

Division of Corporations

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DIVISION OF CORPORATIONS

P 95000080267

Florida Department of State

Division of Corporations

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To:

Division of Corporations

Fax Number : (850)922-4000

From:

Account Name : RUDEN, MCCLOSKEY, SMITH, SCHUSTER & RUSSELL, P.A.

Account Number : 076077000521

Phone : (954)527-2428

Fax Number : (954)764-4996

REGISTERED AGENT RESIGNATION

COBRE CENTRAL CORP.

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

00 DEC -7 PM 3:33

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RESIGNATION OF REGISTERED AGENT

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00 DEC -7 PM 3:33
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Pursuant to the provisions of sections 607.0502(2), 617.0502(2), 607.1509, or 617.1509

Florida Statutes, the undersigned, Donald L. Epstein
(Name of registered agent)

hereby resigns as Registered Agent for Cobre Central Corp.
(Name of corporation)

A copy of this resignation was mailed to the above listed corporation at its last known address.

The agency is terminated and the office discontinued on the 31st day after the date on which this statement is filed.

By: Pamela J. Epstein, Personal Representative
(Signature of resigning agent)

Pamela J. Epstein, as Personal Representative of the Estate of Donald L. Epstein

If signing on behalf of an entity:

(Typed or Printed Name)

(Capacity)

Fee for filing this document:

\$87.50 - Active corporation

\$35.00 - Administratively dissolved corporation

Make checks payable to Florida Department of State and mail to:
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

FA#: H00000063857

STATE OF FLORIDA

FA#: H000000063857

OFFICE of VITAL STATISTICS

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDA

1 DECEDENT'S NAME FIRST: Donald MIDDLE: L. LAST: Epstein		2 SEX Male	
3 DATE OF DEATH (Month, Day, Year) March 18, 1998		4 SOCIAL SECURITY NUMBER 067-34-9579	
5 DATE OF BIRTH (Month, Day, Year) November 4, 1943		6 BIRTHPLACE (City and State or Foreign Country) Oklahoma City, Oklahoma	
7 PLACE OF DEATH (Check only one and indicate on other side) HOSPITAL <input checked="" type="checkbox"/> Home <input type="checkbox"/> Euthanasia <input type="checkbox"/> DCA <input type="checkbox"/> OTHER <input type="checkbox"/>		8 WAS DECEDENT EVER IN U.S. ARMY, NAVY, AIR FORCE, OR MARINE CORPS? (Yes or No) No	
9 FACILITY NAME (First number, last number) Coral Springs Medical Center		10 CITY, TOWN, OR LOCATION OF DEATH Coral Springs	
11 COUNTY OF DEATH Broward		12	
13 DECEASED'S USUAL OCCUPATION Executive		14 KIND OF BUSINESS/INDUSTRY Chemicals	
15 MARITAL STATUS Married		16	
17 RESIDENCE - STATE Florida		18 COUNTY Broward	
19 CITY, TOWN, OR LOCATION Coral Springs		20	
21 ZIP CODE 33067		22	
23 FATHER'S NAME (First, Middle, Last) Bernard Epstein		24 MOTHER'S NAME (First, Middle, Last) Mildred Epstein	
25 INFORMANT'S NAME (Last, First, Middle) Pamela Epstein		26 MAILING ADDRESS (Street and Number or Rural Route number, City or Town, State, Zip Code) 7605 N.W. 51st Place Coral Springs, Florida 33067	
27 METHOD OF DISPOSITION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Other <input type="checkbox"/>		28 PLACE OF DISPOSITION (Name of cemetery, funeral home, or other place) Star of David Memorial Gardens	
29 SIGNATURE OF FUNERAL SERVICE LICENSEE (Print name and title) R. J. F. F.		30 LICENSE NUMBER FE9390	
31 DATE SIGNED (Month, Day, Year) 3/20/98		32 HOUR OF DEATH 4:12 PM	
33 NAME OF ATTENDING PHYSICIAN (If other than certifier, type or print) Steven Foster, M.D.		34	
35 NAME AND ADDRESS OF CERTIFIER (Physician, Medical Examiner, or other) Steven Foster, M.D. 9750 N.W. 33rd Street #220 Coral Springs, Florida		36 DATE REGISTERED MAR 23 6 1998	
37 PART I: Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, etc., unless it is the immediate cause of death. Do not enter the cause of death on each line.			
38 IMMEDIATE CAUSE (Disease or injury resulting in death) Cardiopulmonary Failure			
39 DUE TO (OR AS A CONSEQUENCE OF) Renal Failure			
40 DUE TO (OR AS A CONSEQUENCE OF) Aortic Aneurysm			
41 DUE TO (OR AS A CONSEQUENCE OF) Aortic Aneurysm			
42 PART II: Other significant conditions contributing to death but not resulting in the underlying cause (Death in Part I)			
43 IF FEMALE: WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		44 IF SURGERY IS MENTIONED IN PART I, ENTER CONDITION FOR WHICH IT WAS PERFORMED	
45 PROBABLE MANNER OF DEATH (Specify: Natural, accident, suicide, homicide, or undetermined)		46 DATE OF INJURY (Month, Day, Year)	
47 TIME OF INJURY		48 INJURY AT WORK? (Yes or No)	
49 PLACE OF INJURY - As above, term, street, factory, etc. (Specify)		50 LOCATION (Street and Number or Rural Route Number, City or Town, State, Zip Code)	

THIS IS MAR 27 1998 AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

Doris Owens, Chief Deputy Registrar
State Registrar

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NRS FORM 1564 (10-98)

CERTIFICATION OF VITAL RECORD

VOID IF ALTERED OR ERASED

