

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Jun 06, 2003 8:00 am
Secretary of State

06-06-2003 90044 036 ***150.00

0576770 AV

DOCUMENT # P96000053023



1. Entity Name
FOE LANDSCAPING, INC.

Principal Place of Business
**3011 ENDSLEY ROAD
BROOKSVILLE FL 34609**

Mailing Address
**3011 ENDSLEY ROAD
BROOKSVILLE FL 34609**



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 **59-3391711**

Applied For
Not Applicable

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

☐ CHECK HERE IF MAKING CHANGES

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**FOE, CHARLOTTE M
3011 ENDSLEY RD
BROOKSVILLE FL 34609**

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. I am familiar with, and accept the obligations of registered agent.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

**FILE NOW!!! FEE IS \$150.00
After May 1, 2003 Fee will be \$550.00
Make Check Payable to Florida Department of State**

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 **P** ☐ Delete
NAME **FOE, STEPHEN O**
STREET ADDRESS **3011 ENDSLEY ROAD**
CITY-ST-ZIP **BROOKSVILLE FL 34609**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE **VP** ☐ Delete
NAME **FOE, CHARLOTTE M**
STREET ADDRESS **3011 ENDSLEY ROAD**
CITY-ST-ZIP **BROOKSVILLE FL 34609**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE ☐ Delete
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STREET ADDRESS
CITY-ST-ZIP

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TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

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: **X Stephen O. Foe**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

X 6/04/03
Date

X 3527996963
Daytime Phone #

CR2E034 (10/02)

OFFICE of VITAL STATISTICS

CERTIFIED COPY

Affidavit #
80124807
PA6000053023CERTIFICATE OF DEATH
FLORIDA

LOCAL FILE NO.

1. DECEDENT'S NAME James Edward McKenzie			2 SEX Male							
3. DATE OF DEATH (Month, Day, Year) April 24, 2003		4. SOCIAL SECURITY NUMBER 010 01 7953		5a. AGE-Last Birthday (years) 83		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 Day Hours Minutes		
6. DATE OF BIRTH (Month, Day, Year) May 29, 1919		7. BIRTHPLACE (City and State or Foreign Country) Holyoke, Massachusetts			8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) Yes					
9a. PLACE OF DEATH (Check only one: see instructions on other side) HOSPITAL: Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <input type="checkbox"/>					9b. INSIDE CITY LIMITS? (Yes or No) Yes					
9c. FACILITY NAME (If not institution, give street and number) Largo Medical Center			9d. CITY, TOWN, OR LOCATION OF DEATH Largo			9e. COUNTY OF DEATH Pinellas				
10a. DECEDENT'S USUAL OCCUPATION Career Military		10b. KIND OF BUSINESS/INDUSTRY U.S. ARMY		11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Widowed		12. SURVIVING SPOUSE (If alive, give maiden name)				
13a. RESIDENCE - STATE Florida		13b. COUNTY Pinellas		13c. CITY, TOWN, OR LOCATION Seminole		13d. STREET AND NUMBER 11950 68th Avenue North				
13e. INSIDE CITY LIMITS? (Yes or No) Yes		13f. ZIP CODE 33772		14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes - If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:		15. RACE - American Indian, Black, White, etc. Specify: White		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 4		
17. FATHER'S NAME (First, Middle, Last) John McKenzie			18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte Curtin							
19a. INFORMANT'S NAME (Type/Print) Robert J. McKenzie			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 5th Avenue NE #270- St. Petersburg, FL 33701							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Bay Pines National Cemetery			20c. LOCATION - City or Town, State Bay Pines, Florida				
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH E. James Reese			21b. LICENSE NUMBER (of Licensee) 1599		21c. NAME AND ADDRESS OF FACILITY E. James Reese Funeral Home, P.A. 6767 Seminole Blvd. Seminole, Fla. 33772					
22a. 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) David H. Silverstein, M.D.			22b. DATE SIGNED (Mo., Day, Yr) April 24, 2003			22c. HOUR OF DEATH 3:19 P.			22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) David H. Silverstein, M.D.	
23a. To be Completed by MEDICAL EXAMINER ONLY 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) Joanne Hunter			23b. DATE SIGNED (Mo., Day, Yr) April 25, 2003			23c. HOUR OF DEATH Approximate Interval Between Onset and Death			23d. MEDICAL EXAMINER'S CASE #	
24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print) David H. Silverstein, M.D. 5880-49th. St. No. #207 St. Pete., Fla. 33709										
25a. SUBREGISTRAR - SIGNATURE AND DATE Joanne Hunter					25b. LOCAL REGISTRAR - SIGNATURE Joanne Hunter			25c. DATE REGISTERED April 25, 2003		
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) -> a. MULTIPLE DISEASES OF THE AGED b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. 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										
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) no		27b. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? (Yes or No) no		28. CASE REPORTED TO MEDICAL EXAMINER? (Yes or No) no	
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		
Natural		32e. PLACE OF INJURY - At home, farm, street, factory, etc. (Specify)		32f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						

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

BY

Carolyn DeLuggiero
Chief Deputy Registrar, Pinellas County

State Registrar

issued: Apr. 29, 2003

WARNING:

10082748

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.

HEALTH

DOH FORM 150-1A (3/95)

CERTIFICATION OF VITAL RECORD