2000 UNIFORM BUSINESS REPORT (UBR)

FILED
Feb 16, 2000 8:00 am
Secretary of State
02-16-2000 90062 033 ***150.00

DOCUMENT # P97000010463

1. Entity Name

ST. CLOUD INTERNATIONAL TILE, INC.

Principal Place of Business	Mailing Address
1318 MICHIGAN AVE ST CLOUD FL 34769	1318 MICHIGAN AVE ST CLOUD FL 34769-4537

000022310

DO NOT WRITE IN THIS SPACE

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 59-3460010 ☐ 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
QUARBERG, MARIA F 1318 MICHIGAN AVE ST CLOUD FL 34769	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 NAME STREET ADDRESS CITY-ST-ZIP	PD QUARBERG, MARIA F 1318 MICHIGAN AVE ST CLOUD FL 34769	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VD QUARBERG, HILMAR 1318 MICHIGAN AVE ST CLOUD FL 34769	☒ 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
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
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition

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: M. Maria Quarberg 2/10/00 407-892-8177
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

P9710000104463

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDA

VOID IF ALTERED OR ERASED

LOCAL FILE NO.

1. DECEDENT'S NAME — FIRST	MIDDLE	LAST	2. SEX
HILMAR	A.	QUARBERG	MALE

3. DATE OF DEATH (Month, Day, Year)	4. SOCIAL SECURITY NUMBER	5a. AGE-Last Birthday (years)	5b. UNDER 1 YEAR: Months	Days	5c. UNDER 1 Day: Hours	Minutes
December 16, 1999	225-46-6957	73				

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)
January 21, 1926	Alma, Wisconsin	

9a. PLACE OF DEATH (Check only one - see instructions on other side)
HOSPITAL — Inpatient — ER/Outpatient — DOA — OTHER — Nursing Home X Residence — Other (Specify)

9b. INSIDE CITY LIMITS? (Yes or No): Yes

9c. FACILITY NAME (If not institution, give street and number)	9d. CITY, TOWN, OR LOCATION OF DEATH	9e. COUNTY OF DEATH
2757 Andes Way	St. Cloud	Osceola

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)
Owner	Tile Business	Married	Maria Ferreira

13a. RESIDENCE — STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Florida	Osceola	St. Cloud	2757 Andes Way

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 (1-4 or 5+)
Yes	34769	X No — Yes Specify:	White		4

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Joseph Quarberg	Jessie Hanson

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Maria Quarberg	2757 Andes Way St. Cloud, Florida 34769

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION — City or Town, State
— Burial — Cremation X Removal from State — Donation — Other (Specify)	Modena Lutheran Cemetery	Modena, Wisconsin

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (of Licensee)	21c. NAME AND ADDRESS OF FACILITY
[signature]	3890	Osceola Memory Gardens Funeral Home 1717 Boggy Creek Road Kissimmee, Florida 34744

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) [signature]

22b. DATE SIGNED (Mo., Day, Yr.)	22c. HOUR OF DEATH
12-20-99	12:50 P.M.

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)

23b. DATE SIGNED (Mo., Day, Yr.)	23c. HOUR OF DEATH
	A.M.

23d. MEDICAL EXAMINER'S CASE #

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print)
Dr. Joseph A. McClure 200 E. Sheridan Road Suite I Melbourne, Florida 32901

25a. SUBREGISTRAR — SIGNATURE AND DATE	25b. LOCAL REGISTRAR — SIGNATURE	25c. DATE REGISTERED
	[signature] Margaret Lane	DEC 23 1999

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

BY [signature] Margaret Lane State Registrar DEC 27 1999

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.

10703496

FLORIDA DEPARTMENT OF HEALTH

DOH FORM 1564 (10/98)

CERTIFICATION OF VITAL RECORD