2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P96000011083

FILED
Mar 22, 2000 8:00 am
Secretary of State

03-22-2000 90013 017 ***150.00

1. Entity Name

P & T PLUMBING, INC.

Principal Place of Business	Mailing Address
P & T PLUMBING INC PO BOX 13371 MEXICO BEACH FL 32410 US	P.O. BOX 13371 MEXICO BEACH FL 32410-3371

2. Principal Place of Business	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

DO NOT WRITE IN THIS SPACE

4. FEI Number 59-3364221 — 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
STOMP, PATRICK J 205 VIRGINIA AVE MEXICO BEACH FL 32410	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 _____
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 $150.00
After MAY 1, 2000 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	P	☐ Delete	TITLE	☐ Change ☐ Addition
NAME	STOMP, PATRICK		NAME	
STREET ADDRESS	254 PINE ST		STREET ADDRESS	
CITY-ST-ZIP	ST JOE BEACH FL		CITY-ST-ZIP	
TITLE	VP	☐ Delete	TITLE	☐ Change ☐ Addition
NAME	STOMP. TRACIE		NAME	
STREET ADDRESS	254 PINE ST		STREET ADDRESS	
CITY-ST-ZIP	ST JOE BEACH FL		CITY-ST-ZIP	
TITLE	AS	☒ Delete	TITLE	☐ Change ☐ Addition
NAME	MADRID, VINI	DECEASED	NAME	
STREET ADDRESS	1619 MONUMENT AVE APT 1A		STREET ADDRESS	
CITY-ST-ZIP	PORT ST JOE FL		CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	

CR2E034 (9/99)

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: Patrick Stomp — 03/17/00 — 850-647-8947

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

9600001108J

Attachment
00042834

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY
FLORIDA

LOCAL FILE NO 000201

DECEDENT

1. DECEDENT'S NAME — FIRST: Jorge — MIDDLE: Vinicid — LAST: Madrid
2. SEX: Male
3. DATE OF DEATH (Month Day Year): February 1, 2000
4. SOCIAL SECURITY NUMBER: 333-84-0096
5a. AGE (Last Birthday years): 40
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 Day: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): January 18, 1960
7. BIRTHPLACE (City and State or Foreign Country): Guatemala
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No): No
9a. PLACE OF DEATH (Check only one - see instructions on other side): HOSPITAL __ Inpatient __ ER/Outpatient X DOA; OTHER __ Nursing Home __ Residence __ Other (Specify)
9b. INS DE CITY LIMITS? (Yes or No): Yes
9c. FACILITY NAME (If not institution, give street and number): Bay Medical Center
9d. CITY, TOWN, OR LOCATION OF DEATH: Panama City
9e. COUNTY OF DEATH: Bay
10. GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE. DO NOT USE RETIRED
10a. DECEDENT'S USUAL OCCUPATION: Plumber
10b. KIND OF BUSINESS/INDUSTRY: Commercial
11. MARITAL STATUS (Married, Never Married, Widowed, Divorced (Specify)): Married
12. SURVIVING SPOUSE (If wife, give maiden name): Pamela Stomp
13a. RESIDENCE — STATE: Florida
13b. COUNTY: Bay
13c. CITY, TOWN, OR LOCATION: Mexico Beach
13d. STREET AND NUMBER: 203 Virginia Drive
13e. INSIDE CITY LIMITS? (Yes or No): Yes
13f. ZIP CODE: 32410
14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes — If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.): No X Yes — Specify: Guatemalan
15. RACE — American Indian, Black, White, etc. Specify: White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+)

PARENTS

17. FATHER'S NAME (First, Middle, Last): Ervin Madrid
18. MOTHER'S NAME (First, Middle, Maiden Surname): Teresa Fajardode
19a. INFORMANT'S NAME (Type or Print): Pamela Madrid
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 13814, Mexico Beach, Florida 32410

DISPOSITION

20a. METHOD OF DISPOSITION: __ Burial X Cremation __ Removal from State __ Donation __ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Southerland Cremation Services
20c. LOCATION — City or Town, State: Panama City, Florida
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: [signature]
21b. LICENSE NUMBER (of Licensee): 4486
21c. NAME AND ADDRESS OF FACILITY: Gilmore-Southerland Funeral Home, 507 10th St., Port St. Joe, Florida 32456

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

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]
23b. DATE SIGNED (Mo., Day, Yr.): February 3, 2000
23c. HOUR OF DEATH: 2200 hours
23d. MEDICAL EXAMINER'S CASE #: 00-14-00038

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print): Andrea N. Minyard, M.D. 3737 Frankford Avenue Panama City, Florida 32405
25a. SUBREGISTRAR — SIGNATURE AND DATE ▶
25b. LOCAL REGISTRAR — SIGNATURE: [signature]
25c. DATE REGISTERED: 2/8/00

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.
Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF)
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)
c. DUE TO (OR AS A CONSEQUENCE OF)
d.
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): Yes
27b. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? (Yes or No): Yes
28. CASE REPORTED TO MEDICAL EXAMINER? (Yes or No): 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: Natural
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, 9/96 (Replaces HRS Form 512)

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

BY Cheryl S. Murray, Chief Deputy State Registrar

2/8/00

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.

11152544

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 1584 (10/98)

CERTIFICATION OF VITAL RECORD

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED