

PERPETUAL CARE CEMETERY REGISTRATION FORM

Mail to: Secretary of State, Regulation and Enforcement Division
Post Office Box 136, Jackson, MS 39205-0136
Phone: 601-359-9055; Fax: 601-576-2546
Website: www.sos.ms.gov

NOTE: A \$25.00 registration fee is **REQUIRED** upon submission of this form for new registrations or registration renewals. No fee should be submitted for amendments only. Both the fee and this form must be submitted to the post office box address above prior to **March 31st**. **All registrations expire on March 31st of each year and must be renewed to remain valid.** The report information you submit, items 13 - 15, is submitted for the prior-ending calendar year (January 1 - December 31).

NEW REGISTRATION RENEWAL AMENDMENT OF REGISTRATION

1. Full Legal Business Name:
- Trade Name or any other Names Used:
2.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CEMETERY STREET ADDRESS (P.O. BOX NOT ACCEPTED)	CITY	STATE	ZIP CODE
3.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CEMETERY MAILING ADDRESS	CITY	STATE	ZIP CODE
4. Contact Person's Name and Title:
5. Email Address:
6. Telephone Number: Facsimile Number:
7. Total Number of Acres Included in Cemetery:
8. Company's Principal Place of Business:
9. Date When Cemetery Was Established:
10. Type of Business (select only one):

Sole Proprietorship: <input type="checkbox"/>	Partnership: <input type="checkbox"/>
Limited Liability Company: <input type="checkbox"/>	Association: <input type="checkbox"/>
Corporation: <input type="checkbox"/>	Other: <input type="text"/> <input type="checkbox"/>

If Corp. or LLC,
State of Incorp./Formation:

11. Company's Fiscal Year Beginning Date: Ending Date:

12. Enter the name (first, middle initial, last and generation), title, address, and phone number of all company officers and directors (i.e., the sole proprietor; the partners of your partnership; the officers and/or directors of your association; the managers or members of your limited liability company; or, the officers of your corporation). Use an additional page, if needed:

Name	Title	Address	Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

13. Sales Activity for Calendar Year 20 (Prior Ending Calendar Year).

ITEMS SOLD	NUMBER OF UNITS SOLD	TOTAL <i>CONTRACT</i> SALES MADE IN CALENDAR YEAR	AMOUNT <i>COLLECTED</i> IN CALENDAR YEAR REGARDLESS OF WHEN SALE WAS MADE	AMOUNT <i>SUBMITTED</i> TO TRUST OR CD ON COLLECTIONS
Cemetery Ground Interments	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Mausoleum Crypt Spaces	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Columbarium Niche Spaces	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
TOTAL	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>

14. Perpetual Care Trust:

(Complete this portion of the Form if your business' perpetual care funds are in Trust. Do not answer Question #15.)

A. Perpetual Care Trust Officer/Trust Institution:

PERPETUAL CARE TRUSTEE'S ADDRESS CITY STATE ZIP CODE

Telephone Number: Facsimile Number:

B. Perpetual Care Trust Balance on January 1st of Prior Calendar Year: \$

C. Amount of Interest/Earnings Withdrawn from Perpetual Care Trust: \$

D. Interest/Income Earned by Perpetual Care Trust: \$

E. Perpetual Care Trust Balance on December 31st of Prior Calendar Year: \$

15. Perpetual Care Certificate of Deposit:

(Complete this portion of the Form if your business' perpetual care funds are in a CD. Do not answer Question #14.)

A. Name of Financial Institution where CD is held:

B. CD Balance on January 1st of Prior Calendar Year: \$

(Attach a copy of a statement from the financial institution verifying this amount.)

C. Amount of Interest earned by CD: \$

D. CD Balance on December 31st of Prior Calendar Year: \$

(Attach a copy of a statement from the financial institution verifying this amount.)

Affidavit

I certify that all information provided herein is true and correct to the best of my knowledge.

SIGNATURE OF COMPANY OFFICER OR OTHER AUTHORIZED OFFICER

PRINTED OR TYPED NAME AND TITLE

Sworn to and subscribed before me this the ___ day of _____, 20__.

NOTARY PUBLIC

MY COMMISSION EXPIRES