2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 30, 2004 8:00 am
Secretary of State

04-30-2004 90294 021 ***158.75

DOCUMENT # G34533

1. Entity Name
GILBERT'S ANGELS NURSERY & DAY CARE CENTER, INC.

Principal Place of Business	Mailing Address
3038 N.W. 48 TERR MIAMI, FL 33142	3038 N.W. 48 TERR MIAMI, FL 33142

2. Principal Place of Business	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

04272004 Chg-P CR2E034 (10/03)

4. FEI Number: 59-2275734 — ☐ 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
~~GILBERT, ALONZO B.~~ Deceased See attached death certificate 14825 ROBINSON ST. MIAMI, FL 33176	Name: CECELIA C. GILBERT Street Address (P.O. Box Number is Not Acceptable): SAME 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. I am familiar with, and accept the obligations of registered agent.

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

FILE NOW!!! FEE IS $150.00
After May 1, 2004 Fee will be $550.00

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

10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V GILBERT, CECELIA C 14825 ROBINSON ST. MIAMI, FL 33176	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	Director/owner	☒ 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
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition

12. 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 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: Cecelia C. Gilbert — 4/28/04 — 305-634-6268
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

OFFICE of VITAL STATISTICS

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDA

0014787
LOCAL FILE NO.

DECEDENT

1. DECEDENT'S NAME	FIRST	MIDDLE	LAST	2. SEX
	Alonzo	Benjamin	Gilbert	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
October 15, 2003	261-90-3444	56				

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)
March 17, 1947	Miami, Florida	No

9a. PLACE OF DEATH (Check only one - see instructions on other side)	9b. INSIDE CITY LIMITS? (Yes or No)
HOSPITAL: Inpatient, ER/Outpatient, DOA; OTHER: Nursing Home, Residence, Other (Specify)	No

9c. FACILITY NAME (If not institution, give street address)	9d. CITY, TOWN, OR LOCATION OF DEATH	9e. COUNTY OF DEATH
Jackson South Community Hospital	Miami	Miami-Dade

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)
Owner	Day Care Center	Married	Cecelia Callahan

PARENTS

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Florida	Miami-Dade	Miami	14825 Robinson Street

INSIDE CITY LIMITS? (Yes or No)	13e. 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, Asian, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
No	33176	No	Black	12	5

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Jack Pearson	Edith Juanita Gilbert

DISPOSITION

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cecelia Gilbert	14825 Robinson Street Miami Florida 33176

20a. METHOD OF DISPOSITION: 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
	Woodlawn South	Miami, Florida

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (of Licensee)	21c. NAME AND ADDRESS OF FACILITY
[signature]	2098	Barrett Pryar Funeral Home 14545 Carver Drive Miami, Florida 33176

CERTIFIER

22a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner stated. (Signature and Title)	22b. 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 stated. (Signature and Title)

22c. DATE SIGNED (Mo., Day, Yr.)	22d. HOUR OF DEATH	23c. DATE SIGNED (Mo., Day, Yr.)	23d. HOUR OF DEATH
	M	October 15, 2003	10:45 PM

22e. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	23e. MEDICAL EXAMINER'S CASE #
	03-1411-0214-29

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print): MARK SHUMAN, M.D.
MEDICAL EXAMINER DEPARTMENT NUMBER ONE ON BOB HOPE ROAD, MIAMI, FLORIDA 33136

25a. SUBREGISTRAR - SIGNATURE AND DATE	25b. LOCAL REGISTRAR - SIGNATURE	25c. DATE REGISTERED
	Maurice Darden	OCT 20 2003

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)	Pulmonary thromboembolism	
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): Phlebothrombosis following knee surgery	
	DUE TO (OR AS A CONSEQUENCE OF): Blunt injury of left knee	
	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.

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)
Yes	Yes	Yes

29. IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? (Yes or 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)
	Knee injury	September 25, 2003

31. PROBABLE MANNER OF DEATH (Specify) Natural, Accident, Homicide, Suicide, Undetermined	32a. DATE OF INJURY (Month, Day, Year)	32b. TIME OF INJURY	32c. INJURY AT WORK? (Yes or No)	32d. DESCRIBE HOW INJURY OCCURRED
Accident	Aug. 2, 1999	Unknown M	No	Deceased fell

32e. PLACE OF INJURY - At home, farm, street, factory, etc. (Specify)	32f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Field	10875 Quailroost Drive, Miami, Florida

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

DEC 05 2003

BY Maurice Darden State Registrar

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

14988120

FLORIDA DEPARTMENT OF HEALTH

DOH FORM 1584 (10-98)

CERTIFICATION OF VITAL RECORD