2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Mar 12, 2003 8:00 am
Secretary of State
03-12-2003 90141 033 ***150.00

DOCUMENT # G64045

1. Entity Name
EMORY LEWIS INCORPORATED

Principal Place of Business	Mailing Address
21190 PALM BEACH BLVD ALVA FL 33920	21190 PALM BEACH BLVD ALVA FL 33920 US

☐ CHECK HERE IF MAKING CHANGES

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 59-2474688 — ☐ Applied For — ~~Not Applicable~~

5. Certificate of Status Desired ☐ — **$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent

LEWIS, EMORY S.
21190 PALM BEACH BLVD
ALVA FL 33920

7. Name and Address of New Registered Agent

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. 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, 2003 Fee will be $550.00
Make Check Payable to Florida Department of State

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	DP	☐ Delete	TITLE	☐ Change ☐ Addition
NAME	LEWIS, EMORY S		NAME	
STREET ADDRESS	21190 PALM BEACH BLVD		STREET ADDRESS	
CITY-ST-ZIP	ALVA FL		CITY-ST-ZIP	
TITLE	D	☒ Delete	TITLE	☐ Change ☐ Addition
NAME	LEWIS, ELIZABETH M.		NAME	
STREET ADDRESS	21190 PALM BEACH BLVD		STREET ADDRESS	
CITY-ST-ZIP	ALVA FL		CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	

CR2E034 (10/02)

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: SIGNATURE REQUIRED Emory S. Lewis DP — 3/10/03 — (239) 560-2555
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

STATE OF FLORIDA

ATTACHMENT
10037518
G64045

OFFICE of VITAL STATISTICS

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDA

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NO. 4339

DECEDENT

1. DECEDENT'S NAME (First / Middle / Last)	2. SEX
ELIZABETH MAY LEWIS	Female

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 13, 2002	220-26-0694	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)
February 13, 1933	Carroll County, Maryland	No

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
Southwest Florida Regional Medical Center	Fort Myers	Lee

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/Operator	Restaurant	Married	Emory Lewis

PARENTS

13a. RESIDENCE – STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Florida	Lee	Alva	21190 Palm Beach Blvd.

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	33920		White		1

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Russell A. Wilson	Viola May Barnes

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Emory Lewis	21190 Palm Beach Blvd., Alva, Florida 33920

DISPOSITION

20a. METHOD OF DISPOSITION: ___ Burial X Cremation ___ Removal from State ___ Donation ___ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION – City or Town, State
Fort Myers Crematory Service	Fort Myers, Florida

Part 1a.

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (of Licensee)	21c. NAME AND ADDRESS OF FACILITY
▸ [signature]	FE # 2272	Anderson Funeral Home Of Lehigh Acres, Inc. 2701 Lee Blvd. Lehigh Acres, Florida 33971

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) ▸ [signature]

22b. DATE SIGNED (Mo., Day, Yr.): 10/14/02

22c. HOUR OF DEATH: 11:24 PM

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

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): James A. Reeves, M.D., 15681 New Hampshire Court, Fort Myers, Florida 33908

25a. SUBREGISTRAR – SIGNATURE AND DATE	25b. LOCAL REGISTRAR – SIGNATURE	25c. DATE REGISTERED
▸ [signature] 10-16-02	▸ Mary Lou Holley, Dep Reg	Oct 17, 2002

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.	Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):	
b.	Metastatic Lung Cancer DUE TO (OR AS A CONSEQUENCE OF):	
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

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

32e.

29. IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? Yes X 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)

32f.

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
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: Mary Lou Holley State Registrar

OCTOBER 17, 2002

WARNING: 14060407

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)

VOID IF ALTERED OR ERASED