P10000010868

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COVER LETTER

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15 MAR 16 AM 11:36
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TALLAHASSEE, FLORIDA

TO: Amendment Section
Division of Corporations

SUBJECT: K&R Data Resources Inc.

DOCUMENT NUMBER: P10000010868

The enclosed **Articles of Dissolution** and fee are submitted for filing.

Please return all correspondence concerning this matter to the following:

Kathi Evans
(Name of Contact Person)

K&R Data Resources Inc.
(Firm/Company)

2 Cheyenne Drive
(Address)

Laurel, MS 39440
(City/State and Zip Code)

For further information concerning this matter, please call:

Kathi Evans at (601) 335-3110
(Name of Contact Person) (Area Code & Daytime Telephone Number)

Enclosed is a check for the following amount:

☑ $35 Filing Fee ☐ $43.75 Filing Fee & Certificate of Status ☐ $43.75 Filing Fee & Certified Copy (Additional copy is enclosed) ☐ $52.50 Filing Fee, Certificate of Status & Certified Copy (Additional copy is enclosed)

MAILING ADDRESS:
Amendment Section
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

STREET ADDRESS:
Amendment Section
Division of Corporations
Clifton Building
2661 Executive Center Circle
Tallahassee, FL 32301

ARTICLES OF DISSOLUTION

FILED
15 MAR 16 AM 11:36
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Pursuant to section 607.1403, Florida Statutes, this Florida profit corporation submits the following articles of dissolution:

FIRST: The name of the corporation as currently filed with the Florida Department of State:
K&R Data Resources Inc.

SECOND: The document number of the corporation (if known): P10000010868

THIRD: The date dissolution was authorized: 08/29/14

Effective date of dissolution if applicable: 08/29/14
(no more than 90 days after dissolution file date)

FOURTH: Adoption of Dissolution (CHECK ONE)

☑ Dissolution was approved by the shareholders. The number of votes cast for dissolution was sufficient for approval.

☐ Dissolution was approved by the shareholders through voting groups.

The following statement must be separately provided for each voting group entitled to vote separately on the plan to dissolve:

The number of votes cast for dissolution was sufficient for approval by

_____
(voting group)

Signature: Kathi Evans
(By a director, president or other officer - if directors or officers have not been selected, by an incorporator - if in the hands of a receiver, trustee, or other court appointed fiduciary, by that fiduciary)

Kathi Evans
(Typed or printed name of person signing)

Vice President
(Title of person signing)

Filing Fee: $35

GEORGIA DEATH CERTIFICATE

State File Number **2014GA000046500**

1 DECEDENT'S LEGAL FULL NAME (First, Middle, Last) **RANDY CARL EVANS**	1a IF FEMALE, ENTER LAST NAME AT BIRTH	2. SEX **MALE**	2a DATE OF DEATH (Mo., Day, Year) **ACTUAL DATE OF DEATH 08/29/2014**

3 SOCIAL SECURITY NUMBER **425-35-8721**	4a. AGE (Years) **48**	4b UNDER 1 YEAR Mos / Days	4c UNDER 1 DAY Hours / Mins	5. DATE OF BIRTH (Mo., Day, Year) **10/16/1965**	

6 BIRTHPLACE **MISSISSIPPI**	7a RESIDENCE - STATE **MISSISSIPPI**	7b COUNTY **JONES**	7c CITY, TOWN **LAUREL**

7d STREET AND NUMBER **2 CHEYENNE DRIVE**	7e ZIP CODE **39440**	7f. INSIDE CITY LIMITS? **NO**	8. ARMED FORCES? **NO**

8a USUAL OCCUPATION **BUSINESS OWNER**	8b KIND OF INDUSTRY OR BUSINESS **COMPUTER PROGRAMMING**

9 MARITIAL STATUS **MARRIED**	10 SPOUSE NAME **KATHI DALE GRANT**	11 FATHER'S FULL NAME (First, Middle, Last) ***JOSEPH CLYDE EVANS***

12 MOTHER'S MAIDEN NAME (First, Middle, Last) **SARAH ANN JACOBS**	13a INFORMANT'S NAME (First, Middle, Last) **KATHI GRANT EVANS**	13b RELATIONSHIP TO DECEDENT **WIFE**

13c. MAILING ADDRESS **2 CHEYENNE DRIVE LAUREL MISSISSIPPI 39440**	14. DECEDENT'S EDUCATION **ASSOCIATE DEGREE**

15 ORIGIN OF DECEDENT *(Italian, Mex.,French, Englsn, etc.)* **NO, NOT SPANISH/HISPANIC/LATINO**	16 DECEDENT'S RACE *(White, Black, Amercan Indian, etc.) (Specify)* **WHITE**
17a IF DEATH OCCURRED IN HOSPITAL **INPATIENT**	17b. IF DEATH OCCURRED OTHER THAN HOSPITAL (Specify)

18 HOSPITAL OR OTHER INSTITUTION NAME *(If not in either give street and no.)* **ST JOSEPHS HEALTH SYSTEM**	19 CITY, TOWN or LOCATION OF DEATH **ATLANTA**	20 COUNTY OF DEATH **FULTON**

21. METHOD OF DISPOSITION (specify) **CREMATION**	22. PLACE OF DISPOSITION **NATIONAL CREMATION SOCIETY CREMATORY 500 HARBINS ROAD LILBURN GEORGIA 30047**	23 DISPOSITION DATE (Mo., Day, Year) **09/02/2014**

24a EMBALMER'S NAME **NOT EMBALMED**	24b EMBALMER LICENSE NO	25 FUNERAL HOME NAME **H M PATTERSON AND SON ARL CHP**

25a FUNERAL HOME ADDRESS
173 ALLEN ROAD SANDY SPRINGS GEORGIA 30328

26a. SIGNATURE OF FUNERAL DIRECTOR **MATT TAYLOR**	26b FUN. DIR. LICENSE NO ***4215***	AMENDMENTS
27 DATE PRONOUNCED DEAD (Mo., Day, Year) **08/29/2014**	28. HOUR PRONOUNCED DEAD **08:07 AM**	

29a PRONOUNCER'S NAME **LAUREN C KILPATRICK**	29b. LICENSE NUMBER **006091**	29c. DATE SIGNED **08/29/2014**
30 TIME OF DEATH **08:07 AM**	31. WAS CASE REFERRED TO MEDICAL EXAMINER **NO**	

32 Part I Enter the chain of events-diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE

		Approximate interval between onset and death
IMMEDIATE CAUSE *(Final disease or condition resulting in death)*	A **CEREBRAL VASCULAR ACCIDENT**	**UNKNOWN**
	Due to, or as a consequence of	
	B.	
	Due to, or as a consequence of	
	C	
	Due to, or as a consequence of	
	D	

Part II Enter significant conditions contributing to death but not related to cause given in Part 1A. *If female, indicate if pregnant or birth occurred within 90 days of death.*	33 WAS AUTOPSY PERFORMED? **NO**	34 WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?

35 TOBACCO USE CONTRIBUTED TO DEATH **NO**	36 IF FEMALE (range 10-54) PREGNANT **NOT APPLICABLE**	37 ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED (Specify) **NATURAL**

38 DATE OF INJURY (Mo., Day, Year)	39 TIME OF INJURY	40. PLACE OF INJURY (Home, Farm, Street, Factory, Office, Etc.) (Specify)	41. INJURY AT WORK? (Yes or No)

42 LOCATION OF INJURY *(Street, Apartment Number, City or Town, State, Zip, County)*

43 DESCRIBE HOW INJURY OCCURRED	44. IF TRANSPORTATION INJURY

45 To the best of my knowledge death occurred at the time, date and place and due to the cause(s) stated. Medical Certifier (Name, Title, License No.) **STEVEN A ACCARINO, MD, 036077**	46. 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) stated. Medical Examiner/Coroner (Name, Title, License No.)

45a DATE SIGNED (Mo., Day, Year) **09/04/2014**	45b HOUR OF DEATH **08:07 AM**	46a. DATE SIGNED (Mo., Day, Year)	46b HOUR OF DEATH

47. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH
STEVEN A ACCARINO 1505 NORTHSIDE BOULEVARD CUMMING GEORGIA 30041

48 REGISTRAR (Signature) **/S/ DONNA L. MOORE**	49. DATE FILED - REGISTRAR *(Mo., Day, Year)* **09/05/2014**