2008 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Aug 07, 2008 8:00 am
Secretary of State
08-07-2008 90063 008 ***150.00

DOCUMENT # P99000096269

1. Entity Name

L. GRANATO SERVICES, INC.

Principal Place of Business	Mailing Address
14659 COLLECTING CANAL RD LOXAHATCHEE FL 33470	14659 COLLECTING CANAL RD LOXAHATCHEE FL 33470

2nd MOORE CR2E034 (4/08)

2. Principal Place of Business - No P.O. Box #		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. FEI Number 59-2473765 ☐ 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
KEMBRA BAYS 14659 COLLECTING CANAL ROAD LOXAHATCHEE FL 33470	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 Lawrence Granato 8-1-08
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

FILE NOW!!! FEE IS $550.00
DUE BY September 3, 2008
Make Check Payable to Florida Department of State

S.607.193(2)(b), F.S., allows for the waiver of the $400.00 late fee. By checking this box, the corporation certifies it did not receive prior notice. Fee to file is $150.00. ☑

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	PV GRANATO, LAWRENCE L 14659 COLLECTING CANAL RD LOXAHATCHEE FL 33470	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	TS BAYS, KEMBRA L 14659 COLLECTING CANAL ROAD LOXAHATCHEE FL 33470	☑ 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

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: Lawrence Granato 8-1-08
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

STATE OF FLORIDA

ATTACHMENT

OFFICE of VITAL STATISTICS

CERTIFIED COPY

40112849

#P99000096269

TYPE IN PERMANENT BLACK INK

LOCAL FILE NO. 6008-4674

FLORIDA CERTIFICATE OF DEATH

VOID IF ALTERED OR ERASED

DEMOGRAPHIC INFORMATION TO BE COMPLETED BY: FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last, Suffix)							2. SEX
KEMBRA BAYS KAULEN							FEMALE
3. DATE OF BIRTH (Month, Day, Year)	4a. AGE-Last Birthday (Years)	4b. UNDER 1 YEAR Months	Days	4c. UNDER 1 DAY Hours	Minutes	5. DATE OF DEATH (Month, Day, Year)	
OCTOBER 26, 1961	46					April 30, 2008	
6. SOCIAL SECURITY NUMBER	7. BIRTHPLACE (City and State or Foreign Country)					8. COUNTY OF DEATH	
266-67-7797	HOMESTEAD, FLORIDA					Palm Beach	

9. PLACE OF DEATH (Check only one) HOSPITAL: ___ Inpatient ___ Emergency Room/Outpatient ___ Dead on Arrival
NON-HOSPITAL: ___ Hospice Facility ___ Nursing Home/Long Term Care Facility X Decedent's Home ___ Other (Specify)

10. FACILITY NAME (If not institution, give street address)	11a. CITY, TOWN, OR LOCATION OF DEATH	11b. INSIDE CITY LIMITS?
14659 Collecting Canal Road	Loxahatchee	X Yes ___ No

12. MARITAL STATUS (Specify)	13. SURVIVING SPOUSE'S NAME (If wife, give maiden name)
___ Married ___ Married, but Separated ___ Widowed X Divorced ___ Never Married	

14a. RESIDENCE - STATE	14b. COUNTY	14c. CITY, TOWN, OR LOCATION			
FLORIDA	PALM BEACH	LOXAHATCHEE			
14d. STREET ADDRESS		14e. APT. NO.	14f. ZIP CODE	14g. INSIDE CITY LIMITS?	
14659 COLLECTING CANAL ROAD			33470	X Yes ___ No	

15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) Do not use "Retired"	15b. KIND OF BUSINESS/INDUSTRY
HOMEMAKER	OWN HOME

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.)	19. WAS DECEDENT EVER IN U.S. ARMED FORCES?
___ 8th or less ___ High school but no diploma ___ High school diploma or GED X College but no degree College degree (Specify): ___ Associate ___ Bachelor's ___ Master's ___ Doctorate	___ Yes X No

20. FATHER'S NAME (First, Middle, Last, Suffix)	21. MOTHER'S NAME (First, Middle, Maiden Surname)	
MORGAN WEST BAYS	FRANCIS INEZ HESTER	
22a. INFORMANT'S NAME	22b. RELATIONSHIP TO DECEDENT	22c. INFORMANT'S MAILING - STATE
JACQUELINE LYNN FELCH	DAUGHTER	NORTH CAROLINA
23b. CITY OR TOWN	23c. STREET ADDRESS	23d. ZIP CODE
FAYETTEVILLE	6437 HIDDEN LAKE LOOP, #203	28304
24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	25a. LOCATION - STATE	25b. LOCATION - CITY OR TOWN
NORTHWOOD CREMATORY	FLORIDA	WEST PALM BEACH

26a. METHOD OF DISPOSITION ___ Burial ___ Entombment X 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)	27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH
X Yes ___ No	Fd0602	

28. NAME OF FUNERAL FACILITY	28a. FACILITY'S MAILING - STATE
NORTHWOOD FUNERAL HOME	FLORIDA
29b. CITY OR TOWN	29c. STREET ADDRESS	29d. ZIP CODE
WEST PALM BEACH	5608 BROADWAY	33407

MEDICAL CERTIFIER

30. CERTIFIER: (Check one) ___ 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.
X 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.

31a. (Signature and Title of Certifier)	31b. DATE SIGNED (mm/dd/yyyy)	32. TIME OF DEATH (24 hr.)	33. MEDICAL EXAMINER'S CASE NUMBER
SIGNATURE MD/ME	05/01/2008	1500	08-15-00515
34a. LICENSE NUMBER (of Certifier)	34b. CERTIFIER'S NAME	35. NAME OF ATTENDING PHYSICIAN (If other than Certifier)	
ME54359	Michael Bell, MD/ME		
36a. CERTIFIER'S - STATE	36b. CITY OR TOWN	36c. STREET ADDRESS	36d. ZIP CODE
FL	West Palm Beach	3126 Gun Club Road	33406

37. SUBREGISTRAR - Signature and Date	38a. LOCAL REGISTRAR - Signature	38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.)
5-5-08		MAY 06 2008

State of Florida, Department of Health, Vital Statistics

VOID IF ALTERED OR ERASED