

**MEDICAL POWER OF ATTORNEY DESIGNATION OF
HEALTH CARE AGENT FOR NORA ALMONA MORTON**

THE STATE OF MISSISSIPPI :
: **KNOW ALL MEN BY THESE PRESENTS**
COUNTY OF DESOTO :

I, NORA ALMONA MORTON (social security # _____), being of sound mind, willfully and voluntarily appoint my son, MICHAEL W. VESTAL (social security # _____), as my agent to make any and all health care decisions for me except to the extent that I state otherwise in this document. This medical power of attorney takes effect immediately and is given to make provision for the care and treatment of me in the event that I am unable to make health care decisions for myself by reason of illness, incapacity, or otherwise.

LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

None.

The original of this document is kept with MICHAEL W. VESTAL located at ADDRESS.

The following individuals or institutions have signed copies:

Name: Michael W. Vestal
Address: 4903 San Antonio, Midland, Texas 79707
Home Phone: (432) 520-5679
Work Phone: (432) 638-3631

DURATION.

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke this power of attorney.

The authority I have granted my agent shall include, but not be limited to the following:

1. To request, review, and receive any and all medical, hospital and related information and records, and to execute a release or other document required to obtain such information;
2. To consent to the disclosure of medical and related information to others;
3. To employ and discharge medical and related personnel;

Prepared
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7

4. To consent, refuse consent, or withdraw consent to medical care, treatment, service or procedure.
5. To provide appropriate relief from pain;
6. To arrange for care and lodging in a hospital or other medical facility;
7. To grant releases to health care professionals or institutions to assure that my wishes for my care are fulfilled; and
8. To arrange to hire and to pay the salaries of employees, nurses and similar health care providers, and to see that required tax returns are filed.

This power of attorney ends on the following date: WHEN REVOKED BY ME.

PRIOR DESIGNATIONS REVOKED.

I revoke any prior medical power of attorney I executed for myself.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

I sign my name to this medical power of attorney for me on the 4th day of March, 2008 at Nesbit, DeSoto County, Mississippi.



NORA ALMONA MORTON

STATEMENT OF WITNESSES

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that NORA ALMONA MORTON is personally known to me, that NORA ALMONA MORTON signed or acknowledged this power of attorney in my presence, that NORA ALMONA MORTON appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not the attending physician of NORA ALMONA MORTON or an employee of the attending physician, nor am I involved in providing direct patient care to NORA ALMONA MORTON. I am not related to NORA ALMONA MORTON by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of NORA ALMONA MORTON upon the death of NORA ALMONA MORTON under a will now existing or by operation of law.

SIGNATURE OF FIRST WITNESS

Name: Evans Wells
Printed Name: Evans Wells
Address: 2510 Hwy 51 S
Hernando, MS 38632

On the 4th day of March, 2008

SIGNATURE OF SECOND WITNESS.

Name: Dewayne Flagg
Printed Name: Dewayne Flagg
Address: 1145 Milton Ln
Hernando, MS

On the 4 day of March, 2008

SUBSCRIBED AND SWORN TO BEFORE ME by the said NORA ALMONA MORTON, Principal, and witnesses, Evans Wells, and Dewayne Flagg, on the 4th day of March, 2008.



Charlotte C Gahagan
Notary Public, State of Mississippi
my Commission expires 12/20/11

State of Mississippi

County of DeSoto

Personally appeared before me, the undersigned authority in and for the said County and State, on this the 4th day of March, 2008 within my jurisdiction, the within named, Nora Almona Morte who acknowledged that (he) (she) (they) executed the above and foregoing instrument.

Charlotte C. Gahagan
Notary Public

By Charlotte C. Gahagan



**INFORMATION CONCERNING THE
MEDICAL POWER OF ATTORNEY**

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you, in accordance with your wishes when you are no longer capable of making them for yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins immediately so that proper care and treatment can be provided for you in the event you lack the competence to make health care decisions for her.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had if you had been personally present.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you have a physician, you should talk with your physician or if you do not have a physician, with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent for you should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., her physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for you as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent

or your health or residential care provider orally or in writing, or by your execution of a subsequent medical power of attorney for you. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

- (1) the person you have designated as your agent;
- (2) a person related to you by blood or marriage;
- (3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- (4) your attending physician;
- (5) an employee of your attending physician;
- (6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
- (7) a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

I certify I have received a copy of this "Information Concerning the Medical Power of Attorney."

Nora Almona Morton

NORA ALMONA MORTON

On the 4 day of March, 2008

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 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.

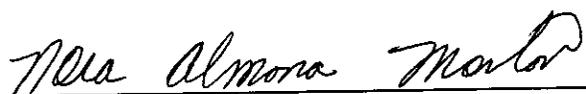
The document gives your agent authority to consent, to refuse to consent or to withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. 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.

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.

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 and do not sign this document until you understand. By my signature I do hereby indicate that I understand the purpose and effect of this document.



NORA ALMONA MORTON

On the 4 day of March, 2008