


2006 FOR PROFIT CORPORATION ANNUAL REPORT


FILED
Apr 18, 2006 8:00 am
Secretary of State

04-18-2006 90066 022 ***150.00

DOCUMENT # P97000044597

1. Entity Name
GARY E. MASSEY, P.A.



Principal Place of Business  Massey
 1150 Winderwycke Ct
 Winter Spgs, FL 32708

Mailing Address
 100 W CITRUS ST
 ALTAMONTE SPRINGS, FL 32714-2502
*208 1150 Winderwycke Ct
 Winter Springs FL*

Suite, Apt. #, etc. Suite, Apt. #, etc.

City & State City & State

Zip Country Zip Country



02082006 Chg-P CR2E034 (11/05)

4. FEI Number **59-3452132** Applied For Not Applicable

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

6. Name and Address of Current Registered Agent
MASSEY, GARY E
 100 W CITRUS ST
 ALTAMONTE SPRINGS, FL 32714-2502
Deceased


7. Name and Address of New Registered Agent
 Name *Paula Massey*
 Street Address (P.O. Box Number is Not Acceptable)
1150 Winderwycke Ct
 City *Winter Springs* FL Zip Code *32708*

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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

FILE NOW!!! FEE IS \$150.00 After May 1, 2006 Fee will be \$550.00

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 NAME STREET ADDRESS CITY-ST-ZIP	PSTD MASSEY, GARY E. 100 W CITRUS ST ALTAMONTE SPRINGS, FL 32714 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<i>Secretary Paula</i>  Massey 1150 Winderwycke Ct Winter Spgs, FL 32708 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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: *Paula Massey* 4-10-06 407-896-3261
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY ATTACHMENT

40052179

#P97000044597

FLORIDA CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last, Suffix) Gary Earl Massey 2. SEX Male 3. DATE OF BIRTH (Month, Day, Year) November 3, 1946 4a. AGE-Last Birthday (Years) 58 4b. UNDER 1 YEAR Months Days 4c. UNDER 1 DAY Hours Minutes 5. DATE OF DEATH (Month, Day, Year) January 4, 2005 6. SOCIAL SECURITY NUMBER 266-82-0756 7. BIRTHPLACE (City and State or Foreign Country) Lakeland, Florida 8. COUNTY OF DEATH Seminole 9. PLACE OF DEATH (Check only one) HOSPITAL: X Inpatient Emergency Room/Outpatient Dead on Arrival NON-HOSPITAL: Hospice Facility Nursing Home/Long Term Care Facility Decedent's Home Other (Specify) 10. FACILITY NAME (If not institution, give street address) South Seminole Hospital 11a. CITY, TOWN, OR LOCATION OF DEATH Longwood 11b. INSIDE CITY LIMITS? X Yes No 12. MARITAL STATUS (Specify) X Married Married, but Separated Widowed Divorced Never Married 13. SURVIVING SPOUSE'S NAME (If wife, give maiden name) Paula Ann Naughton 14a. RESIDENCE - STATE Florida 14b. COUNTY Seminole 14c. CITY, TOWN, OR LOCATION Winter Springs 14d. STREET ADDRESS 1150 Winderwycke Court 14e. APT. NO. 14f. ZIP CODE 32708 14g. INSIDE CITY LIMITS? X Yes No 15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) (Do not use "Retired") Attorney 15b. KIND OF BUSINESS/INDUSTRY Law 16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.) X White Black or African American American Indian or Alaskan Native (Specify tribe) Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian (Specify) Native Hawaiian Guamanian or Chamorro Samoan Other Pacific Isl. (Specify) Other (Specify) 17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin.) Yes X No Mexican Puerto Rican Cuban Central/South American Haitian 18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.) 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 20. FATHER'S NAME (First, Middle, Last, Suffix) Earl Monroe Massey 21. MOTHER'S NAME (First, Middle, Maiden Surname) Ollie Mae Sears 22a. INFORMANT'S NAME Phyllis A. Massey 22b. RELATIONSHIP TO DECEDENT Wife 22c. INFORMANT'S MAILING - STATE Florida 22d. CITY OR TOWN Winter Springs 22e. STREET ADDRESS 1150 Winderwycke Court 22f. ZIP CODE 32708 24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Forest Hill Cemetery 25a. LOCATION - STATE Florida 25b. LOCATION - CITY OR TOWN Haines City 26a. METHOD OF DISPOSITION X Burial Entombment Cremation Donation Removal from State Other (Specify) 26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? 27a. LICENSE NUMBER (of Licensee) 4650 27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH [Signature] 28. NAME OF FUNERAL FACILITY Family Funeral Care 28a. FACILITY'S MAILING - STATE Florida 28b. CITY OR TOWN Oviedo 28c. STREET ADDRESS 7565 Red Bug Lake Road 28d. ZIP CODE 32765 30. CERTIFIER X Certifying Physician - To the best of my knowledge, death occurred at the time, place, and due to the cause(s) and manner stated. (Check one) Medical Examiner - On the basis of coroner's inquest, medical investigation in my office, death occurred at the time, date and place, due to the cause(s) and manner stated. 31a. (Signature and Title of certifier) [Signature] 31b. DATE SIGNED (Month, Day, Year) 2005 33. MEDICAL EXAMINER'S CASE NUMBER 34a. LICENSE NUMBER (of Certifier) 0003300 34b. CERTIFIER'S NAME Gregory P. Samano, Sr., D.O. 35. NAME OF ATTENDING PHYSICIAN (If other than Certifier) 36a. CERTIFIER'S STATE Florida 36b. CITY OR TOWN Winter Park 36c. STREET ADDRESS 2830 Casa Aloma Way 36d. ZIP CODE 32792 37. SUBREGISTRAR [Signature] 38a. LOCAL REGISTRAR [Signature] 38b. DATE FILED BY REGISTRAR (Month, Day, Year) January 13, 2005

VOID IF ALTERED OR ERASED

Michael J. [Signature]

DOH-SEMINOLE CHD LOCAL REGISTRAR

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE 1/13/2005

WARNING: THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH A WATERMARK OF THE GREAT SEAL OF THE STATE OF FLORIDA ON THE FRONT AND THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK



B1285036

CERTIFICATION OF VITAL RECORD

