2007 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Feb 21, 2007 8:00 am
Secretary of State
02-21-2007 90024 017 ****61.25

DOCUMENT # **N95000005840**

1. Entity Name

HARVEST HOUSE OUTREACH CENTER, INC.

Principal Place of Business	Mailing Address
7750 NW 4TH AVE MIAMI FL 33150 US	7821 NW 4 CT MIAMI FL 33150

2. Principal Place of Business - No P.O. Box #	3. Mailing Address
SAME AS ABOVE	SAME AS ABOVE
Suite, Apt. #, etc.: NO-CHANGES	Suite, Apt. #, etc.: NO-CHANGES
City & State: SAME	City & State: SAME
Zip: SAME / Country: SAME	Zip: SAME / Country: SAME

40021300

1st MOORE CR2E037 (10/06)

4. FEI Number: 65-0675601 — 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
SIMPSON, WALTER L 7821 NW 4TH CT MIAMI FL 33150	Name: N/A Street Address (P.O. Box Number is Not Acceptable): " — SAME — 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: Pastor Walter L. Simpson 2-7-07

Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered agent signature required when reinstating) DATE

FILE NOW: FEE IS $61.25
Due By May 1, 2007

9. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

Make Check Payable to Florida Department of State

10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD SIMPSON, WALTER L 7821 NW 4 CT MIAMI FL 33150 ☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition SAME
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MD SIMPSON, BARBARA V 7821 NW 4 CT MIAMI FL 33150 ☑ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition Deceased 5-24-06 Copy of Death Cert. inclosed
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T MCCARTHY, ONELL 6751 SW 10 CT PEMBROKE PINES FL 33023 ☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition SAME
TITLE NAME STREET ADDRESS CITY-ST-ZIP	S MCCARTHY, TONYA 6751 SW 10 CT PEMBROKE PINES FL ☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition SAME
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 exemptions contained in Section 119, 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 617, 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: Pastor Walter L. Simpson 2-9-07

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

FLORIDA CERTIFICATE OF DEATH

TYPE IN PERMANENT BLACK INK

LOCAL FILE NO.

DEMOGRAPHIC INFORMATION TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last, Suffix): Barbara Simpson
2. SEX: Female
3. DATE OF BIRTH (Month, Day, Year): December 17, 1940
4a. AGE (Last Birthday) (Years): 65
4b. UNDER 1 YEAR: Months / Days
4c. UNDER 1 DAY: Hours / Minutes
5. DATE OF DEATH (Month, Day, Year): May 24, 2006
6. SOCIAL SECURITY NUMBER: 265-60-8029
7. BIRTHPLACE (City and State or Foreign Country): Cocoa, Florida
8. COUNTY OF DEATH: Miami-Dade
9. PLACE OF DEATH (Check only one): HOSPITAL — X Inpatient — Emergency Room/Outpatient — Dead on Arrival; NON-HOSPITAL — Hospice Facility — Nursing Home/Long Term Care Facility — Decedent's Home — Other (Specify)
10. FACILITY NAME (If not institution, give street address): Jackson Memorial Hospital
11a. CITY, TOWN, OR LOCATION OF DEATH: Miami
11b. INSIDE CITY LIMITS? X Yes — No
12. MARITAL STATUS (Specify): X Married — Married but Separated — Widowed — Divorced — Never Married
13. SURVIVING SPOUSE'S NAME (If wife, give maiden name): Walter L. Simpson
14a. RESIDENCE - STATE: Florida
14b. COUNTY: Miami Dade
14c. CITY, TOWN OR LOCATION: Miami
14d. STREET ADDRESS: 7821 NW 4 Court
14e. APT. NO.:
14f. ZIP CODE: 33150
14g. INSIDE CITY LIMITS? X Yes — No
15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life) Do not use "Retired": Homemaker
15b. KIND OF BUSINESS/INDUSTRY: Own Home
16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.): — White — X Black or African American — American Indian or Alaskan Native (Specify tribe) — Asian Indian — Chinese — Filipino — Japanese — Korean — Vietnamese — Other Asian (Specify) — Native Hawaiian — Guamanian or Chamorro — Samoan — Other Pacific Is. (Specify) — Other (Specify)
17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin.) — Yes (If Yes, specify) X No — Mexican — Puerto Rican — Cuban — Central/South American — Other Hispanic (Specify) — Haitian
18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.): — 8th or less — X High school but no diploma — High school diploma or GED — College but no degree — College degree (Specify) — Associate — Bachelor's — Master's — Doctorate
19. WAS DECEDENT EVER IN U.S. ARMED FORCES? — Yes X No
20. FATHER'S NAME (First, Middle, Last, Suffix): Abraham B. Weaver
21. MOTHER'S NAME (First, Middle, Maiden Surname): Rachel Rollins
22a. INFORMANT'S NAME: Walter L. Simpson
22b. RELATIONSHIP TO DECEDENT: Husband
23a. INFORMANT'S MAILING - STATE: Florida
23b. CITY OR TOWN: Miami
23c. STREET ADDRESS: 7821 NW 4 Court
23d. ZIP CODE: 33150
24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Dade Memorial Park
24a. LOCATION - STATE: Florida
24b. LOCATION - CITY OR TOWN: Miami
26a. METHOD OF DISPOSITION: X Burial — Entombment — Cremation — Donation — Removal from State — Other (Specify)
26b. IF CREMATION, DONATION OR BURIAL AT SEA WAS MEDICAL EXAMINER APPROVAL GRANTED? — Yes — No
27a. LICENSE NUMBER (of Licensee): 6062
27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: [signature]
28. NAME OF FUNERAL FACILITY: Wright Funeral Home, Inc
29a. FACILITY'S MAILING - STATE: Florida
29b. CITY OR TOWN: Miami
29c. STREET ADDRESS: 15332 NW 7 Avenue
29d. ZIP CODE: 33169

MEDICAL CERTIFIER

30. CERTIFIER: X Certifying Physician - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) — Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, due to the cause(s) and manner stated.
31a. (Signature and Title of Certifier): [signature] MD
31b. DATE SIGNED (mm/dd/yyyy): 05/25/2006
32. TIME OF DEATH (24 hr.): 11:12
33. MEDICAL EXAMINER'S CASE NUMBER:
34a. LICENSE NUMBER (of Certifier): TRN 00006743
34b. CERTIFIER'S NAME: Angel Alejandro, M.D.
35. NAME OF ATTENDING PHYSICIAN (if other than Certifier):
36a. CERTIFIER'S - STATE: Florida
36b. CITY OR TOWN: Miami
36c. STREET ADDRESS: 1611 N.W. 12 Avenue
36d. ZIP CODE: 33136
37. SUBREGISTRAR - Signature and Date:
38a. LOCAL REGISTRAR: [signature]
38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.): JUN 05 2006 PW

CAUSE OF DEATH TO BE COMPLETED BY MEDICAL CERTIFIER

39. PROBABLE MANNER OF DEATH: X Natural — Accident — Suicide — Homicide — Pending Investigation — Undetermined
40. REPORTED TO MEDICAL EXAMINER DUE TO CAUSE OF DEATH? — Yes X No
41. CAUSE OF DEATH - PART I (See instructions on back). Enter the chain of events - diseases, injuries, or complications - that directly caused the death. Enter only one cause on a line. DO NOT enter terminal event such as cardiac arrest, respiration arrest, or ventricular fibrillation without showing the etiology. Approximate Interval: Onset to Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Multisystem Organ Failure
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST
b. Sepsis
c. Multiple Myeloma
d.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.
42a. WAS AN AUTOPSY PERFORMED? — Yes X No
42b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? — Yes — No
43a. IF SURGERY MENTIONED IN PART I OR II, ENTER REASON FOR SURGERY:
43b. DATE OF SURGERY (Mo., Day, Yr.):
44. DID TOBACCO USE CONTRIBUTE TO DEATH? — Yes — No — Probably — Unknown
45. IF FEMALE, WAS SHE PREGNANT WITHIN THE PAST YEAR? — Yes — No — Unknown. If Yes, specify time: — at time of death — within 1 to 42 days of death — within 43 days to 1 year of death
46. DATE OF INJURY (Month, Day, Year):
47. TIME OF INJURY (24 hr.):
48. INJURY AT WORK? — Yes — No
49a. LOCATION OF INJURY - STATE:
49b. CITY OR TOWN:
49c. STREET ADDRESS:
49d. APT. NO.:
49e. ZIP CODE:
50. DESCRIBE HOW INJURY OCCURRED:
51. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area):
IF TRANSPORTATION INJURY: 52a. Status of Decedent — Driver/Operator — Passenger — Pedestrian — Other (Specify)
52b. Type of Vehicle — Car/Minivan — S.U.V. — Motorcycle — Pickup Truck/Cargo Van — Bus — Heavy Transport — Other (Specify)

Dir. Form 512, Jul. 2004 (Obsoletes previous editions which may not be used)

State of Florida, Department of Health, Vital Statistics

VOID IF ALTERED OR ERASED

[signature] JUN 06 2006

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. THE DOCUMENT FACE CONTAINS A MULTICOLORED BACKGROUND AND GOLD EMBOSSED SEAL. THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.

GREAT SEAL OF THE STATE OF FLORIDA — IN GOD WE TRUST

FLORIDA DEPARTMENT OF HEALTH

DH FORM 1947 (08/04).

32740808

CERTIFICATION OF VITAL RECORD

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