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Secretary of State

5/12/

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2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P02000107446

1. Entity Name
ALL FREIGHT SOLUTIONS, CORPORATION

44003924

Principal Place of Business	Mailing Address
15620 SW 147 AVE MIAMI, FL 33187	15620 SW 147 AVE MIAMI, FL 33187

[redacted]

☑ CHECK HERE IF MAKING CHANGES

2. Principal Place of Business	3. Mailing Address
2701 N.E. 10th St.	2701 N.E. 10th St.
Suite, Apt. #, etc. #805	Suite, Apt. #, etc. #805
City & State Ocala, FL	City & State Ocala, FL
Zip 34471 Country USA	Zip 34471 Country USA

4. FEI Number 37-1444294 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ $8.75 Additional Fee Required

6. Name and Address of Current Registered Agent
SILVOSA, RAQUEL
15620 SW 147 AVE
MIAMI, FL 33187

7. Name and Address of New Registered Agent
Name Raquel Silvosa
Street Address (P.O. Box Number is Not Acceptable) 2701 N.E. 10th St.
#805
City Ocala FL Zip Code 34471

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] Raquel Silvosa 5-8-03
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

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

10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D GUIA, GRISELDA 15620 SW 147 AVE MIAMI, FL 33187	☑ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	Director CHRIS SILVOSA 2701 N.E. 10th St. #805 Ocala, FL 34471	☐ 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
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TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition

CR2E034 (10/02)

12. 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 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: [signature] Raquel Silvosa 5-8-03 305-238-5392
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

Attachment DO # PD20001074L/44003924

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

Attachment #1

CERTIFIED COPY
CERTIFICATE OF DEATH
FLORIDA

PD20001074L

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NO.

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last)			2. SEX
Manuel		Silvosa	Male

3. DATE OF DEATH (Month, Day, Year)	4. SOCIAL SECURITY NUMBER	5a. AGE-Last Birthday (Years)	5b. UNDER 1 YEAR (Months / Days / Hours / Minutes)	5c. UNDER 1 Day
December 05, 2002	265-74-1072	70		

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)
July 27, 1932	Cuba	No

9a. PLACE OF DEATH (Check only one; see instructions on other side)	9b. INSIDE CITY LIMITS? (Yes or No)
HOSPITAL: X Inpatient — ER/Outpatient — DOA — OTHER — Home — Residence — Other (Specify)	No

9c. FACILITY NAME (If not institution, give street and number)	9d. CITY, TOWN, OR LOCATION OF DEATH	9e. COUNTY OF DEATH
Baptist Hospital	Miami	Miami Dade

10. IF WORK-CONNECTED DEATH, DURATION OF WORK (Hours, Days, Weeks, Months, Years) IF NOT, DO NOT USE RETIRED	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)
	Customer Service	Building Supplies Store	Married	Raquel Hernandez

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Florida	Miami Dade	Miami	15620 S.W. 147 Avenue

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 or 2 or 3 or 4+)
No	33187	No X Yes Specify: Cuban	White	NA	NA

PARENTS

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Manuel Silvosa	Alejandrina Rosalina Serpa

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Raquel Silvosa	15620 S.W. 147 Avenue, Miami, Florida 33187

DISPOSITION

20a.

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)	Woodlawn Park Crematory	Miami, Florida

Part Ia.

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (or Licensee)	21c. NAME AND ADDRESS OF FACILITY
Dennis Lee	4623	Caballero Rivero Woodlawn Funeral Homes 11655 S.W. 117 Avenue, Miami, FL 33186

CERTIFIER

22a. To the best of my knowledge, death occurred due to the cause(s) and manner as stated. (Signature and Title)	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)
22b. DATE SIGNED (Mo., Day, Yr.) 12/12/02	22c. HOUR OF DEATH 3:50 P.M.
22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	23b. DATE SIGNED (Mo., Day, Yr.)
	23c. HOUR OF DEATH
	23d. MEDICAL EXAMINER'S CASE #

Part Ib. To be Completed by CERTIFIER Only — Part Ic. To be Completed by MEDICAL EXAMINER Only

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print): Felipe A. Del Valle, M.D. 9260 Sunset Drive # 107, Miami, Florida 33173

25a. REGISTRAR – SIGNATURE AND DATE	25b. REGISTRAR – SIGNATURE	25c. DATE REGISTERED
12-13-02	Maurice Dawkins	DEC 12 2002

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) →	a. ACUTE CARDIOPULMONARY ARREST	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): MASSIVE CEREBROVASCULAR ACCIDENT	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

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)
	No		Yes

32a.

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)

32f.

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, 8/96 (Replaces HRS Form 512)

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

BY: Maurice Dawkins DEC 13 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 1964 (10-96)

CERTIFICATION OF VITAL RECORD

VOID IF ALTERED OR ERASED