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DESOTO COUNTY, MS
W.E. DAVIS, CH CLERK

Prepared by:
H. R. Garner, MSB #4754
Attorney at Law
P.O. Box 443/283 Loshier Street
Hernando, MS 38632-0443
office telephone 662-429-4411

Return to:
* H. R. Garner, MSB #4754
Attorney at Law
P.O. Box 443/283 Loshier Street
Hernando, MS 38632-0443
office telephone 662-429-4411

POWER OF ATTORNEY

KNOW ALL MEN by these presents, that I, Anita Carol Sellari Sides, SSN: ***-**-9357, DOB: 11/1/1941 of 356 Shady Grove, Hernando, DeSoto County, Mississippi, have constituted and appointed and by these presents do make, constitute and appoint Tina Marie Smith, SSN: ***-**-6146, DOB: 4/9/1971 of 356 Shady Grove, Hernando, DeSoto County, Mississippi, my true and lawful attorney for me and in my name, place and stead to ask, demand, sue for, collect and receive all sums of money, dividends, interest, payments on account of debts and legacies and all property now due or which may hereafter become due and owing to me, and give good and valid receipts and discharges for such payments; to sell, assign and transfer stocks and bonds and securities standing in my name and belonging to me; to buy and sell securities of all kinds in my name and for my account and at such prices as shall seem good to them; to sign, execute, acknowledge and deliver in my name all transfers and assignments of securities; to borrow money and to pledge securities for such loans if in the judgment of my attorneys such action should be necessary; to consent in my name to reorganizations and merges, and to the exchange of securities for new securities; to manage real property, to sell, convey and mortgage realty, and to foreclose mortgages, and to take title of

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property in my name if they think proper, to execute, acknowledge and deliver deeds of real property, mortgages, releases, satisfactions and other instruments relating to realty, which they consider necessary; to place and effect insurance; to do business with banks, and particularly to endorse all checks and drafts made payable to my order and collect the proceeds; to sign in my name checks on all accounts standing in my name, and to withdraw funds from said accounts, to open accounts in my name or in their names as my attorneys in fact; to make such payments and expenditures as may be necessary in connection with any of the foregoing matters or with the administration of my affairs; to retain counsel and attorneys on my behalf, to appear for me in all actions proceedings to which I may be a part in the Courts of Mississippi or any other state in the United States, or in the United States Courts, to commence actions and proceedings in my name if necessary; to sign and verify in my name all complaints, petitions, answers and other pleadings of every description; to represent me in all income tax matters before all officers of the income tax bureau, to make and verify income tax returns, claims for refund, requests for extension of time, and consents in my name, to execute petitions to the Board of tax Appeals and to cause me to be represented in such proceedings; hereby giving and granting to my said attorneys full power and authority to do and perform all and every act and things whatsoever necessary to be done in the premises, as fully to all extent and purposes as I might or could do if personally present with full power of substitution and revocation, hereby ratifying and confirming all that my said attorneys may do pursuant to this power.

This Power of Attorney shall not be affected by the subsequent disability or incompetence of the principal. Miss. Code Ann. Section 87-3-107, effective from and after July 1, 1994, (Cumm. Supp. 1999).

Including any authority granted under the "Mississippi Uniform Durable Power of Attorney Act" pursuant to Miss. Code Ann. §§ 87-3-101, et seq (1972 as amended).

WITNESS MY SIGNATURE, this the 12th day of April, 2011.

Anita Carol Sellari Sides
Anita Carol Sellari Sides

STATE OF MISSISSIPPI

COUNTY OF DESOTO

Personally appeared before me, the undersigned authority in and for the said county and state, on this the 12th day of April, 2011, within my jurisdiction, the within named Anita Carol Sellari Sides who acknowledged that she executed the above and foregoing instrument.

Sherry Hearington
Notary Public



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H. R. Garner, MSB #4754
Attorney at Law
P.O. Box 443/283 Loshier Street
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**ADVANCE HEALTH CARE DIRECTIVE
OF
ANITA CAROL SELLARI SIDES**

NOTICE TO PERSON EXECUTING THIS DOCUMENT

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

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now and even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care

decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- (b) Select or discharge health-care providers and institutions;
- (c) Approve or disapprove diagnostic tests, surgical procedures, programs or medication, and orders not to resuscitate; and
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provisions, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

Tina Marie Smith, SSN# ***-**-6146, DOB: 4/9/1971 of 356 Shady Grove, Hernando, DeSoto County, Mississippi, phone no. 901-848-7984.

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

Carol Jean Smith, SS#***-**-_____, DOB: 2/1/1961 of 2184 Nelson, Memphis, Shelby County, Tennessee, phone no. 901-274-7723.

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

Harry Eugene Smith, SS# _____, DOB: 6/20/1958 of 650 Reed Road, Hernando, DeSoto County, Mississippi, phone no. 901-246-7689.

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, all other forms of health care to keep me alive, except as I state here:

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [X], my agent's authority to make health-care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you

may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

(a) Choice Not To Prolong Life

I do not want my life to be prolonged if my physician, with the concurrence of two (2) other physicians believes, (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

(b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box , artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that: _____

PART 3

PRIMARY PHYSICIAN

(OPTIONAL)

(10) I designate the following physician as my primary physician:

Dr. Jack Hopkins
Sutherland Clinic
7460 Wolf River Blvd # 101
Germantown, TN

(11) EFFECT OF COPY: A copy of this form has the same effect as the original.

(12) SIGNATURES: Sign and date the form here:

April 12, 2011
(Date)

Anita Carol Sellari Sides
(Signature)

Anita Carol Sellari Sides

(13) WITNESSES: This power of attorney will not be valid for making health-care decisions unless it is either (a) signed by two (2) qualified 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.

H. R. Garner
H. R. Garner
283 Loshier Street
Hernando, MS 38632

Francine Davis
Francine Davis
283 Loshier Street
Hernando, MS 38632

STATE OF MISSISSIPPI

COUNTY OF DESOTO

On this the 12th day of April, 2011, before me, Sherry Hearington a Notary Public, personally appeared Anita Carol Sellari Sides, 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, and acknowledged that he executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Sherry Hearington
NOTARY PUBLIC

