

DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE DECISIONS  
OF  
KATHLEEN GALE POUNDERS

KNOW ALL MEN BY THESE PRESENTS: That I, Kathleen Gale Pounders, as principal, a resident of Hernando, DeSoto County, Mississippi, do hereby make, constitute and appoint Perry Larkin Pounders, a resident of Hernando, DeSoto County, Mississippi, my true and lawful attorney-in-fact, for me, in my name, place and stead, on my behalf, and for my use and benefit:

1. To exercise or perform any act, power, duty, right or obligation whatsoever that I now have, or may hereafter acquire the legal right, power or capacity to exercise or perform, in connection with, arising from or relating to health care decisions for me, including but not limited to, (a) giving consent, refusing to give consent, withholding of consent, and/or withdrawal of consent to health care or medical care, both before and after my death, and (b) exercising any of said powers in the event I should have a terminal condition, coma, persistent vegetative state, or other incurable illness (any of which is hereinafter called an "incurable illness").

2. Without limiting the generality of the foregoing, in the event I have an incurable illness, I authorize said attorney-in-fact to direct, approve, or consent to the withholding or withdrawal of medical care, including but not limited to, the withholding or withdrawal of artificially provided food, water, or other nourishment or fluids, permitting me to die naturally with only the administration of palliative care. PROVIDED, HOWEVER, that if, at the time any health care decision is made by said attorney-in-fact for me, there is in existence a valid living will, medical directive, or other written instrument in which I have declared my intentions regarding the medical care to be administered to me upon an incurable illness (any of which is hereafter called a "living will"), I DIRECT that my attorney-in-fact may not take any action or make any medical decision which would conflict with my living will. In the event of a conflict between any provision of this Durable Power of Attorney and any provision of my living will, the provision of my living will shall govern.

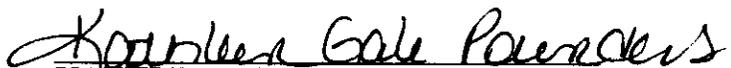
3. I hereby grant to said attorney-in-fact full power and authority to do, take and perform all and every act and thing whatsoever requisite, proper or necessary to be done, in the exercise of any of the rights and powers herein granted, as fully to all intents and purposes as I might or could do if personally present, but without power of substitution or revocation; and I hereby ratify and confirm all that said attorney-in-fact shall lawfully do or cause to be done by virtue of this power of attorney and the rights and powers herein granted.

4. This instrument is not to be construed and interpreted as a general power of attorney. This instrument does not affect the validity or application of any other power of attorney heretofore or hereafter executed by me to the extent that such other power of attorney relates to any matter or subject other than health care decisions.

5. The rights, powers and authority of said attorney-in-fact herein granted shall commence and be in full force and effect at such time or times as I shall not be competent to give informed consent to health care decisions, as reasonably determined by my attending physician.

6. This power of attorney and the rights, powers and authority herein granted unto said attorney-in-fact shall not be affected by my subsequent disability or incapacity, if any, and will remain in full force and effect and will not be revoked by operation of law if I should become subject to any mental or physical debility, as provided in the Mississippi Code of 1972, Section 41-41-201, et seq., as amended and supplemented from time to time.

IN WITNESS WHEREOF, I have executed this Durable power of Attorney for Health Care Decisions this the 25<sup>th</sup> day of August, 2005.

  
KATHLEEN GALE POUNDERS

STATE OF Mississippi  
COUNTY OF Adams

Before me, a Notary Public in and for said State and County, duly commissioned and qualified, personally appeared KATHLEEN GALE POUNDERS, to me known to be the person described in and who executed the foregoing instrument, and acknowledged that she executed the same as her free act and deed.

WITNESS my hand and Notarial Seal this the 25<sup>th</sup> day of August,  
2005.

Shirley C. Hudd  
Notary Public

(SEAL)

My Commissions Expires:

12/27/06

## DECLARATION OF WITNESSES

Each of the undersigned hereby declares as follows:

1. I am over the age of twenty-one (21) years and reside at the address set forth under my signature below.
2. On this date, KATHLEEN GALE POUNDERS, signed and executed this written instrument contained in 2 pages and dated this date in the sight and presence of both of us. We executed this declaration in the sight and presence of the Principal, as attesting witnesses.
3. The person who signed this instrument as principal is personally known to me to be the Principal, or the Principal has given satisfactory proof of identity to be the person of KATHLEEN GALE POUNDERS. In our opinion, the Principal is on this date over the age of twenty-one (21) years and appears to be of sound mind and under no duress, fraud, or undue influence. I am not a person appointed as attorney-in-fact in the foregoing instrument.
4. I further declare that (a) I am not related to the Principal by blood, marriage, or adoption, (b) I am not entitled to any part of the estate of the Principal upon Principal's death under a will or codicil now existing or by operation of law, (c) I am not a health care provider, an employee of a health care provider, the operator of a health care institution or facility, or the employee of the operator of a health care institution or facility, and (d) I do not have, at the present time, any claim against any portion of the estate of the Principal upon the Principal's death.

**IN WITNESS WHEREOF**, we have made and executed this affidavit at the request of the Principal, at Southaven, DeSoto County, Mississippi, this the 25<sup>th</sup> day of August, 2005.

Kelly Nelson  
 Signature  
1657 Mary Payton Dr.  
 Address  
Southaven, MS 38671  
 City, State, Zip Code  
414-57-3820  
 Social Security Number

Candace Moddy  
 Signature  
8344 cedarnush  
 Address  
Southaven, MS 38671  
 City, State, Zip Code  
429-496532  
 Social Security Number

STATE OF MISSISSIPPI

COUNTY OF DESOTO

BEFORE ME, a Notary Public in and for said State and County, duly commissioned and qualified, personally appeared Kelby Nelson and Carlace Doldridge, to me known to be the persons described in and who executed the foregoing instrument, and acknowledged that they executed the same as their free act and deed.

WITNESS my hand and Notarial Seal at my office this the 25<sup>th</sup> day of August, 2005.

Shirley C. Funder  
Notary Public

(SEAL)

My Commission Expires:

12/27/06

This Document Prepared By:

Vanessa W. Price  
P. O. Box 1406  
Southaven, MS 38671  
(662)536-1616

## NOTICE TO PERSON EXECUTING THIS DOCUMENT

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 our 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 your agent (a) 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 interests.

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 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 (2) 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.