PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM. 192

~~CORPORATION REINSTATEMENT~~

FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

00-01 UBR

FILED
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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

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****300.00 ****300.00

DOCUMENT # M41984

1. Corporation Name

PINEVIEW APARTMENTS, INC.

2. Principal Office Address	3. Mailing Office Address
4550 Meridian Ave	same
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: Miami Beach, FL	City & State
Zip: 33140 Country: USA	Zip Country

4. Date Incorporated or Qualified To Do Business in Florida

5. FEI Number 59-2761423 ☐ Applied For ☐ Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐ $8.75 Additional Fee required for a Certificate of Status

7. Name and Address of Current Registered Agent

Name: William J. Segal, Esq.

Street Address (P.O. Box Number is Not Acceptable): 20801 Biscayne Boulevard

Suite, Apt. #, Etc.: Suite 304

City: Aventura, FL State: FL Zip Code: 33180

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of Registered Agent X _____ Date 2/12/01
REGISTERED AGENT MUST SIGN

9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
D	HARRIET SEGAL	4550 Meridian Ave	Miami Beach, FL 33140
			SP

10. I certify that I am an officer or director or the receiver or trustee empowered to execute this application as provided for in chapter 607 or 617, F.S. I further certify that when filing this reinstatement application, the reason for dissolution has been eliminated, the corporate name satisfies the requirements of section 607.0401 or 617.0401, F.S., that all fees owed by the corporation have been paid and the names of individuals listed on this form do not qualify for an exemption under section 119.07(3)(i), F.S. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.

SIGNATURE: Harriet Segal 2/12/01 305 682 1110
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

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LAW OFFICES
WILLIAM J. SEGAL, P. A.
20801 BISCAYNE BOULEVARD
SUITE 304
AVENTURA, FLORIDA 33180

WILLIAM J. SEGAL
OF COUNSEL
FRANKLIN J. SIEGEL
GARY R. SASLAW

TELEPHONE
(305) 682-1110
TELEFAX
(305) 682-1800

February 12, 2001

Florida Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, Florida 32314

Re: Pineview Apartments, Inc. - Document Number M41984

To Whom it May Concern:

Enclosed herewith you will find an original Corporation Reinstatement form and a check payable to the Department of State in the sum of $300.00. We request that the $600.00 penalty be waived. My Dad died on October 8, 2000, a copy of his death certificate is enclosed. He was in Mount Sinai Hospital for two (2) months prior to his death. Accordingly, I enclose $300.00 representing annual fee for 2000 and 2001.

I hope you will agree to waive the penalty and reinstate the corporation. Thank you in advance for your cooperation.

I have enclosed a self-addressed stamped envelope so that you may return a receipt for the reinstatement.

Very truly yours,

WILLIAM J. SEGAL, P.A.

By: _____
William J. Segal, Esq.

WJS/ml
encls.
C:\WPF\SEGAL.HAR\division of corp.ltr.wpd

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY
CERTIFICATE OF DEATH
FLORIDA

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NO.

DECEDENT

1. DECEDENT'S NAME — FIRST	MIDDLE	LAST	2. SEX
HAROLD	J.	SEGAL	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 8, 2000	100-16-1215	80		

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)
OCTOBER 12, 1919	BRONX, NEW YORK	YES

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
MT. SINAI MEDICAL CENTER	MIAMI BEACH	MIAMI DADE

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)
REALTOR	REAL ESTATE	MARRIED	HARRIET FREUD

13a. RESIDENCE — STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
FLORIDA	MIAMI DADE	MIAMI BEACH	4550 MERIDIAN AVE.

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+)
YES	33140	X No __ Yes Specify	WHITE		4

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
WILLIAM SEGAL	HADASSAH WEINKLE

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WILLIAM J. SEGAL	21163 N.E. 18TH PLACE, NORTH MIAMI BEACH, FL 33179

DISPOSITION

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION — City or Town, State
X Burial __ Cremation __ Removal from State __ Donation __ Other (Specify)	MT. NEBO CEMETERY	MIAMI, FLORIDA

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (of Licensee)	21c. NAME AND ADDRESS OF FACILITY
Stanley O. Rubin	1564	RIVERSIDE-GORDON MEMORIAL CHAPEL 1920 ALTON RD., MIAMI BEACH, FLORIDA

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)

22b. DATE SIGNED (Mo., Day, Yr.)	22c. HOUR OF DEATH
10/12/2000	4 AM 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)

LAWRENCE CIMENT,M.D. 4302 ALTON ROAD, MIAMI BEACH, FLORIDA ##1S)

25a. SUBREGISTRAR — SIGNATURE AND DATE	25b. LOCAL REGISTRAR — SIGNATURE	25c. DATE REGISTERED
Mary Oliver 10-17-00	Maurice Dadac	OCT 17 2000

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):	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Stage 4 Prostate Cancer DUE TO (OR AS A CONSEQUENCE OF):	1 month
	c. 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		NO

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, 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 Maurice Dadac

OCT 18 2000

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.

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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)

CERTIFICATION OF VITAL RECORD

VOID IF ALTERED OR ERASED