

A29075

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA


MAR 30 2009

J. BRYAN

APR - 9 2009

EXAMINER

COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: Gil-Mar Associates Limited Partnership
(Name of Florida Limited Partnership or Limited Liability Limited Partnership)

The enclosed Certificate of Amendment and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to:

Joanne D. Dannemiller, Managing Partner
(Contact Person)

Gil-Mar Associates Limited Partnership
(Firm/Company)

333 North Portage Path #3
Mailing (Address)

Akron, OH 44303-1250
(City, State and Zip Code)

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TALLAHASSEE, FLORIDA

For further information concerning this matter, please call:

Joanne D. Dannemiller at (330) 836-0324
(Name of Contact Person) (Area Code and Daytime Telephone Number)

Enclosed is a check for the following amount:

\$52.50 Filing Fee

\$61.25 Filing Fee
and Certificate of
Status

\$105.00 Filing Fee
and Certified Copy

\$113.75 Filing Fee,
Certified Copy, and
Certificate of Status

STREET ADDRESS:

Registration Section
Division of Corporations
Clifton Building
2661 Executive Center Circle
Tallahassee, FL 32301

MAILING ADDRESS:

Registration Section
Division of Corporations
P. O. Box 6327
Tallahassee, FL 32314



FLORIDA DEPARTMENT OF STATE
Division of Corporations

March 30, 2009

JOANNE D. DANNEMILLER
GIL-MAR ASSOCIATES LIMITED PARTNERSHIP
333 NORTH PORTGAGE PATH #3
AKRON, OH 44303-1250

SUBJECT: GIL-MAR ASSOCIATES LIMITED PARTNERSHIP
Ref. Number: A29075

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

We have received your document for GIL-MAR ASSOCIATES LIMITED PARTNERSHIP and your check(s) totaling \$113.75. However, the enclosed document has not been filed and is being returned for the following correction(s):

The document must be signed by the dissociating general partner unless the document states the general partner is deceased or a guardian or general conservator has been appointed or the general partner previously filed a Statement of Dissociation with the Florida Department of State.

Please return your document, along with a copy of this letter, within 60 days or your filing will be considered abandoned.

If you have any questions concerning the filing of your document, please call (850) 245-6043.

Joey Bryan
Regulatory Specialist II

Letter Number: 109A00010601

CERTIFICATE OF AMENDMENT
TO
CERTIFICATE OF LIMITED PARTNERSHIP
OF

Gil-Mar Associates Limited Partnership
(Insert name currently on file with Florida Department of State)

Pursuant to the provisions of section 620.1202, Florida Statutes, this Florida limited partnership or limited liability limited partnership, whose certificate was filed with the Florida Department of State on October 7, 1989, adopts the following certificate of amendment to its certificate of limited partnership.

FIRST: Amendment(s): (Indicate information being amended, added, or deleted)

Delete: General Partner Marguerite H Dilley
Deceased - Copy of Death Certificate enclosed.
No additional changes.

SECOND: Effective date, if other than the date of filing: _____

(Effective date cannot be prior to nor more than 90 days after the date this document is filed by the Florida Department of State.)

Signature(s) of a general partner(s)*:

(*Note: If adding or deleting an election to be a limited liability limited partnership statement, all general partners must sign the amendment.)

Joanne R. Panemiller

Signature(s) of new or dissociating general partner(s), if any:

Marguerite H. Dilley (Deceased) by Joanne R. Panemiller
Trustee

Filing Fee: \$52.50
Certified Copy (optional): \$52.50
Certificate of Status (optional): \$8.75

Marguerite H. Dilley Trust

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

FILED

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDATYPE OR
PRINT IN
PERMANENT
BLACK INK

LOCAL FILE NO. 03-0462

1. DECEDENT'S NAME		FIRST		MIDDLE		LAST		2. SEX	
Marguerite		Hudson		Dilley				Female	
3. DATE OF DEATH (Month, Day, Year)		4. SOCIAL SECURITY NUMBER		5a. AGE-Last Birthday (years)		5b. UNDER 1 YEAR		5c. UNDER 1 Day	
January 25, 2003		293-42-9225		95					
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)					
August 21, 1907		Baltimore, Maryland		NO					
9a. PLACE OF DEATH (Check only one: see instructions on other side)		9b. INSIDE CITY LIMITS? (Yes or No)							
HOSPITAL _____ Inpatient _____ EPOutpatient _____ DOA _____ OTHER: <input checked="" type="checkbox"/> Nursing Home _____ Residence _____ Other (Specify) _____		Yes							
9c. FACILITY NAME (If not institution, give street and number)		9d. CITY, TOWN, OR LOCATION OF DEATH		9e. COUNTY OF DEATH					
Alterra Sterling House		West Melbourne		Brevard					
10a. DECEDENT'S USUAL OCCUPATION		10b. KIND OF BUSINESS/INDUSTRY		11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)		12. SURVIVING SPOUSE (If wife, give maiden name)			
Homemaker		Own Home		Widowed					
13a. RESIDENCE - STATE		13b. COUNTY		13c. CITY, TOWN, OR LOCATION		13d. STREET AND NUMBER			
Florida		Brevard		West Melbourne		7300 Greenboro Road			
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 Italian, Cuban, Mexican, Puerto Rican, etc.)		15. RACE - American Indian, Black, White, etc. Specify:		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary _____ College (1-4 or 5+) _____	
Yes		32904		No		White		4	
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)							
John Serrel Hudson		Margaret Fleckenstein							
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Joanne Dannemiller		766 Merriman Road, Akron, Ohio 44303							
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)		20c. LOCATION - City or Town, State					
Burial _____ Cremation <input checked="" type="checkbox"/> Removal from State _____ Donation _____ Other (Specify) _____		Holy Cross Cemetery		Akron, Ohio					
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH		21b. LICENSE NUMBER (of Licensee)		21c. NAME AND ADDRESS OF FACILITY					
		4135		Atlantic Mortuary P.O. Box 560433 Rockledge, FL 32956					
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		22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
Sue Mitra, M.D.		1/30/03		2:40 A.					
24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print)		25a. REGISTRAR - SIGNATURE AND DATE		25b. LOCAL REGISTRAR - SIGNATURE		25c. DATE REGISTERED			
Sue Mitra, M.D., 240 N. Wickham Road, Melbourne, Florida 32935		James L. Smith, 2/5/03		James L. Smith		FEB 05 2003			
26. PART I. Enter the disease, injury, 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 AUTOPSY FINDINGS 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) → ACUTE CARDIORESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): END STAGE CARDIOMYOPATHY AND PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):		No		No		No			
29. IF FEMALE, WAS THERE A FREQUENCY IN THE LAST 3 MONTHS? Yes <input checked="" type="checkbox"/> 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		32c. INJURY AT WORK? (Yes or No)		32d. DESCRIBE HOW INJURY OCCURRED	
Natural						No			
32e. PLACE OF INJURY - At home, farm, street, factory, etc. (Specify)		32f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							

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

BY

Sue Mitra, M.D.

FEB 05 2003
State RegistrarWARNING:
14254844THIS 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.FLORIDA DEPARTMENT OF
HEALTH

DOH FORM 1564 (10-98)

CERTIFICATION OF VITAL RECORD