

James R. West and Clinton D. West and Leopold F. West and Carol L. West Skelton
GRANTORS

WARRANTY

TO

DEED

Marie A. Koczka, an unmarried person
GRANTEE

For and in consideration of the sum of Ten Dollars (\$10.00), cash in hand paid, and other good and valuable considerations, the receipt and sufficiency of all of which is hereby acknowledged, James R. West and Clinton D. West and Leopold F. West and Carol L. West Skelton, do hereby sell, convey, and warrant unto Marie A. Koczka, an unmarried person, the following described property situated in the County of DeSoto, State of Mississippi, together with all improvements and appurtenances thereon more particularly described as follows:

Lot 546, Section C, Revised, Greenbrook Subdivision, in Section 19, Township 1 South, Range 7 West, DeSoto County, Mississippi, as per Plat thereof recorded in Plat Book 8, Page 49, in the Office of the Chancery Clerk of DeSoto County, Mississippi.

By way of explanation Clinton West past away on March 22, 1993.

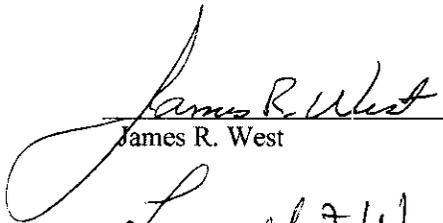
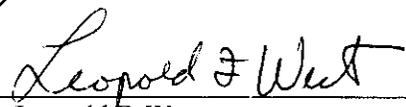
By way of explanation Louise Urbancic West past away on January 07, 2005.

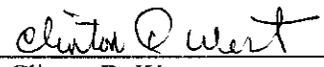
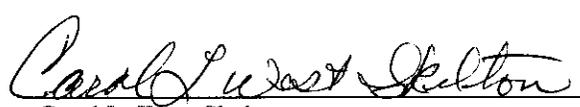
The warranty in this deed is subject to subdivision and zoning regulations in effect in DeSoto County, rights of ways and easements for public roads and public utilities and restrictive covenants and easements of record.

It is understood and agreed that the taxes for the year 2005 have been prorated as of this date on an estimated basis and when said taxes are actually determined, if the proration is incorrect then Grantor(s) agree to pay Grantee(s) or their assigns any deficiency and likewise Grantee(s) agree to pay Grantor(s) or their assigns any amount overpaid.

Possession is to be given with delivery of this Deed.

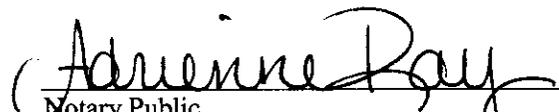
WITNESS OUR SIGNATURES, this the 14th day of April, 2005


James R. West

Leopold F. West


Clinton D. West

Carol L. West Skelton

STATE OF Mississippi
COUNTY OF DeSoto

Personally appeared before me, the undersigned authority in and for the said county and state, on this the 14th day of April, 2005, within my jurisdiction, the within named James R. West, Clinton D. West, Leopold F. West and Carol L. West Skelton, who acknowledged that they executed the above and foregoing instrument.


Notary Public
Adrienne Ray

My Commission Expires:

July 15, 2008

GRANTOR'S ADDRESS:
8745 Carriage Drive West
Southaven, Mississippi 38671
Work Phone #: N/A
Home Phone #: (662) 342-0495

GRANTEE'S ADDRESS:
727 Thornwood Cove
Southaven, Mississippi 38671
Work Phone #: (800) 456-0711
Home Phone #: (662) 393-0133



THIS INSTRUMENT PREPARED BY:
Eric L. Sappenfield, PLLC
6858 Swinnea Road
#5 Rutland Place
Southaven, Mississippi 38671
(662) 349-3436

FILE NUMBER: 11193

TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT
CERTIFICATE OF DEATH

STATE FILE NO.

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS HANDBOOK

NAME OF DECEASED: For use by physician or institution

DECEASED

PARENTS

INFORMANT

DISPOSITION

REGISTRAR

CERTIFIER

PHYSICIAN OR MEDICAL EXAMINER EXISTING CERTIFICATE NOT COMPLETE AND NO MEDICAL CERTIFICATION WITHIN 48 HRS.

INSTRUCTIONS ON OTHER SIDE

CAUSE OF DEATH

PH-1659 REV. 1/89

1. DECEASED'S NAME (First, Middle, Last) **CLINTON (NMN) WEST** 2. SEX **MALE** 3. DATE OF DEATH (Month, Day, Year) **MARCH 22, 1993**

4. SOCIAL SECURITY NUMBER (of Deceased) **412-07-3366** 5a. AGE - LAST BIRTHDAY (Years) **82** 5b. UNDER 1 YEAR **MOS.** 5c. UNDER 1 DAY **HOURS** 6. DATE OF BIRTH (Month, Day, Year) **FEB. 14, 1911** 7. BIRTHPLACE (City and State or Foreign Country) **WATER VALLEY, MS**

8. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 Yes 2 No 9a. PLACE OF DEATH (Check only one) **HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)**

9b. FACILITY NAME (If not institution, give street and number) **BAPTIST HOSPITAL EAST** 9c. CITY, TOWN, OR LOCATION OF DEATH **MEMPHIS** 9d. COUNTY OF DEATH **SHELBY**

10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) **MARRIED** 11. SURVIVING SPOUSE (If wife, give maiden name) **LOUISE URBANCIC** 12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) **MEAT CUTTER** 12b. KIND OF BUSINESS/INDUSTRY **WEONA GROCERY STORE**

13a. RESIDENCE—STATE **MISSISSIPPI** 13b. COUNTY **DESOTO** 13c. CITY, TOWN OR LOCATION **SOUTHAVEN** 13d. STREET AND NUMBER OR RURAL LOCATION **727 THORNWOOD**

13e. INSIDE CITY LIMITS? 1 Yes 2 No 13f. ZIP CODE **38671** 14. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes No Specify, if yes: 15. RACE—American Indian, Black, White, etc. (Specify) **WHITE** 16. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) **12** College (14 or 5+)

17. FATHER'S NAME (First, Middle, Last) **BENJAMIN WEST** 18. MOTHER'S NAME (First, Middle, Maiden Surname) **DONNIA PARKS**

19a. INFORMANT'S NAME (Type/Print) **LOUISE WEST** 19b. RELATIONSHIP TO DECEASED **WIFE** 19c. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **727 THORNWOOD, SOUTHAVEN, MS 38671**

20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **MEMORIAL PARK CEMETERY** 20c. LOCATION—City or Town, State **MEMPHIS, TN**

21a. SIGNATURE OF FUNERAL DIRECTOR **CANDACE STOKES** 21b. LICENSE NUMBER OF FUNERAL DIRECTOR **4189** 21c. SIGNATURE OF EMBALMER **NANCY LOGGINS** 21d. LICENSE NUMBER OF EMBALMER **4131**

22a. NAME AND ADDRESS OF FUNERAL HOME **MEMORIAL PARK FUNERAL HOME 5668 POPLAR, MEMPHIS, TN 38119** 22b. LICENSE NUMBER OF FUNERAL HOME **522**

23. REGISTRAR'S SIGNATURE *[Signature]* 24. DATE FILED (Month, Day, Year) **APR 22 1993**

25a. PHYSICIAN -- To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. 1 SIGNATURE AND TITLE OF PHYSICIAN *[Signature]* 25b. LICENSE NUMBER **2996 TN** 25c. DATE SIGNED (Month, Day, Year) **3/19/93**

25a. MEDICAL EXAMINER -- On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. 2 SIGNATURE AND TITLE OF MEDICAL EXAMINER 25b. LICENSE NUMBER 25c. DATE SIGNED (Month, Day, Year)

27. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR MEDICAL EXAMINER) (Type/Print) **DR. MICHAEL WILONS 20 S. DUDLEY, #908-B, MEMPHIS, TN 38103**

28. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Acute Bronchitis**
DUE TO (OR AS A CONSEQUENCE OF):
pulmonary edema
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Unresectable Cancer of Bladder**

29a. WAS AN AUTOPSY PERFORMED? 1 Yes 2 No 29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 Yes 2 No

30. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be Determined 31a. DATE OF INJURY (Month, Day, Year) 31b. TIME OF INJURY **M** 31c. INJURY AT WORK? 1 Yes 2 No 31d. DESCRIBE HOW INJURY OCCURRED 31e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) 31f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

BIRTH NO.

MISSISSIPPI STATE DEPARTMENT OF HEALTH
VITAL RECORDS

TYPE OR PRINT
IN BLACK INK

FILING DATE JAN 18 2005

CERTIFICATE OF DEATH
STATE OF MISSISSIPPI

STATE FILE NUMBER 123-05-000440

DECEASED Death occurred in institution, see NDBOOK regarding completion of RESIDENCE items RESIDENCE Home, or actual location same rather than mailing address	1. NAME First Middle Last LOUISE URBANCIC WEST			2. SEX FEMALE		3a. HOUR OF DEATH 10:00A m		3b. DATE OF DEATH (Month, Day, Year) JANUARY 07, 2005				
	4. RACE (Specify White, Black, American Indian, etc.) WHITE		5a. AGE AT LAST BIRTHDAY 90 Years		5b. MOS 90		5c. DAYS 90		5d. HOURS 90		5e. MINS 90	
	6. DATE OF BIRTH (Month, Day, Year) AUG. 19, 1914		7a. COUNTY OF DEATH DESOTO		7b. CITY OR TOWN OF DEATH SOUTHAVEN			7c. HOSPITAL OR OTHER INSTITUTION-NAME AND NUMBER (If not in either, give street address, route number or other location) BAPTIST HOSPITAL-DESOTO 17B			7d. IF IN HOSP. OR INST. SPECIFY INPT., OUTPT., EMER. RM. OR DOA INPT	
	8. STATE OF BIRTH TN			9. DECEDENT'S EDUCATION (Specify only highest grade completed) Elem/High School College 11 (1-4 5+)		10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		11. SURVIVING SPOUSE (If wife, give maiden name) NONE		12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) NO		
	13. ORIGIN OR DESCENT (Specify Cuban, Afro-American, Mexican, etc.) AMERICAN		14. SOCIAL SECURITY NUMBER 414-10-3316			15a. USUAL OCCUPATION (Kind of work done, most of working life) HOMEMAKER			15b. KIND OF BUSINESS OR INDUSTRY HOME			
	16a. RESIDENCE—STATE MS		16b. COUNTY DESOTO		16c. CITY OR TOWN SOUTHAVEN		16d. INSIDE CITY LIMITS (Specify Yes or No) YES		16e. STREET AND NUMBER OR RURAL LOCATION 727 THORNWOOD PLACE			
	17. FATHER—NAME First Middle Last LEOPOLE URBANCIC				18. MOTHER—NAME First Middle Maiden JULIA RHEINSHAKER							
	19a. INFORMANT—NAME (Type or print) CAROL SKELTON						19b. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code) 4725 SHERRY DR., HORN LAKE, MS 38637					
	20a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		20b. CEMETERY, CREMATORY—NAME MEMORIAL PARK CEM.		20c. LOCATION (City and State) MEMPHIS, TN		21a. EMBALMER—SIGNATURE AND NUMBER CHARLES VINSON, #3556					
	21b. FUNERAL HOME—NAME AND MISSISSIPPI I.D. NUMBER MEMORIAL PARK F.H., #522				21c. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code) 5668 POPLAR AVE., MEMPHIS, TN 38119							
22a. PERSON WHO PRONOUNCED DEATH—NAME AND TITLE (Type or print) SANJAY RATNAKANT, MD						22b. PRONOUNCED DEAD (Month, Day, Year) ON JANUARY 07, 2005		22c. PRONOUNCED DEAD (Hour) AT 10:00A m				
23a. CERTIFIER—NAME (Type or print) JEFFERY POUNDERS, CMEI				23b. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code) 4942 POUNDERS RD, NESBIT, MS 38651								
This section to be completed by physician if NOT a medical examiner 24a. To the best of my knowledge, death occurred due to the cause(s) and manner as stated: SIGNATURE: Jeffery P. Moulder MD 24b. DATE SIGNED (Month, Day, Year) 24c. STATE LICENSE NUMBER 24d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or print)												
This section to be completed by medical examiner ONLY 24e. On the basis of examination and/or investigation, in my opinion, death occurred due to the cause(s) and manner as stated: SIGNATURE: Jeffery P. Moulder 24f. TITLE CMEI 24g. DATE SIGNED (Month, Day, Year) 01-10-2005												
USE OF DEATH 25. PART I: IMMEDIATE CAUSE (Enter one cause only): (a) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c) ASCD												
26. PART II: OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not resulting in the underlying cause given in PART I SEIZURE DISORDER												
27. AUTOPSY (Yes or No) NO		28. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No) YES										
Use if death NOT due to natural causes 29a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify) 29b. DATE OF INJURY (Month, Day, Year) 29c. HOUR OF INJURY 29d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED		29e. INJURY AT WORK (Yes or No) 29f. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building, etc.) 29g. LOCATION Street or route number: City or town: State:										
29. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify) 29e. INJURY AT WORK (Yes or No)		29b. DATE OF INJURY (Month, Day, Year) 29c. HOUR OF INJURY 29d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED 29f. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building, etc.) 29g. LOCATION Street or route number: City or town: State:										

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THIS OFFICE



FEB - 8 2005

Judy Moulder
STATE REGISTRAR

WARNING:

A REPRODUCTION OF THIS DOCUMENT RENDERS IT VOID AND INVALID. DO NOT ACCEPT UNLESS EMBOSSED SEAL OF THE MISSISSIPPI STATE BOARD OF HEALTH IS PRESENT. IT IS ILLEGAL TO ALTER OR COUNTERFEIT THIS DOCUMENT.