

Erin Tribble
Florida Information Associates, Inc.
Requester's Name

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Office Use Only

CORPORATION NAME(S) & DOCUMENT NUMBER(S), (if known):

1. TECHNICAL MARINE PLANNING (OVERSEAS) INC.
(Corporation Name) (Document #)

2. _____
(Corporation Name) (Document #)

3. _____
(Corporation Name) (Document #)

4. _____
(Corporation Name) (Document #)

☒ Walk in

☐ Pick up time _____

☐ Certified Copy

☐ Mail out

☐ Will wait

☐ Photocopy

☐ Certificate of Status

NEW FILINGS

- ☐ Profit
- ☐ Not for Profit
- ☐ Limited Liability
- ☐ Domestication
- ☐ Other

AMENDMENTS

- ☐ Amendment
- ☒ Resignation of R.A., Officer/Director
- ☐ Change of Registered Agent
- ☐ Dissolution/Withdrawal
- ☐ Merger

OTHER FILINGS

- ☐ Annual Report
- ☐ Fictitious Name

REGISTRATION/QUALIFICATION

- ☐ Foreign
- ☐ Limited Partnership
- ☐ Reinstatement
- ☐ Trademark
- ☐ Other

Resignation
Officer
FILED
02 MAR 20 AM 11:15
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

300005136633--1
-03/20/02--01001--019
*****70.00 *****35.00

Examiner's Initials

AR

3/20/02

OFFICER RESIGNATION

I, Christine Bulgarides, hereby request that my late husband, Peter C. Bulgarides, be immediately removed as President and Director of TECHNICAL MARINE PLANNING (OVERSEAS), INC., a corporation organized under the laws of the State of Florida and affirm that the corporation has been notified in writing of the request that my husband be removed. In addition, I have attached a copy of a death certificate as evidence of the death of my husband.

FILED
MAR 20 AM 11:15
CLERK OF STATE
TALLAHASSEE, FLORIDA

C. Bulgarides

Christine Bulgarides, authorized representative and
wife of the deceased President/Director

STATE OF FLORIDA)
) SS:
COUNTY OF MIAMI-DADE)

I HEREBY CERTIFY that on this day, before me, personally appeared Christine Bulgarides, who is well known to me to be the person described in and who executed this Resignation as authorized representative and wife of Peter C. Bulgarides, and acknowledged before me that she executed the same freely and voluntarily for the purposes therein expressed.

15 SWORN TO AND SUBSCRIBED before me at the County and State last aforesaid this day of February 2002.



[Signature]
NOTARY PUBLIC
STATE OF FLORIDA AT-LARGE

My Commission Expires:

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDATYPE OR
PRINT IN
PERMANENT
BLACK INK

LOCAL FILE NO.		1 DECEDENT'S NAME FIRST PETER MIDDLE C. LAST BULGARIDES		2 SEX MALE	
3 DATE OF DEATH (Month, Day, Year) AUGUST 10, 2001		4 SOCIAL SECURITY NUMBER 594-13-4637		5a AGE-Last Birthday (years) 72	
6 DATE OF BIRTH (Month, Day, Year) SEPTEMBER 28, 1928		7 BIRTHPLACE (City and State or Foreign Country) GREECE		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 <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		9b INSIDE CITY LIMITS? (Yes or No) YES			
9c FACILITY NAME (If not institution, give street and number) CEDARS MEDICAL CENTER		9d CITY, TOWN, OR LOCATION OF DEATH MIAMI		9e COUNTY OF DEATH MIAMI DADE	
10a DECEDENT'S USUAL OCCUPATION MECHANICAL ENGINEER		10b KIND OF BUSINESS/INDUSTRY CRUISE LINE		11 MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) MARRIED	
12 SURVIVING SPOUSE (If wife, give maiden name) CHRISTINA BERMAN					
13a RESIDENCE - STATE FLORIDA		13b COUNTY MIAMI DADE		13c CITY, TOWN, OR LOCATION MIAMI	
13d STREET AND NUMBER 5110 S.W. 73rd. TERRACE					
13e INSIDE CITY LIMITS? (Yes or No) NO		13f ZIP CODE 33143		14 WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes - If yes, specify Mexican, Cuban, Mexican, Puerto Rican, etc.) NO	
15 RACE - American Indian, Black, White, etc. Specify WHITE		16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (18-12) 4			
17 FATHER'S NAME (First, Middle, Last) CONSTANTINOS BULGARIDES		18 MOTHER'S NAME (First, Middle, Maiden Surname) PENELOPE GOUNARAKIS			
19a INFORMANT'S NAME (Type/Print) ANNA MARIA BULGARIDES		19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7255 S.W. 54th. AVENUE MIAMI, FLORIDA 33144			
20a METHOD OF DISPOSITION Burial <input type="checkbox"/> Cremation <input checked="" 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) ALLEN & SHAW CREMATIONS, INC.		20c LOCATION - City or Town, State OPA LOCKA, FLORIDA	
21a SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>[Signature]</i>		21b LICENSE NUMBER (of Licensee) #1093		21c NAME AND ADDRESS OF FACILITY AHERN PLUMMER FUNERAL HOME 6001 BIRD ROAD MIAMI, FLORIDA 33155	
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) <i>[Signature]</i>		22b DATE SIGNED (Mo., Day, Yr.) AUGUST 13, 2001		22c HOUR OF DEATH 11:45 A.M.	
22d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) DR. COHEN M.D.		22e LOCAL REGISTRAR - SIGNATURE <i>[Signature]</i>			
22f DATE REGISTERED AUG 16 2001		22g DATE OF DEATH AUG 10 2001			
23a IMMEDIATE CAUSE (Final disease or condition resulting in death) CARDIAL ARREST, ASYSTOLE		23b DATE REGISTERED AUG 16 2001			
23c SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ADULT RESPIRATORY DISTRESS SYNDROME DUE TO (OR AS A CONSEQUENCE OF) PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF) MYELODYSPLASTIC SYNDROME		23d DATE REGISTERED AUG 16 2001			
24 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print) DR. COHEN M.D. 1321 N.W. 14th. STREET #207 MIAMI, FLORIDA 33125		25a LOCAL REGISTRAR - SIGNATURE <i>[Signature]</i>			
25b DATE REGISTERED AUG 16 2001		25c DATE OF DEATH AUG 10 2001			
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 CARDIAL ARREST, ASYSTOLE		26b DATE REGISTERED AUG 16 2001			
26c SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ADULT RESPIRATORY DISTRESS SYNDROME DUE TO (OR AS A CONSEQUENCE OF) PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF) MYELODYSPLASTIC SYNDROME		26d DATE REGISTERED AUG 16 2001			
27a WAS AN AUTOPSY PERFORMED? (Yes or No) NO		27b WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? (Yes or No) NO		27c CASE REPORTED TO MEDICAL EXAMINER? (Yes or No) YES	
28 IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? YES NO		29a IF SURGERY IS MENTIONED IN PART I OR II ENTER CONDITION FOR WHICH IT WAS PERFORMED		29b DATE OF SURGERY (Mo., Day, Year)	
30 PROBABLE MANNER OF DEATH (Specify) Natural, accident, suicide, homicide, or undetermined		31a DATE OF INJURY (Month, Day, Year)		31b TIME OF INJURY	
31c INJURY AT WORK? (Yes or No)		31d DESCRIBE HOW INJURY OCCURRED			
32a PLACE OF INJURY - At home, farm, street, factory, etc. (Specify)		32b LOCATION (Street and Number or Rural Route Number, City or Town, State)			

OH 512, 9/94
(Replaces HRS
Form 512)

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

BY

*Maurice Darden*AUG 16 2001
State Registrar

WARNING:

12511665

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.

DOH FORM 1564 (10/98)

FLORIDA DEPARTMENT OF
HEALTH