

2002 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # K50872

1. Entity Name
WORLD OF AMERICA FINANCIAL GROUP INC.

FILED
Aug 01, 2002 8:00 am
Secretary of State

08-01-2002 90167 013 ***150.00

0064427 AV



DO NOT WRITE IN THIS SPACE

Principal Place of Business 175 FOUNTAINE BLUE BLVD. SUITE 201 MIAMI FL 33172 US		Mailing Address 175 FOUNTAINE BLUE BLVD. SUITE 201 MIAMI FL 33172 US	
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 65-0146645		Applied For Not Applicable	
5. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required	

6. Name and Address of Current Registered Agent PETERS, CHARLES M. 175 FOUNTAINEBLUE BLVD SUITE 2-D-1 MIAMI FL 33172		7. Name and Address of New Registered Agent Name: MARIA CECILIA PETERS Street Address (P.O. Box Number is Not Acceptable) 175 FOUNTAINEBLUE BLVD. SUITE 2-D-1 City: MIAMI FL Zip Code: 33172	
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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: *Maria Cecilia Peters*
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. ☐ **FILE NOW!!! FEE IS \$550.00**
After September 13, 2002 Fee will be \$750.00
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	PD PETERS, CHARLES M. 175 FOUNTAINEBLUE BLVD STE 201 MIAMI FL <input checked="" type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	ST PETERS, MARIA CECILIA 175 FOUNTAINEBLUE BLVD STE 201 MIAMI FL <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
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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: X *Maria Cecilia Peters*

07/29/02 305-225-9989

CR2E034 (4/02)

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDAAttachment
K80872
971939TYPE OR
PRINT IN
PERMANENT
BLACK INK

LOCAL FILE NO.

1. DECEDENT'S NAME

Charles

Maurice

LAST

Peters

2. SEX

Male

3. DATE OF DEATH (Month, Day, Year)

June 1, 2002

4. SOCIAL SECURITY NUMBER

265-76-9024

5a. AGE-Last Birthday (years)

74

5b. UNDER 1 YEAR

Months

Days

Hours

Minutes

5c. UNDER 1 Day

6. DATE OF BIRTH (Month, Day, Year)

December 9, 1927

7. BIRTHPLACE (City and State or Foreign Country)

Cuba

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)

No

9a. PLACE OF DEATH (Check only one - see instructions on other side)

HOSPITAL - ☒ Home - ☐ ER/Outpatient - ☐ DOA - ☐ OTHER - ☐ Nursing Home - ☐ Residence - ☐ Other (Specify)

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

No

9c. FACILITY NAME (If not institution, give street and number)

Kendall Regional Medical Center

Miami

9d. CITY, TOWN, OR LOCATION OF DEATH

Miami-Dade

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

10a. DECEDENT'S USUAL OCCUPATION

Sales

10b. KIND OF BUSINESS/INDUSTRY

General Insurance Company

11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)

Married

12. SURVIVING SPOUSE (If wife, give maiden name)

Maria Cecilia Quijano

13a. RESIDENCE - STATE

Florida

13b. COUNTY

Miami-Dade

13c. CITY, TOWN, OR LOCATION

Miami

13d. STREET AND NUMBER

497 NW 98th Court

13e. INSIDE CITY LIMITS? (Yes or No)

No

13f. ZIP CODE

33172

14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes - If yes, specify Mexican, Cuban, Mexican Puerto Rican, etc.)

Cuban

15. RACE - American Indian, Black, White, etc. (Specify)

White

16. DECEDENT'S EDUCATION (Specify only highest grade completed)

College 4 yrs + 1

17. FATHER'S NAME (First, Middle, Last)

Charles Peters

18. MOTHER'S NAME (First, Middle, Maiden Surname)

Caridad Clemente

19a. INFORMANT'S NAME (Type/Print)

Rodrigo A Mena

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

497 NW 98th Court Miami FL 33172

20a. METHOD OF DISPOSITION

☒ Cremation - ☐ Removal from State - ☐ Donation - ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)

Dade South Memorial Park

20c. LOCATION - City or Town, State

Miami, Florida

21a. SIGNATURE OF GENERAL SERVICES LICENSEE OR PERSON DESIGNATED AS SUCH

[Signature]

21b. LICENSE NUMBER (of Licensee)

4316

21c. NAME AND ADDRESS OF FACILITY

Bernardo Garcia

Funeral Home (Westchester), Inc

8215 Bird Road Miami FL 33155

22a. On the basis of my knowledge, death occurred at (Specify date and place and due to the cause(s) as stated)

[Signature and Title]

22b. DATE SIGNED (Mo., Day, Yr.)

6-4-02

22c. HOUR OF DEATH

11:10 A

23a. On the basis of examination and/or investigation, in my opinion death occurred at (Specify date and place and due to the cause(s) and manner as stated)

[Signature and Title]

23b. DATE SIGNED (Mo., Day, Yr.)

[Signature]

23c. HOUR OF DEATH

[Signature]

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print)

Tomas Villanueva, D.O., 11760 SW 40th Street #112, Miami FL 33175

25a. SURREGISTRAR - SIGNATURE AND DATE

[Signature] 6/5/02

25b. LOCAL REGISTRAR - SIGNATURE

[Signature]

25c. DATE REGISTERED

JUN 07 2002

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

Respiratory Failure

Sequently 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: Myocardial Infarction

Due to (OR) AS A CONSEQUENCE OF:

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)

No

27b. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? (Yes or No)

No

28. CASE REPORTED TO MEDICAL EXAMINER? (Yes or No)

No

29. IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? - YES - NO

No

30a. IF SURGERY IS MENTIONED IN PART I, 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)

M

32d. DESCRIBE HOW INJURY OCCURRED

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 312, 6/96
(Replaces NRS
Form 312)

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

BY

[Signature]

JUN 13 2002

State Registrar

WARNING:

13536943

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.

DOH FORM 1564 (10-98)

FLORIDA DEPARTMENT OF
HEALTH