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Austin Law Firm, P.A.
6928 Cobblestone Drive, Suite 100
Southaven, MS 38671
Phone: 662-890-7575

File No.: 07-110164

GENERAL DURABLE POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that I, Myra A. Fricks of Southaven, Desoto County, Mississippi, have made, constituted and appointed and by these presents do make, constitute and appoint Deborah Fricks Appleton and/or Joseph Appleton, as my true and lawful attorney-in-fact for me and in my name, place and stead, to demand, receive, collect and hold any and all monies, securities, personal and real property of any nature whatsoever belonging to me or in which I may have any interest; to deal generally and in all respect without restriction in and with any property of any nature whatsoever in which I may have any interest; including transferring of title and ownership; to carry bank accounts for me and in my name in such banks as my said attorney-in-fact may deem best and to make deposits of money belonging to me in such accounts and to endorse all checks, bonds and securities, whether from U. S. Treasury, or any other source, and disburse said monies on the signature of my said attorney-in-fact, for any purposes in connection with the personal needs, support, maintenance and medical attention of myself, in any such amounts and for such purposes and at such times as my said attorney-in-fact in his/her sole

MYRA FRICKS
4510 Brighton Cr.
Southaven Ms 38671

unrestricted discretion and judgment may deem best; to make disbursements of monies belonging to me in such manner, at such times and for such purposes as my said attorney-in-fact may in his/her sole unrestricted discretion and judgment deem best for maintenance, upkeep, repair, sell or any other purposes in connection with any real estate or personal property owned by me; to operate, manage, control and lease any and all real estate owned by me or by me and any other person to the extent of my interest and to collect, demand and receive the rents, issues, incomes, and profits derived therefrom, and to exercise in all respects general control and supervision over any real estate belonging to me or to me and any other person to the extent of my interest; to exercise general supervision and control over any securities and other personal property of any nature whatsoever belonging to me and to collect dividends, profits or accruals therefrom and thereon, and to make sale and disposition of the same, all as my said attorney-in-fact may in his/her sole and unrestricted discretion and judgment deem best; to use generally any monies and property belonging to me in the proper support, maintenance, care and attention of myself, and as my said attorney-in-fact may in his/her sole unrestricted judgment and discretion deem best; to exercise in all respects as full management, control and powers with respect to all of my property, whether the same be real or personal, as I myself could do; to liquidate any assets of mine and to make such investment of any monies belonging to me as my said attorney-in-fact in his/her sole and unrestricted judgment and discretion may deem best; to demand, and receive, sue for and recover, any and all monies or rights of any nature whatsoever and from whatever source derived that may now be due to me or which may at any time hereafter become due, and to give in all respects proper receipts, releases and acquittances therefore, with no liability on the part of any obligor making payments to my attorney-in-fact to see to the application of the proceeds of such payments or collections, hereby giving and granting unto my said attorney-in-fact full power and authority to do and perform all and every act

and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents 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 attorney-in-fact may do.

Deborah Fricks Appleton and Joseph Appleton may act independently of each other as attorney-in-fact and do not require counter-signatures.

This power of attorney shall not be affected by the subsequent disability or incompetence of the principal or lapse of time. That this Power of Attorney shall remain in full force and effect until such time as terminated by me in writing.

IN WITNESS WHEREOF, I have subscribed my name hereto this the 17 day of August, 2011.

Myra A. Fricks
Myra A. Fricks

**STATE OF MISSISSIPPI
COUNTY OF DESOTO**

This day personally appeared before me, the undersigned authority in and for said County and State the within named, Myra A. Fricks, who acknowledged that she signed and delivered the above and foregoing Power of Attorney as her free and voluntary act and deed and for the purposes therein expressed.

Given under my hand and official seal of office, this the 17 day of August, 2011.

Lorisa K. Carlisle
NOTARY PUBLIC



ADVANCE HEALTH CARE DIRECTIVE OF MYRA A. FRICKS**Notice to person executing this document**

This document is a 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 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 this form 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 of 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 provision, 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 responsibility.

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

**PART 1
POWER OF ATTORNEY FOR HEALTH CARE**

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

Name: Deborah Fricks Appleton
 Address: 34 Blake Ridge Drive
Newnan, GA 30265
 Phone: 770-304-5594

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:

Name: Joseph Appleton
 Address: 34 Blake Ridge Drive
Newnan, GA 30265
 Phone: 770-304-5594

(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, and 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.

(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.

**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 including artificial nutrition and hydration in accordance with the choice I have marked below:

(a) Choice Not to Prolong Life

I do not want my life to be prolonged and I direct my health care provider to withhold or withdraw treatment including artificial nutrition and hydration as specified herein if both the physicians designated herein under Part 3 as primary physician and optional physician, determine either of the following: (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:**

(a) I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

(b) I direct that treatment for alleviation of pain or discomfort be withheld at all times, even if it prolongs my life.

(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**

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

Name: Dr. Troy Morris
DeSoto Family Medical Center
Address: 75 Physicians Lane
Southaven, MS 38671
Phone: 662-393-7722

OPTIONAL: If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name: The Primary Physician at
the time this document
is being used

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

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

Aug 17, 2011 (Date) Myra A. Fricks (Signature)
4510 Brighton Cir (Address) MYRA A. FRICKS (Printed Name)
Southaven Ms 38671 (City) (State) (Zip)

(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 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 you are signing.

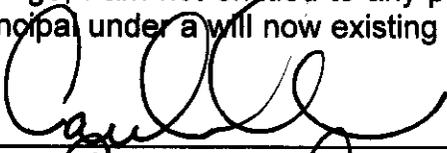
Witness

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a healthcare provider, nor an employee of a health care provider or facility. 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.

August 17, 2011
(Date)

1928 Cobblestone Blvd #100
(Address)

Southaven MS 38672
(City) (State) (Zip)


(Signature of Witness)

Candace Corder
(Printed name of witness)

Witness

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a healthcare provider, nor an employee of a healthcare provider or facility. 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.

August 17, 2011
(Date)

8595 Chesterfield Drive
(Address)

Southaven MS 38671
(City) (State) (Zip)


(Signature of Witness)

Martha Huggins
(Printed name of witness)