FILED
Jul 25, 2002 8:00 am
Secretary of State
07-10-2002 90193 039 ***550.00

2002 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # V34896

1. Entity Name
TDK RESOURCES INC.

[redacted]

[redacted]

DO NOT WRITE IN THIS SPACE

Principal Place of Business	Mailing Address
9036 WINGED FOOT DRIVE TALLAHASSEE FL 32312	9036 WINGED FOOT DRIVE TALLAHASSEE FL 32312

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 59-3121391 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ **$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent

KOBES, THIERRY E
9036 WINGED FOOT DRIVE
TALLAHASSEE FL 32312

7. Name and Address of New Registered Agent

Name: Diane C. Kobes
Street Address (P.O. Box Number is Not Acceptable): 9036 Winged Foot Drive
City: Tallahassee FL Zip Code: 32312

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: Diane C. Kobes   DATE: 7/22/02
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

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 $550.00
After September 13, 2002 Fee will be $750.00
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	P KOBES, THIERRY E 9036 WINGED FOOT DRIVE TALLAHASSEE FL 32312	☑ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	VT KOBES, DIANE 9036 WINGED FOOT DRIVE TALLAHASSEE FL 32312	☐ 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
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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: Diane C. Kobes / Diane C. Kobes   7/8/02   850 906-9668
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR   Date   Daytime Phone #

CR2E034 (4/02)

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

Attachment # 39649 V34896

CERTIFICATE OF DEATH
FLORIDA

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NO.

DECEDENT

1. DECEDENT'S NAME	FIRST	MIDDLE	LAST	2. SEX
	Thierry	Eugene	Kobes	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
January 16, 2002	062-62-5085	40				

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)
October 29, 1961	Iowa City, Iowa	No

9a. PLACE OF DEATH (Check only one; see instructions on other side)

HOSPITAL: ___ Inpatient ___ ER/Outpatient ___ DOA OTHER: ___ Nursing Home XX Residence ___ Other (Specify)

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

9c. FACILITY NAME (If not institution, give street and number)	9d. CITY, TOWN, OR LOCATION OF DEATH	9e. COUNTY OF DEATH
9036 Winged Foot Drive	Tallahassee	Leon

PARENTS

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)
Lobbyist	Consulting	Married	Diane Chambers

13a. RESIDENCE – STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Florida	Leon	Tallahassee	9036 Winged Foot Drive

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+)
No	32312	XX No ___ Yes Specify:	White	12	4

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Eugene H. Kobes	Monique Dardillac

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Diane Kobes	9036 Winged Foot Dr. Tallahassee, FL. 32312

DISPOSITION

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION – City or Town, State
XX Burial ___ Cremation ___ Removal from State ___ Donation ___ Other (Specify)	MeadowWood Memorial Park	Tallahassee, Flori

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (of Licensee)	21c. NAME AND ADDRESS OF FACILITY
[signature]	4157	Bevis Funeral Home 2710 N. Monroe St. Tallahassee, F

CERTIFIER

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] MD

22b. DATE SIGNED (Mo., Day, Yr.)	22c. HOUR OF DEATH
1/22/02	4:00 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

23d. MEDICAL EXAMINER'S CASE #

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print)
Dr. Frank A. Santoli, 1632 Rigging Rd. Tallahassee, FL. 32308

25a. SUBREGISTRAR – SIGNATURE AND DATE	25b. LOCAL REGISTRAR – SIGNATURE	25c. DATE REGISTERED
▶	▶ [signature]	Jan. 23 '02

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

BY [signature] 1-23-02
State Registrar

WARNING: ANY REPRODUCTION OF THIS DOCUMENT IS PROHIBITED BY LAW. DO NOT ACCEPT UNLESS ON SECURITY PAPER WITH LINES AND SECURITY WATERMARK ON BACK AND COLORED BACKGROUND AND GOLD EMBOSSED GREAT SEAL OF THE STATE OF FLORIDA ON FRONT. ALTERATION OR ERASURE VOIDS THIS CERTIFICATION.

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HRS FORM [illegible]

CERTIFICATION OF VITAL RECORD