2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Jan 16, 2002 8:00 am
Secretary of State
01-16-2002 90004 050 ***150.00

DOCUMENT # P01000097358

1. Entity Name
M.I. X TREME INC.

Principal Place of Business	Mailing Address
1095 AUDOBON RD. MERRITT ISLAND FL 32953	1095 AUDOBON RD. MERRITT ISLAND FL 32953

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 59-3750009 ☐ 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
SISSON, LARRY 218 SOUTHERN COUNTRY LN. QUINCY FL 32351	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	DPS OEHLER, CARL 1095 AUDOBON DR. MERRITT ISLAND FL 32953	☑ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	DVT HACKETT, JEFF 1095 AUDOBON RD. MERRITT ISLAND FL 32953	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D GRANT, DONNIE 1095 AUDOBON RD. MERRITT ISLAND FL 32953	☑ 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
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition

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: SIGNATURE REQUIRED 1-20-02 (321)243-2489
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

CR2E034 (9/01)

OFFICE of VITAL STATISTICS

CERTIFIED COPY Attachment

Doc#P01000097358/802051

TYPE OR PRINT IN PERMANENT BLACK INK

CERTIFICATE OF DEATH
FLORIDA

LOCAL FILE NO.

DECEDENT

1. DECEDENT'S NAME	FIRST	MIDDLE	LAST	2. SEX
	CARL	MICHAEL	OEHLER	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
DECEMBER 15, 2001	040-82-7077	29				

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)
April 12, 1972	Chicago, Illinois	NO

9a. PLACE OF DEATH (Check only one; see instructions on other side) — STREET

HOSPITAL: ___ Inpatient ___ ER/Outpatient ___ DOA OTHER: ___ Nursing Home ___ Residence X Other (Specify)

9b. INSIDE CITY LIMITS? (Yes or No): NO

9c. FACILITY NAME (If not institution, give street and number): WEST ON BLUE MARLIN ROAD

9d. CITY, TOWN, OR LOCATION OF DEATH: PLACIDA

9e. COUNTY OF DEATH: CHARLOTTE

10a. DECEDENT'S USUAL OCCUPATION	10b. KIND OF BUSINESS/INDUSTRY	11. MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify)	12. SURVIVING SPOUSE (If wife, give maiden name)
Stunt Rider	Motorcycle Stunt Riding	Never Married	

PARENTS

13a. RESIDENCE – STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Florida	Brevard	Merritt Island	1095 Audubon Road

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 +)
No	32953	X No ___ Yes Specify:	White	12	

17. FATHER'S NAME (First, Middle, Last): Ralph E. Oehler

18. MOTHER'S NAME (First, Middle, Maiden Surname): Joan Poli

19a. INFORMANT'S NAME (Type/Print): Joy Smiling

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1095 Audubon Road, Merritt Island, Florida 32953

DISPOSITION

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION – City or Town, State
___ Burial X Cremation ___ Removal from State ___ Donation ___ Other (Specify)	ORCC Services, Inc.	Orlando, Florida

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (of Licensee)	21c. NAME AND ADDRESS OF FACILITY
Arthur A. Holloway	FE 1720	HollowayFuneralHome,Inc.,1128ayviewBlvd., P.O.Box1148,Oldsmar,Florida34677-1148

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 ___ M

22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

MEDICAL EXAMINER (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) ▶ [signature] DME

23b. DATE SIGNED (Mo., Day, Yr): DECEMBER 17, 2001

23c. HOUR OF DEATH: ab.2:19P M

23d. MEDICAL EXAMINER'S CASE #: 01.22.0153 6

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print): R. H. IMAMI, M.D., DME, 18130 PAULSON DRIVE, PORT CHARLOTTE, FLORIDA 33954

25a. SUBREGISTRAR – SIGNATURE AND DATE	25b. LOCAL REGISTRAR – SIGNATURE	25c. DATE REGISTERED
Juanita S. Holloway Dec. 19,2001	Doreen A. Johnson Deputy	Dec 24 2001

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) →	CRANIOCEREBRAL INJURIES	
a.	DUE TO (OR AS A CONSEQUENCE OF):	
b.	DUE TO (OR AS A CONSEQUENCE OF):	
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

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

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)
	YES	YES	YES

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
ACCIDENT	DEC.15,2001	AB. 2:19P M	NO	DRIVER OF MOTORCYCLE INVOLVED IN ACCIDENT

32e. PLACE OF INJURY – At home, farm, street, factory, etc. (Specify): STREET

32f. LOCATION (Street and Number or Rural Route Number, City or Town, State): WEST ON BLUE MARLIN ROAD PLACIDA, FLORIDA

DH 512, 9/98 (Replaces HRS Form 512)

DECEMBER 24, 2001

THIS IS A CERTIFIED TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE
Charlotte County Health Dept. 20101 Peachland Bl. Ste 208, Port Charlotte, FL 33954

BY Christine J. Washington, Deputy 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.

9171336 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 1564A (3/99)

VOID IF ALTERED OR ERASED