103

2002 UNIFORM BUSINESS REPORT (UBR)

02-05-2003 90TTT042 ***300.00
P01000005694

03 FEB 18 PM 4:25

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

J001F000

DO NOT WRITE IN THIS SPACE

DOCUMENT # P01000005694

1. Entity Name
CRYSTAL CLEAR WATER SYSTEMS INC.

Principal Place of Business	Mailing Address
13621 EXOTICA LANE WEST PALM BEACH FL 33414	13621 EXOTICA LANE WEST PALM BEACH FL 33414

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 — 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
SANCHEZ-BROWNING, MARIA 13621 EXOTICA LANE WEST PALM BEACH FL 33414	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. I am familiar with, and accept the obligations of registered agent.

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

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 $550.00
After September 13, 2002 Fee will be $750.00
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	DP SANCHEZ-BROWNING, SANCHEZ 13621 EXOTICA LANE WEST PALM BEACH FL 33414 ☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T BROWNING, RICHARD A 13621 EXOTICA LANE WEST PALM BEACH FL 33414 ☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V SANCHEZ, PEDRO R 13621 EXOTICA LANE WEST PALM BEACH FL 33414 ☐ 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
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CR2E034 (4/02)

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: Maria Sanchez-Browning RECEIVED Sept 14/2002

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

Attachment Sc. # P0100008294 9001859

VOID VOID VOID

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NO. 6002-9128

CERTIFICATE OF DEATH
FLORIDA

DECEDENT

1. DECEDENT'S NAME — FIRST: Oscar; MIDDLE: Felipe; LAST: Diaz
2. SEX: Male
3. DATE OF DEATH (Month, Day, Year): August 15, 2002
4. SOCIAL SECURITY NUMBER: 266-31-5702
5a. AGE (Last Birthday): 74
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 Day: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): June 23, 1928
7. BIRTHPLACE (City and State or Foreign Country): Cuba
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No): No
8a. PLACE OF DEATH (Check only one; see instructions on other side): HOSPITAL: Inpatient / ER/Outpatient / DOA / OTHER: Nursing Home / Residence X / Other (Specify): Other Residence
8b. INSIDE CITY LIMITS? (Yes or No): Yes
8c. FACILITY NAME (If not institution, give street and number): 13621 Exotica Lane
8d. CITY, TOWN, OR LOCATION OF DEATH: Wellington
8e. COUNTY OF DEATH: Palm Beach
10. DATE OF WORK DONE DURING WEEK OF WORKED LAST; DOTOT USE RETIRED
10a. DECEDENT'S USUAL OCCUPATION: Owner
10b. KIND OF BUSINESS/INDUSTRY: Trucking Company
11. MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify): Divorced
12. SURVIVING SPOUSE (If wife, give maiden name): None
13. RESIDENCE – STATE: Florida
13b. COUNTY: Hendry
13c. CITY, TOWN, OR LOCATION: Clewiston
13d. STREET AND NUMBER: 629 West Obispo Avenue
13e. INSIDE CITY LIMITS? (Yes or No): Yes
13f. ZIP CODE: 33440

PARENTS

14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes – If yes, specify Mexican, Cuban, Puerto Rican, etc.): No X Yes — Specify: Cuban
15. RACE – American Indian, Black, White, etc. Specify: White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary: 10 – 12 – 18 X; College: 1-4 or 5+
17. FATHER'S NAME (First, Middle, Last): Cecilio Diaz
18. MOTHER'S NAME (First, Middle, Maiden Surname): Josefina Diaz
19a. INFORMANT'S NAME (Type/Print): Omar Diaz
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 629 West Obispo Avenue, Clewiston, Florida 33440

DISPOSITION

20a. METHOD OF DISPOSITION: Burial / Cremation / Removal from State / Donation / X Other (Specify): Entombment
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Vista Memorial Gardens
20c. LOCATION – City or Town, State: Hialeah, Florida
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR AUTHORIZED AGENT: Nilsy J. Gonzalez II
21b. LICENSE NUMBER (If licensed): 3054
21c. NAME AND ADDRESS OF FACILITY: Caballero Rivero Woodlawn Funeral Homes, 373-377 West 9 Street, Hialeah, FL 33010

CERTIFIER

To be Completed by CERTIFYING PHYSICIAN Only
22. 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): Paul Tritel
22b. DATE SIGNED (Mo., Day, Yr.): 4/10/02
22c. HOUR OF DEATH: 4:45 P.M.
22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

To be Completed by MEDICAL EXAMINER
23. 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
23d. MEDICAL EXAMINER'S CASE #

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print): Paul Tritel M.D. 5300 East Avenue, West Palm Beach, Florida 33407
25a. SUBREGISTRAR – SIGNATURE AND DATE
25b. LOCAL REGISTRAR – SIGNATURE: Donna Pettel
25c. DATE REGISTERED: AUG 29 2002

CAUSE OF DEATH BY CERTIFIER

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): Liver Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST:

DUE TO (OR AS A CONSEQUENCE OF):

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Approximate Interval Between Onset and Death:

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): No
27b. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? (Yes or No):
28. CASE REPORTED TO MEDICAL EXAMINER? (Yes or 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
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, 9/98 (Replaces HRS Form 512)

VOID IF ALTERED OR ERASED

THIS IS A CERTIFIED TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

Pearlie Brown AUGUST 29, 2002 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. THE DOCUMENT FACE CONTAINS A MULTI-COLORED BACKGROUND AND GOLD EMBOSSED SEAL. THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.

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FLORIDA DEPARTMENT OF HEALTH

DOH FORM 1564A (3/99)

1/31/03 Attachment

90017859

Crystal Clear Water Syst Inc. Document # P01000005894

on maria Sandez Browning

my Phone:
561-795-7182

The Helen and Harry Gray
CANCER INSTITUTE
At Good Samaritan Medical Center

- ☐ 1309 North Flagler Drive 561.366.4100
- ☐ 3401 PGA Boulevard 561.691.6060
- ☐ 11903 Southern Boulevard 561.790.4659

Maria Browning

Date: 6/10/03 Time: 9.45

- ☐ David J. Ahr, M.D.
- ☐ Robert J. Green, M.D.
- ☐ James N. Harris, M.D.
- ☐ Robert J. Jacobson, M.D.
- ☐ Elisabeth A. McKeen, M.D.
- ☐ Marilyn M. Raymond, M.D.
- ☐ Neal E. Rothschild, M.D.
- ☐ Augustin J. Schwartz III, M.D.
- ☐ Daniel L. Spitz, M.D.
- ☐ Lorna Baker, ARNP
- ☐ Deidra Brown, ARNP
- ☐ Catherine Marinak, ARNP
- ☐ Marie Martinez, ARNP
- ☐ Mary Wilson, ARNP

Please help me en restablesh my Com.
I was Very ill, and my father was dying
of Cancer. he die on Aug 15, 2002 at home.
Business forms was not given to me
at the time.

Thank Very much.

Maria Sandez Browning

Maria Sandez Browning