2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Jan 11, 2002 8:00 am
Secretary of State
01-11-2002 90016 029 ***150.00

012309 AV

DOCUMENT # G08737

1. Entity Name
WAREHOUSE DEVELOPMENT COMPANY

Principal Place of Business	Mailing Address
% WILLIAM P GILMARTIN 450 DIANA BLVD. MERRITT ISLAND FL 32953-3037	% WILLIAM P GILMARTIN 450 DIANA BLVD. MERRITT ISLAND FL 32953-3037

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 59-2360165 ☐ 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
GILMARTIN, WILLIAM P 450 DIANA BLVD. MERRITT ISLAND FL 32953	Name: Gilmartin Anne L. P.D.T. Street Address (P.O. Box Number is Not Acceptable): 450 Diana Blvd Merritt Island City FL Zip Code 32953

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 Anne L. Gilmartin Dec 5 - 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 NAME STREET ADDRESS CITY-ST-ZIP	D GILMARTIN, ANNE L 450 DIANA BLVD MERRITT ISLAND, FL 00000	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	P/D/T. Gilmartin, Anne L. 450 Diana Blvd Merritt Island Fla. 32953	☒ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD GILMARTIN, WILLIAM P 450 DIANA BLVD MERRITT ISLAND, FL 00000	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	Gilmartin, William P. Deceased	☐ 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
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition

CR2E034 (9/01)

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: Anne L. Gilmartin SIGNATURE REQUIRED P/D/T/S Anne L. Gilmartin
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

STATE OF FLORIDA

Please Return

OFFICE of VITAL STATISTICS

Attachment DH 4087-37 BU002272

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDA

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NO. 01-0343

DECEDENT

1. DECEDENT'S NAME (First)	(Middle)	(Last)	2. SEX
WILLIAM	PATRICK	GILMARTIN	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
JANUARY 22, 2001	520-10-1123	82				

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 6, 1918	PIEDMONT, SOUTH DAKOTA	YES

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

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

9c. FACILITY NAME (If not institution, give street and number)	9d. CITY, TOWN, OR LOCATION OF DEATH	9e. COUNTY OF DEATH
CAPE CANAVERAL HOSPITAL	COCOA BEACH	BREVARD

10. GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE. DO NOT USE RETIRED.

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)
LEIUTENANT COLONEL	U.S. AIR FORCE	MARRIED	ANNE L. DRENNAN

PARENTS

13a. RESIDENCE – STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
FLORIDA	BREVARD	MERRITT ISLAND	450 DIANA BOULEVARD

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.)	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	32953	X No ___ Yes Specify:	WHITE		6

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
EDWARD GILMARTIN	RHODA MOSHER

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ANNE L. GILMARTIN	450 DIANA BOULEVARD MERRITT ISLAND, FLORIDA 32953

DISPOSITION

20a. METHOD OF DISPOSITION: X Burial ___ Cremation ___ Removal from State ___ Donation ___ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION – City or Town, State
	FLORIDA MEMORIAL GARDENS	ROCKLEDGE, FLORIDA

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (of Licensee)	21c. NAME AND ADDRESS OF FACILITY
R. Alan Rhoads II	3983	WYLIE-BAXLEY MERRITT ISLAND FUNERAL HOME 1360 N. COURTENAY MERRITT ISLAND, FL. 32953

CERTIFIER – To be Completed by CERTIFYING PHYSICIAN Only

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
1/24/01	3:50 P M

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

MEDICAL EXAMINER – To be Completed by MEDICAL EXAMINER

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)
LEON COHEN M.D. 375 S. COURTENAY PARKWAY MERRITT ISLAND, FLORIDA 32952

25a. SUBREGISTRAR – SIGNATURE AND DATE	25b. LOCAL REGISTRAR – SIGNATURE	25c. DATE REGISTERED
1/25/01	Marsha L. Faulk	JAN 26 2001

CAUSE OF DEATH BY CERTIFIER

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.	Aortic Celiac Vascular Accident	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST. b.	DUE TO (OR AS A CONSEQUENCE OF): Hypertension	
c.	DUE TO (OR AS A CONSEQUENCE OF): Paralytic Ileus	
d.	DUE TO (OR AS A CONSEQUENCE OF): Chronic Renal Failure	

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		NO

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 Ooccurred
Natural				

32e. 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 Nishmati M.D. BREVARD COUNTY REGISTRAR — State Registrar — JANUARY 26, 2001

VOID IF ALTERED OR ERASED

WARNING 12355020

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.

FLORIDA DEPARTMENT OF HEALTH

DOH FORM 1564 (10/98)