etc. (Specify)	32f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

DH 512, 9/96 (Replaces HRS Form 512)

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

BY Shakti M.D

August 17, 2001
State Registrar

GREAT SEAL OF THE STATE OF FLORIDA IN GOD WE TRUST

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.

12791661

THE DOCUMENT FACE CONTAINS A MULTI-COLORED BACKGROUND AND GOLD EMBOSSED SEAL. THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.

FLORIDA DEPARTMENT OF HEALTH

DOH FORM 1564 (10/98)

VOID IF ALTERED OR ERASED