2005 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Apr 25, 2005 8:00 am
Secretary of State
04-25-2005 90237 019 ***150.00

DOCUMENT # J29890

1. Entity Name
THE CANDLE SHOPPE, INC.

Principal Place of Business	Mailing Address
735 DODECANESE BLVD #9 THE SPONGE EXCHANGE TARPON SPRINGS FL 34689	735 DODECANESE BLVD #9 THE SPONGE EXCHANGE TARPON SPRINGS FL 34689

1st MOORE CR2E034 (10/04)

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 59-2712107 ☐ 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
MYERS, TERRY L. 5423 CELCUS DR HOLIDAY FL 34690 DECEASED 10/25/04 DEATH CERTIFICATE HOLIDAY ENCLOSED	Name: ~~MYERS, SANDRA E.~~ Street Address (P.O. Box Number is Not Acceptable): ~~5529 BAROQUE DRIVE~~ City: HOLIDAY, FL Zip Code: 34690

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] April 20, 2005
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, 2005 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 NAME STREET ADDRESS CITY-ST-ZIP	P MYERS, TERRY L. 5423 CELCUS CRIVE HOLIDAY FL	☒ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	Deceased 10/25/04 Death certificate enclosed	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	TS MYERS, SANDRA E. 5529 BAROQUE DRIVE HOLIDAY FL 34690	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	President/Sec.-Treas.	☒ 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: [signature] 04/20/05 727-934-9262
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

STATE OF FLORIDA

ATTACHMENT 2004398 2

OFFICE OF VITAL STATISTICS #529890

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDA

LOCAL FILE NO.

DECEDENT

1. DECEDENT'S NAME – FIRST	MIDDLE	LAST	2. SEX
TERRY	L.	MYERS	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 25, 2004	235-72-4885	57				

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)
JULY 16, 1947	LAWRENCEBURG, TENNESSEE	NO

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 NEW PORT RICHEY	NEW PORT RICHEY	PASCO

PARENTS

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)
CHANDLER	CANDLE SHOP	MARRIED	SANDRA FARRELL

13a. RESIDENCE – STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
FLORIDA	PASCO	HOLIDAY	5529 BAROQUE DRIVE

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	34690	X No ___ Yes Specify:	WHITE		1

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
GERALD F. MYERS	NEVA BLOCKER

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SANDRA E. MYERS	5529 BAROQUE DR., HOLIDAY, FLORIDA 34690

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)	SOUTHEASTERN CREMATORY	HUDSON, FLORIDA

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (of Licensee)	21c. NAME AND ADDRESS OF FACILITY
	FE4179	NORTH/MEADOWLAWN FUNERAL HOME 4244 MADISON ST., NEW PORT RICHEY, FL. 34652

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) ▶ Mason Hubsher MD

22b. DATE SIGNED (Mo., Day, Yr.): 10/27/04 | 22c. HOUR OF DEATH: 4:50 P. M

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)
MASON HUBSHER, MD., 6545 RIDGE RD., STE. 4, PORT RICHEY, FLORIDA 34668

25a. SUBREGISTRAR – SIGNATURE AND DATE	25b. LOCAL REGISTRAR – SIGNATURE	25c. DATE REGISTERED
▶	▶ Elaine L Llewellyn	Oct. 29 2004

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. Atherosclerotic Heart Disease

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. Hypertension

DUE TO (OR AS A CONSEQUENCE OF):

c. Renal Failure

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

32e. PLACE OF INJURY – At home, farm, ... | 32f. LOCATION (Street and Number or Rural Route Number, City or Town, State)