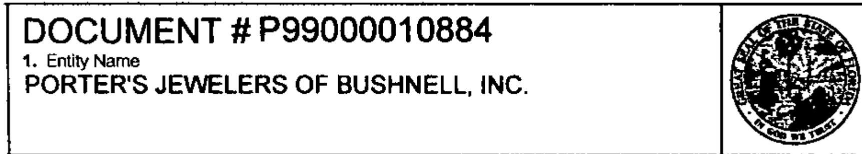

2006 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Jul 26, 2006 8:00 am
Secretary of State

07-26-2006 90001 017 ***158.75

DOCUMENT # P99000010884

1. Entity Name
PORTER'S JEWELERS OF BUSHNELL, INC.

Principal Place of Business	Mailing Address
890 N MAIN ST BUSHNELL, FL 33513	890 N MAIN ST BUSHNELL, FL 33513

50023184

07102006 Chg-P CR2E034 (11/05)

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: 59-3558319 ☐ 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
PORTER, WILLIAM H III. 890 N MAIN ST BUSHNELL, FL 33513	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
Due by September 6, 2006

9. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice.

10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	P PORTER, WILLIAM H III 890 N MAIN ST BUSHNELL, FL 33513	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	V PORTER, C. CONRAD 890 N MAIN ST BUSHNELL, FL 33513	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	T PORTER, PAMELA J 890 N MAIN ST BUSHNELL, FL 33513	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	Pamela J. Porter Sec. + Treas.	☒ Change ☒ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	S PORTER, ELLEN W 890 N MAIN ST BUSHNELL, FL 33513	☒ 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

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: William H. Porter III — 7/22/06 — 352-568-1153
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

#P99000010884

To Whom It May Concern:

We did not Recieve our Renewal notice for our cooperation. The bookkeeper asked us about it. We did not file because we did not get a form. We got a form from The internet & are sending it & payment. Please note there is a Change. Ellen Porter has been deleted, death Certificate enclosed. Also note that Pamela Porter will now serve as Secretary & Treasure - Thanks for your cooperation on the above changes -

Sincerly,
W. A. Porter III

ATTACHMENT

S0023184

#P99000010889

OFFICE of VITAL STATISTICS

CERTIFIED COPY

FLORIDA CERTIFICATE OF DEATH

TYPE IN PERMANENT BLACK INK

LOCAL FILE NO.

Field	Entry
1. DECEDENT'S NAME (First, Middle, Last, Suffix)	Mary Ellen Porter
2. SEX	Female
3. DATE OF BIRTH (Month, Day, Year)	May 11, 1935
4a. AGE-Last Birthday (Years)	70
4b. UNDER 1 YEAR (Months / Days)	
4c. UNDER 1 DAY (Hours / Minutes)	
5. DATE OF DEATH (Month, Day, Year)	January 20, 2006
6. SOCIAL SECURITY NUMBER	267-52-1790
7. BIRTHPLACE (City and State or Foreign Country)	Archer, Florida
8. COUNTY OF DEATH	Citrus
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)	Citrus Memorial Hospital
11a. CITY, TOWN, OR LOCATION OF DEATH	Inverness
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)	William Porter
14a. RESIDENCE - STATE	Florida
14b. COUNTY	Citrus
14c. CITY, TOWN, OR LOCATION	Inverness
14d. STREET ADDRESS	1112 Hillside Ct.
14e. APT. NO.	
14f. ZIP CODE	34450
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"	Office Manager
15b. KIND OF BUSINESS/INDUSTRY	Insurance Office
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 (If Yes, specify) X No ___ Mexican ___ Puerto Rican ___ Cuban ___ Central/South American ___ Other Hispanic (Specify) ___ Haitian
18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.)	___ 8th or less ___ High school but no diploma X High school diploma or GED ___ College but no degree ___ College degree (Specify): ___ Associate ___ Bachelor's ___ Master's ___ Doctorate
19. WAS DECEDENT EVER IN U.S. ARMED FORCES?	___ Yes X No
20. FATHER'S NAME (First, Middle, Last, Suffix)	Edward Wear
21. MOTHER'S NAME (First, Middle, Maiden Surname)	Millie Butler
22a. INFORMANT'S NAME	William Porter
22b. RELATIONSHIP TO DECEDENT	Spouse
23a. INFORMANT'S MAILING - STATE	Florida
23b. CITY OR TOWN	Inverness
23c. STREET ADDRESS	1112 Hillside Ct.
23d. ZIP CODE	34450
24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	Oak Ridge Cemetery
25a. LOCATION - STATE	Florida
25b. LOCATION - CITY OR TOWN	Inverness
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?	___ Yes ___ No
27a. LICENSE NUMBER (of Licensee)	FE 4593
27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	Todd J. McBride (signature)
28. NAME OF FUNERAL FACILITY	Inverness Chapel of Hooper Funeral Homes
29a. FACILITY'S MAILING - STATE	Florida
29b. CITY OR TOWN	Inverness
29c. STREET ADDRESS	501 W. Main St.
29d. ZIP CODE	34450

DEMOGRAPHIC INFORMATION TO BE COMPLETED BY: FUNERAL DIRECTOR

30. CERTIFIER: (Check one) X Certifying Physician - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. ___ Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, due to the cause(s) and manner stated.

Field	Entry
31a. (Signature and Title of Certifier)	PHYSICIAN SIGNATURE (signature)
31b. DATE SIGNED (mm/dd/yyyy)	1/23/06
32. TIME OF DEATH (24 hr.)	0830
33. MEDICAL EXAMINER'S CASE NUMBER	
34a. LICENSE NUMBER (of Certifier)	ME43357
34b. CERTIFIER'S NAME	Craig Englund MD
35. NAME OF ATTENDING PHYSICIAN (If other than Certifier)	
36a. CERTIFIER'S - STATE	Florida
36b. CITY OR TOWN	Inverness
36c. STREET ADDRESS	801 Medical Court East
36d. ZIP CODE	34452
37. SUBREGISTRAR - Signature and Date	
38a. LOCAL REGISTRAR - Signature	Sherry L. Dandy CDR (signature)
38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.)	January 24, 2006

MEDICAL CERTIFIER

Field	Entry
39. PROBABLE MANNER OF DEATH	X Natural. The following are under the jurisdiction of the medical examiner: ___ Accident ___ Suicide ___ Homicide ___ Pending Investigation ___ Undetermined
40. REPORTED TO MEDICAL EXAMINER DUE TO CAUSE OF DEATH?	___ Yes X No

41. CAUSE OF DEATH - PART I. (See instructions on back) Enter the chain of events - diseases, injuries, or complications - that directly caused the death. Enter only one cause on a line. DO NOT enter terminal event such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology.

Line	Cause	Approximate Interval: Onset to Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Acute Myelocytic Leukemia	2 weeks
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST b.	Due to (or as a consequence of):	
c.	Due to (or as a consequence of):	
d.		

Field	Entry
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.	
42a. WAS AN AUTOPSY PERFORMED?	___ Yes X No
42b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?	___ Yes ___ No
43a. IF SURGERY MENTIONED IN PART I OR II, ENTER REASON FOR SURGERY	
43b. DATE OF SURGERY (Mo., Day, Yr.)	
44. DID TOBACCO USE CONTRIBUTE TO DEATH?	___ Yes ___ No ___ Probably ___ Unknown
45. IF FEMALE, WAS SHE PREGNANT WITHIN THE PAST YEAR:	___ Yes X No ___ Unknown. If Yes, specify timeframe: ___ at time of death ___ within 1 to 42 days of death ___ within 43 days to 1 year of death
46. DATE OF INJURY (Month, Day, Year)	
47. TIME OF INJURY (24 hr.)	
48. INJURY AT WORK?	___ Yes ___ No
49a. LOCATION OF INJURY - STATE	
49b. CITY OR TOWN	
49c. STREET ADDRESS	
49d. APT. NO.	
49e. ZIP CODE	
50. DESCRIBE HOW INJURY OCCURRED	
51. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)	
IF TRANSPORTATION INJURY, 52a. Status of Decedent	___ Driver/Operator ___ Passenger ___ Pedestrian ___ Other (Specify)
52b. Type of Vehicle	___ Car/Minivan ___ S.U.V. ___ Motorcycle ___ Pickup Truck/Cargo Van ___ Bus ___ Heavy Transport ___ Other (Specify)

CAUSE OF DEATH TO BE COMPLETED BY: MEDICAL CERTIFIER

DH Form 512, Jul. 2004 (Obsoletes previous editions which may not be used)

State of Florida, Department of Health, Vital Statistics

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

Sherry L. Dandy CDR JAN 24 2006

CITRUS COUNTY HEALTH DEPT.

FLORIDA DEPARTMENT OF HEALTH

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.

DH FORM 1947 (08/04)

C2071959

CERTIFICATION OF VITAL RECORD