2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Mar 06, 2002 8:00 am
Secretary of State
03-06-2002 90007 035 ***150.00

0323353 AV

DOCUMENT-# P00000098649

1. Entity Name
MEDALLION MARINE ENTERPRISES CORP.

Principal Place of Business	Mailing Address
19 ISLA BAHIA DRIVE FORT LAUDERDALE FL 33316	19 ISLA BAHIA DRIVE FORT LAUDERDALE FL 33316

DO NOT WRITE IN THIS SPACE

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 65-1048389 ☐ 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
CORPORATION SERVICE COMPANY 1201 HAYS STREET TALLAHASSEE FL 32301-2525	Name Street Address (P.O. Box Number is Not Acceptable) 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.

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

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. (See criteria on back) ☐

FILE NOW!!! FEE IS $150.00
After May 1, 2002 Fee will be $550.00
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	D ACKERMAN, RICHARD 19 ISLA BAHIA DRIVE FORT LAUDERDALE FL 33316	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D FEUERMAN, CAROLE 19 ISLA BAHIA DRIVE FORT LAUDERDALE FL 33316	☑ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D ACKERMAN, SUE 19 ISLA BAHIA DRIVE FORT LAUDERDALE FL 33316	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D ACKERMAN, MILTON 19 ISLA BAHIA DRIVE FORT LAUDERDALE FL 33316	☐ 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
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition

CR2E034 (9/01)

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: Sue Ackerman
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Attachment

NEW YORK STATE
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER
826263
#P0000098649

RECORDED DISTRICT 2951
REGISTER NUMBER 414

RESIDENCE

NCHS

DECEDENT

1. NAME: FIRST Milton MIDDLE LAST Ackerman
2. SEX: MALE ☑ 1 FEMALE ☐ 2
3A. DATE OF DEATH: MONTH 04 DAY 06 YEAR 2001
3B. HOUR: 7 29 p m
4A. PLACE OF DEATH: (Check only one) HOSPITAL DOA ☐ 1 HOSPITAL ER ☐ 2 HOSPITAL OUTPATIENT ☐ 3 HOSPITAL INPATIENT ☒ 4 NURSING HOME ☐ 5 PRIVATE RESIDENCE ☐ 6 OTHER (Specify) ☐
4B. IF FACILITY, DATE ADMITTED: MONTH 04 DAY 01 YEAR 2001
4C. NAME OF FACILITY: (If not facility, give address) North Shore University
4D. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☒ North Hempstead
4E. COUNTY OF DEATH: Nassau
4F. MEDICAL RECORD NO. 1382930
4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO ☒ YES ☐
5. DATE OF BIRTH: MONTH 11 DAY 20 YEAR 1920
6A. AGE IN YEARS: 80 yrs.
6B. IF UNDER 1 YEAR ENTER: months days
6C. IF UNDER 1 DAY ENTER: hours minutes
7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) Brooklyn NY
7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:
8. SERVED IN U.S. ARMED FORCES? NO ☐ 0 YES ☒ 1 (Specify years) WWII
9. RACE: (Black, White, etc.) WHITE
10. HISPANIC ORIGIN? (If yes, specify) NO ☒ YES ☐
11. DECEDENT'S EDUCATION (Enter only the highest year of school completed. Do not circle range; enter specific number of years.) Elementary/Secondary (0-12) College (1-4 or 5+) C 9
12. SOCIAL SECURITY NUMBER: 072-14-0423
13. MARITAL STATUS: NEVER MARRIED ☐ MARRIED ☒ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐
14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is wife, enter maiden name. DORIS SUE NOLBEGAT
15A. USUAL OCCUPATION: (Do not enter retired) executive
15B. KIND OF BUSINESS OR INDUSTRY: taxi cab
15C. NAME AND LOCALITY OF COMPANY OR FIRM: Brooklyn, NY.
16A. RESIDENCE: (State or Country if not USA) Florida
16B. County or Region/ Province if not USA Boward
16C. LOCALITY: (Check one and specify) CITY ☒ VILLAGE ☐ TOWN ☐ Ft. Lauderdale
16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? ☐ YES ☐ NO IF NO, SPECIFY TOWN:
16D. STREET AND NUMBER OF RESIDENCE: 19 ISLA BAHIA Drive
16E. ZIP CODE: 33316

PARENTS

17. NAME OF FATHER: FIRST May MI LAST Ackerman
18. MAIDEN NAME OF MOTHER: FIRST Anna MI LAST HABER

DISPOSITION

19A. NAME OF INFORMANT: Doris Sue Ackerman
19B. MAILING ADDRESS: (Include zip code) 19 ISLA BAHIA Drive, Ft. Lauderdale, FLA. 33316
20A. BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: (Specify) Burial MONTH 04 DAY 10 YEAR 2001
20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Old Montefiore Cemetery
20C. LOCATION: (City or town and state) St. Albans NY
21A. NAME AND ADDRESS OF FUNERAL HOME: Riverside Nassau North Chapels 55 North Station Plaza Great Neck NY 11021
21B. REGISTRATION NUMBER: 01639
22A. NAME OF FUNERAL DIRECTOR: Peter E Jannone
22B. SIGNATURE OF FUNERAL DIRECTOR:
22C. REGISTRATION NUMBER: 06252
23A. SIGNATURE OF REGISTRAR:
23B. DATE FILED: MONTH 04 DAY 09 YEAR 2001
24A. BURIAL OR REMOVAL PERMIT ISSUED BY:
24B. DATE ISSUED: MONTH 04 DAY 07 YEAR 2001

CERTIFIER

ITEMS 25 A-E THRU 33 COMPLETED BY CERTIFYING PHYSICIAN — OR — ITEMS 25 F-K THRU 33 COMPLETED BY CORONER OR MEDICAL EXAMINER

25A. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED.
SIGNATURE:
MONTH 04 DAY 06 YEAR 2001
25B. THE PHYSICIAN ATTENDED THE DECEDENT FROM: MONTH 04 DAY 01 YEAR 2001 TO: MONTH 04 DAY 06 YEAR 2001
25C. LAST SEEN ALIVE BY ATTENDANT: MONTH 04 DAY 06 YEAR 2001
25D. NAME OF ATTENDING PHYSICIAN: Richard Forte
25E. ATTENDING PHYSICIAN LICENSE NUMBER 187922-01
25F. ON THE BASIS OF INVESTIGATION AND SUCH EXAMINATIONS, AS I FELT NECESSARY, IN MY OPINION, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED. ☐ CORONER ☐ CORONER'S PHYSICIAN ☐ MEDICAL EXAMINER
SIGNATURE AND TITLE:
25G. PRONOUNCED DEAD ON: MONTH XX DAY XX YEAR XXXX
25H. HOUR: m
25I. DATE SIGNED: MONTH XX DAY XX YEAR XXXX
25J. SIGNATURE OF CORONER OR CORONER'S PHYSICIAN, IF OTHER THAN CERTIFIER:
25K. ME/COR. PHYS. LICENSE NUMBER
26. NAME AND ADDRESS OF CERTIFIER WHO SIGNED 25A or 25F: Jonathan Winston 320 Commack Ave Merrimac 11030
27. MANNER OF DEATH: NATURAL CAUSE ☒ 1 ACCIDENT ☐ 2 HOMICIDE ☐ 3 SUICIDE ☐ 4 UNDETERMINED CIRCUMSTANCES ☐ 5 PENDING INVESTIGATION ☐ 6
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? ☒ 0 NO ☐ 1 YES
29A. AUTOPSY? NO ☐ 0 YES ☒ 1 REFUSED ☐ 2
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? ☐ 0 NO ☐ 1 YES

CAUSE OF DEATH

CONFIDENTIAL — SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH — CONFIDENTIAL

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).)

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. IMMEDIATE CAUSE: (A)	Cardiopulmonary Arrest	21 Minutes
DUE TO OR AS A CONSEQUENCE OF: (B)	Septic Shock	Hours
DUE TO OR AS A CONSEQUENCE OF: (C)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):		

31A. IF INJURY, DATE: MONTH DAY YEAR
HOUR: m
31B. INJURY LOCALITY: (City or town and county and state)
31C. DESCRIBE HOW INJURY OCCURRED:
31D. PLACE OF INJURY:
31E. INJURY AT WORK? NO ☐ 0 YES ☐ 1
32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☐ 0 YES ☐ 1
33A. IF FEMALE, WAS DECEDENT PREGNANT IN LAST 6 MONTHS? NO ☐ 0 YES ☐ 1
33B. DATE OF DELIVERY: MONTH XX DAY XX YEAR XXXX

I this is to certify that this is a true and exact copy of the record on file in the Town Clerk's Office
Town of North Hempstead, Manhasset, New York 11030
Michelle Schimel Registrar

DATE OF DEATH: AM/PM
NAME OF DECEDENT:
For use by physician or institution: