

SEP 7 11 04 AM '85

STATE OF MISSISSIPPI
COUNTY OF COAHOMA

DURABLE GENERAL POWER OF ATTORNEY FOR HEALTH CARE

NOTICE TO PERSON EXECUTING THIS DOCUMENT

DK 69 PG 610
by: P. N. [unclear]

This is an important legal document. Before executing this document, you should know these important facts:

This document gives the person you designate as the attorney-in-fact (your agent), the power to make health care decisions for you. This power exists only as to those health care decisions to which you are unable to give informed consent. The attorney-in-fact must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

The document gives your agent authority to consent, to refuse to consent or to withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if (a) your agent authorizes anything that is illegal, (b) acts contrary to your known desires, or (c) where your desires are not known, does anything that is clearly contrary to your best interest.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital or other health care provider in writing of the revocation.

Your agent has the right to examine your medical records and to consent to this disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to (a) authorize an autopsy, (b) donate your body or parts thereof for transplant or for educational, therapeutic or scientific purposes, and (c) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

This Power of Attorney will not be valid for making health care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature, or (b) acknowledged before a notary public in the State.

KNOW ALL MEN by these presents that I, **LELAND E. McCAIN**, the undersigned, do hereby name, nominate and appoint my sister, **CAROL M. GASTON**, whose address is P. O. Box 428, Clarksdale, MS 38614, and whose SS# is 587-54-7637, as my true and lawful attorney-in-fact, hereby conferring upon such attorney-in-fact the unlimited authority to consent to, refuse to consent, or to withdraw consent to any care, treatment, service or procedure, to maintain, diagnose or treat me for any physical condition; further conferring upon said attorney-in-fact the authority to make health care decisions for me before or after my death to the same extent as I could make health care decisions for myself if I had the capacity to do so and including, but not limited to:

- a. Making a disposition under the state's anatomical gift act; and
- b. Authorizing an autopsy; and
- c. Directing the disposition of remains.

This authority is granted only to the extent that I am incapacitated to make decisions in my own behalf. As principal, I appoint my above named "agent" to make health and personal care decisions for me as authorized in this document and as authorized by law. By this document I intend to create a durable power of attorney effective upon, and only during, any period of incapacity in which, in the opinion of my agent and attending physician, I am unable to make or communicate a choice regarding a particular health care decision.

I grant to my agent and attorney-in-fact full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise known to my agent. In making any decision, my agent, and attorney-in-fact, shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what

my agent believes to be in my best interest. My agent's authority to interpret my desires is intended to be as broad as possible, except for limitations that I may state below, if any. Accordingly, unless specifically limited herein, my agent is authorized as follows:

- a. To consent, refuse or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, nutritional support and hydration and cardiopulmonary resuscitation; and
- b. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others; and
- c. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service; and
- d. To contract on my behalf for any health care related service or facility on my behalf, without my attorney-in-fact or agent incurring any personal financial liability for such contract; and
- e. To hire and fire medical, social service, and other support personnel responsible for my care; and
- f. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction or hasten the moment of (but not intentionally cause) my death; and
- g. To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law; and
- h. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name and at the expense of my estate to force compliance with my wishes, as determined by my agent, or to seek actual or punitive action for the failure to comply.

~~I have also executed a living will under the laws of the State of Mississippi and under the laws of the State of Tennessee.~~ I do not want my life to be prolonged nor do I

want life sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, expense involved, and the quality as well as the possible extension of my life in making decisions concerning life sustaining treatment. With respect to nutrition and hydration provided by means of a nasogastric tube or tube in the stomach, intestines or veins, I wish to make clear that I intend to include these procedures among the "life sustaining procedures" that may be withheld or withdrawn under the conditions given above.

This General Durable Health Care Power of Attorney is executed by me in compliance with the "Durable Power of Attorney for Health Care Act" of the State of Mississippi, and before executing the same, I have received full notice of the importance of my execution of this instrument as provided in Mississippi Code Annotated Section 41-41-163, and I have received a copy of that statute, have read it and understand it. I have also read and understood the notice at the beginning of this document as required by the law.

I recognize that this instrument is executed in Mississippi, which is the state of my residence, but it is intended that the authority granted to my said attorney-in-fact and agent shall extend and pertain to any health care or health care decisions that may be made in my behalf outside the State of Mississippi, and any health care provider outside the State of Mississippi may rely on the authority granted herein.

If my attorney-in-fact and agent named by me shall die, become legally disabled, resign, refuse to act, be unavailable or (if any agent is my spouse), be legally separated or divorced from me, I name the following (each to act alone and successively, in the order named) as successors to my attorney-in-fact and agent:

a. First Alternate Agent and Attorney-In-Fact:

NAME: James E. McCain
 ADDRESS: 108 Elm Street, Clarksdale, MS 38614
 PHONE: 601-627-7668
 SS #: 428-78-3247

b. Second Alternate Agent and Attorney-In-Fact:

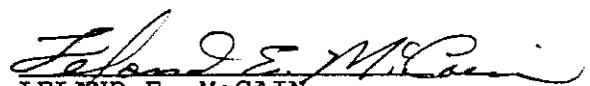
NAME: Danny H. Adkins
 ADDRESS: Rt. 6, Box 530, Byhalia, MS 38611
 PHONE: 601-838-6500
 SS #: 428-98-1131

No person who relies in good faith upon any representations by my agent or successor agent shall be liable to me, my estate, my heirs or assigns, for recognizing the agent's authority. Anywhere the word "Agent" or "Successor Agent" is used, it shall also mean my attorney-in-fact as named herein, and the alternates. If a guardian of my person should for any reason be appointed, I nominate my attorney-in-fact and agent (or his or her successor) named above.

For purposes of the authority of this instrument I revoke any prior power of attorney for health care executed by me. This power of attorney is intended to be valid in any jurisdiction in which it is presented. My agent and attorney-in-fact shall not be entitled to compensation for services performed under this power of attorney, but he or she shall be entitled to reimbursement of all reasonable expenses incurred as a result of carrying out any provision of this power of attorney. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY ATTORNEY-IN-FACT AND AGENT.

I sign my name to this General Durable Health Care Power of Attorney on this 31st day of August, 1995.


 LELAND E. MCCAIN

My social security number is: 427-84-1384

My current home address is: 5883 Cherokee, Walls, MS
38680

My current home telephone number is: 601-781-2111

WITNESS STATEMENT

We, the subscribing witnesses hereto, do hereby declare that the person who signed or acknowledged this document as principal is personally known to me, that LELAND E. McCAIN signed or acknowledged this durable health care power of attorney in my presence, and that he appears to be of sound mind and under no duress, fraud or undue influence. I am not the person appointed as attorney-in-fact and agent by this document, nor am I the patient's health care provider, or an employee of the patient's health care provider. I further declare that I am not related to the principal by blood, marriage or adoption, and, to the best of my knowledge, I am not a creditor of the principal nor entitled to any part of his estate under a will now existing or by operation of law.

We, the subscribing witnesses hereto, are personally acquainted with and subscribe our names hereto after first being duly sworn as provided by law. We the subscribing witnesses subscribe our names hereto at the request of the declarant, an adult, whom we believe to be of sound mind, fully aware of the action taken herein and its possible consequences. We also witnessed the explanation of the Mississippi law to the declarant.

We, the undersigned witnesses, further declare that we are not related to the Declarant by blood or marriage; that we are not entitled to any portion of the estate of the declarant upon the declarant's death under any will or codicil thereto presently existing or by operation of law; that we are not the attending physician, an employee of the attending physician or a health care facility or an employee of the health care

facility of the declarant or in which the declarant is a patient; and that we are not a person who, at the present time, has a present claim against any portion of the estate of the declarant upon declarant's death, and we do not believe we are a creditor.

WITNESS #1: Chari J. Hurley 8/31/95
SIGNATURE DATE

Chari J. Hurley
NAME

1305 W. Second St.
ADDRESS Clarksdale, MS

8 601-627-3621
PHONE NUMBER

WITNESS #2: Meg Murphey 8/31/95
SIGNATURE DATE

Meg Murphey
NAME

226 Maple, Clarksdale, MS 38614
ADDRESS

601-624-9590
PHONE NUMBER

NOTARIZATION

On this, 31st day of August, 1995, before me, Wanda J. Howell, the undersigned notary public, personally appeared LELAND E. McCAIN, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument as principal, and acknowledged that he executed it.

I declare under penalty of perjury that the person whose name is subscribed to this instrument, as principal, appears to be of sound mind and under no duress, fraud or undue influence.

SUBSCRIBED, SWORN TO AND ACKNOWLEDGED BEFORE ME by LELAND E. McCAIN, on this 31st day of August, 1995.

Wanda J. Howell
NOTARY PUBLIC

(SEAL)

My Commission Expires:
My Commission Expires Nov 14, 1998

STATE OF MISSISSIPPI
 COUNTY OF Cochema

On this 31st day of August, 1995, before me, DANA S. Howell, the undersigned notary public, personally appeared Meg Mueshey and Charl J. Hurley, personally known to me (or proved to me on the basis of satisfactory evidence) to be the persons whose names are subscribed as witnesses to the above and foregoing execution of the Durable Health Care Power of Attorney of LELAND E. McCAIN, who after being first duly sworn by me stated on oath that the above and foregoing witness statements are true and correct as therein stated and set forth, and upon said oath each said subscribing witness did declare, under penalty of perjury under the laws of the State of Mississippi, as follows, to-wit: That the Principal is personally known to me; that the principal signed or acknowledged this Durable Power of Attorney in my presence; that the Principal appears to be of sound mind and under no duress, fraud or undue influence; that I am not the person appointed as attorney-in-fact by this document, that I am not a health care provider, nor an employee of a health care provider or facility; that I am not related to the Principal by blood, marriage or adoption; and to the best of my knowledge, I am not entitled to any part of the Estate of the Principal upon the death of the principal under a will now existing or by operation of law.

Meg Mueshey
 WITNESS SIGNATURE

Charl J. Hurley
 WITNESS SIGNATURE

Subscribed, sworn to and acknowledged before me by Meg Mueshey and Charl J. Hurley subscribing witnesses, on this 31st day of August, 1995.

Dana S. Howell
 NOTARY PUBLIC

(SEAL)

My Commission Expires:

My Commission Expires Nov 14, 1996

Prepared by:

CHAPMAN, LEWIS & SWAN
 P. O. BOX 428
 CLARKSDALE, MS 38614
 (601) 627-4105