

LN 0000 44545

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

PICK-UP WAIT MAIL

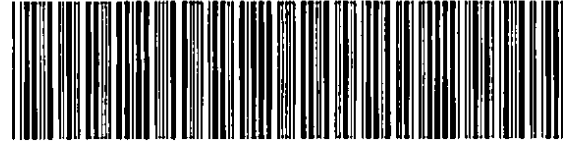
(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

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TALLAHASSEE, FLORIDA

2021 JUN -4 AM 7:06

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COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: KOJAK OF Ocala LLC
(Name of Limited Liability Company)

The enclosed Articles of Dissolution and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

JAMES L. DEAN
(Name of Person)
KOJAK OF Ocala LLC
(Firm/Company)
5309 SW 8TH PLACE
(Address)
Ocala FL 34476
(City/State and Zip Code)

For further information concerning this matter, please call:

JAMES L. DEAN at (352) 237-5103
(Name of Person) (Area Code & Daytime Telephone Number)

Enclosed is a check for the following amount:

- \$25.00 Filing Fee and Certificate of Dissolution
- \$55.00 Filing Fee, Certificate of Dissolution & Certified Copy (additional copy is enclosed)

Mailing Address:
Registration Section
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Street Address:
Registration Section
Division of Corporations
The Centre of Tallahassee
2415 N. Monroe Street, Suite 810
Tallahassee, FL 32303

**ARTICLES OF DISSOLUTION
FOR
A LIMITED LIABILITY COMPANY**

1. The name of a limited liability company is

KOJAK OF OCALA, LLC

2. The Articles of Organization were filed on APRIL 13, 2011 and assigned

document number L11000044545

3. The delayed effective date the dissolution if not effective on the date of filing: _____
(effective date cannot be prior to or more than 90 days later than date document is received for filing)

Note: If the date inserted in this block does not meet the applicable statutory filing requirements, this date will not be listed as the document's effective date on the Department of State's records.

4. A description of occurrence that resulted in the limited liability company's dissolution pursuant to section 605.0707, Florida Statutes, (copy 605.0707 on back cover letter).

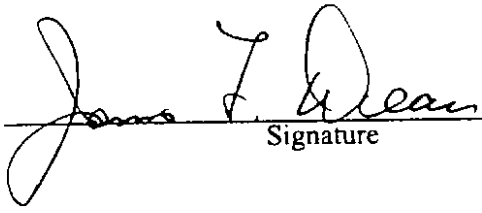
MANAGING MEMBER (DIANIE DEAN) DECEASED
DEATH CERTIFICATE ATTACHED (COPY)

2021 JUN -11 AM 7:06
TALLAHASSEE, FLORIDA

FILED

5. If there are no members, enter the name and address of the person appointed to wind up the company's activities and affairs: _____

6. Signature of an authorized person or if there are no members, the signature of the person appointed and listed above to wind up the company's activities and affairs:


Signature

JAMES L. DEAN
Printed Name

FILING FEE: \$25.00

BUREAU of VITAL STATISTICS

CERTIFICATION OF DEATH

STATE FILE NUMBER: 2019185291

DATE ISSUED: NOVEMBER 27, 2019

DECEDENT INFORMATION

DATE FILED: NOVEMBER 27, 2019

NAME: DIANE LEWIS DEAN

DATE OF DEATH: NOVEMBER 24, 2019

SEX: FEMALE

AGE: 075 YEARS

DATE OF BIRTH: MAY 3, 1944

SSN: ***-**-2491

BIRTHPLACE: ROCKVILLE CENTRE, NEW YORK, UNITED STATES

PLACE WHERE DEATH OCCURRED: INPATIENT

FACILITY NAME OR STREET ADDRESS: WEST MARION COMMUNITY HOSPITAL

LOCATION OF DEATH: OCALA, MARION COUNTY, 34474

RESIDENCE: 5309 SOUTHWEST 89TH PLACE, OCALA, FLORIDA 34476, UNITED STATES

COUNTY: MARION

OCCUPATION, INDUSTRY: REGISTERED NURSE, MEDICAL

EDUCATION: BACHELORS DEGREE

EVER IN U.S. ARMED FORCES? NO

HISPANIC OR HAITIAN ORIGIN? NO, NOT OF HISPANIC/HAITIAN ORIGIN

RACE: WHITE

SURVIVING SPOUSE / PARENT NAME INFORMATION

(NAME PRIOR TO FIRST MARRIAGE, IF APPLICABLE)

MARITAL STATUS: MARRIED

SURVIVING SPOUSE NAME: JAMES L DEAN

FATHER'S/PARENT'S NAME: WILLIAM P LEWIS

MOTHER'S/PARENT'S NAME: RUTH E HARRE

INFORMANT, FUNERAL FACILITY AND PLACE OF DISPOSITION INFORMATION

INFORMANT'S NAME: JAMES L DEAN

RELATIONSHIP TO DECEDENT: SPOUSE

INFORMANT'S ADDRESS: 5309 SOUTHWEST 89TH PLACE, OCALA, FLORIDA 34476, UNITED STATES

FUNERAL DIRECTOR/LICENSE NUMBER: JAMES P GRANT, F046789

FUNERAL FACILITY: HIERS-BAXLEY FUNERAL SERVICES - TIMBER RIDGE F085163
9695 SW 110TH ST, OCALA, FLORIDA 34481

METHOD OF DISPOSITION: CREMATION

PLACE OF DISPOSITION: OCALA CREMATORY
OCALA, FLORIDA

CERTIFIER INFORMATION

TYPE OF CERTIFIER: CERTIFYING PHYSICIAN

MEDICAL EXAMINER CASE NUMBER: NOT APPLICABLE

TIME OF DEATH (24 HOUR): 1610

DATE CERTIFIED: NOVEMBER 25, 2019

CERTIFIER'S NAME: MERY JOSEFINA LOSSADA

CERTIFIER'S LICENSE NUMBER: ME81160

NAME OF ATTENDING PHYSICIAN (IF OTHER THAN CERTIFIER): NOT ENTERED

The first five digits of the decedent's Social Security Number has been redacted pursuant to §119.071(6), Florida Statutes.



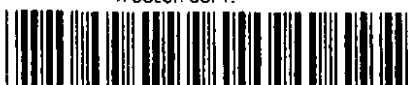
, STATE REGISTRAR

REQ: 2021077418

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

WARNING:

THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH WATERMARKS OF THE GREAT SEAL OF THE STATE OF FLORIDA. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARKS. THE DOCUMENT FACE CONTAINS A MULTICOLORED BACKGROUND, GOLD EMBOSSED SEAL, AND THERMOCHROMIC FL. THE BACK CONTAINS SPECIAL LINES WITH TEXT. THE DOCUMENT WILL NOT PRODUCE A COLOR COPY.



DH FORM 1946 (03-13)

CERTIFICATION OF VITAL RECORD

