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

400621300

1st MOORE CR2E037 (10/06)

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

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	Deceased 5-24-06 Copy of Death Cert. inclosed ☐ Change ☐ Addition
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

TYPE IN PERMANENT BLACK INK

FLORIDA CERTIFICATE OF DEATH

LOCAL FILE NO.

DEMOGRAPHIC INFORMATION TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last, Suffix)			2. SEX
Barbara	Simpson		Female
3. DATE OF BIRTH (Month, Day, Year)	4a. AGE (Last Birthday) (Years)	4b. UNDER 1 YEAR (Months / Days)	4c. UNDER 1 DAY (Hours / Minutes)	5. DATE OF DEATH (Month, Day, Year)
December 17, 1940	65			May 24, 2006
6. SOCIAL SECURITY NUMBER	7. BIRTHPLACE (City and State or Foreign Country)			8. COUNTY OF DEATH
265-60-8029	Cocoa, Florida			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)	11a. CITY, TOWN, OR LOCATION OF DEATH	11b. INSIDE CITY LIMITS?
Jackson Memorial Hospital	Miami	X Yes, No

12. MARITAL STATUS (Specify)	13. SURVIVING SPOUSE'S NAME (If wife, give maiden name)
X Married — Married But Separated — Widowed — Divorced — Never Married	Walter L. Simpson

14a. RESIDENCE - STATE	14b. COUNTY	14c. CITY, TOWN OR LOCATION		
Florida	Miami Dade	Miami		
14d. STREET ADDRESS	14e. APT. NO	14f. ZIP CODE	14g. INSIDE CITY LIMITS?	
7821 NW 4 Court		33150	X Yes No	

15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. Do not use "Retired")	15b. KIND OF BUSINESS/INDUSTRY
Homemaker	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.)	19. WAS DECEDENT EVER IN U.S. ARMED FORCES?
— 8th or less — X High school (or no diploma) — High school diploma or GED — College (but no degree) — College degree (Specify) — Associate's — Bachelor's — Master's — Doctorate	— Yes X No

20. FATHER'S NAME (First, Middle, Last, Suffix)	21. MOTHER'S NAME (First, Middle, Maiden Surname)
Abraham B. Weaver	Rachel Rollins

22a. INFORMANT'S NAME	22b. RELATIONSHIP TO DECEDENT	22c. INFORMANT'S MAILING - STATE
Walter L. Simpson	Husband	Florida
22d. CITY OR TOWN	22e. STREET ADDRESS	22f. ZIP CODE
Miami	7821 NW 4 Court	33150

24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	24a. LOCATION - STATE	24b. LOCATION - CITY OR TOWN
Dade Memorial Park	Florida	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)	27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH
	6062	

28. NAME OF FUNERAL FACILITY	29a. FACILITY'S MAILING - STATE	
Wright Funeral Home, Inc	Florida	
29b. CITY OR TOWN	29c. STREET ADDRESS	29d. ZIP CODE
Miami	15332 NW 7 Avenue	33169

MEDICAL CERTIFIER

30. CERTIFIER: (Check one) 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. — Medical Examiner - 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 stated.

31a. (Signature and Title of Certifier)	31b. DATE SIGNED (mm/dd/yyyy)	32. TIME OF DEATH (24 hr.)	33. MEDICAL EXAMINER'S CASE NUMBER
Angel Alejandro MD	05/25/2006	11:12	
34a. LICENSE NUMBER (of Certifier)	34b. CERTIFIER'S NAME	35. NAME OF ATTENDING PHYSICIAN (if other than Certifier)	
TRN 00006743	Angel Alejandro, M.D.		
36a. CERTIFIER'S - STATE	36b. CITY OR TOWN	36c. STREET ADDRESS	36d. ZIP CODE
Florida	Miami	1611 N.W. 12 Avenue	33136
37. SUBREGISTRAR - Signature and Date	38a. LOCAL REGISTRAR	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. The following are under the jurisdiction of the medical examiner

43. 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 (check one) — 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)

Form 1947, Jul 2004 (Obsoletes previous versions which may not be used)

JUN 06 2006

WARNING: THIS DOCUMENT IS PRINTED ON 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.

DH FORM 1947 (08/04).

32740808

CERTIFICATION OF VITAL RECORD

* 3 2 7 4 0 8 0 8 *

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED