MICHAEL SMILEY ROWE
Attorney at Law
P. O. Box 2080 • Minden, NV 89423
(702) 782-8141

GENERAL POWER OF ATTORNEY
DECLARATION
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

KNOW ALL MEN BY THESE PRESENTS

THAT MARGARET J. MORGAN does by these presents appoint KAREN LEE MORGAN as my attorney-in-fact, for me and in my name. Should she be unable or unwilling to serve, or if she is not reasonably available, I designate STEVEN WADE MORGAN as my attorney-in-fact.

These presents are for the use and benefit of my attorney-in-fact to demand, sue for, collect, and receive all such sums of money, debts, dues, accounts, legacies, bequests, interests, dividends, annuities, and demands whatsoever, as are now or shall hereafter become due, owing, payable, or belonging to me, and to have, use, and take all lawful ways and means in my name or otherwise for the recovery thereof by attachment, arrest, or otherwise, and to compromise and agree for the same; and to make and deliver discharges for the same for me and in my name;

To contract for, purchase, receive, and take lands, tenements, and hereditaments, and accept the seisin and possession of all lands, and all deeds and other assurances in the law therefor, and to lease, let, sell, release, convey, mortgage, convey by way of deed of trust, and hypothecate lands, tenements, and hereditaments upon such terms and conditions, and under such covenants as my attorney-in-fact shall think fit;

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Also to bargain for, buy, sell, mortgage, hypothecate, and in any way and every way and manner deal in and with goods, wares, and merchandise, choses in action, and other property in possession or in action, and to do every kind of business of what nature or kind soever;

Also for me and in my name, and as my act and deed to make, sign, seal, execute, acknowledge, and deliver deeds, leases and assignments of lease, covenants, indentures, agreements, mortgages, deeds of trust and reconveyance thereunder, hypothecations, bottomries, charter-parties, bills of lading, bills, bonds, notes, receipts, evidences of debt, releases and satisfaction of mortgage, judgments, and other debts, and such other instruments in writing of whatever kind and nature as may be necessary, convenient, or proper in the premises including assignments of accounts receivable, notices of the expected assignments of such accounts, and cancellation of such notices;

Also, in case of loss by fire, or otherwise, to adjust insurance losses.

GIVING unto said attorney full power to perform every act and thing which she may think necessary to be done in and about the premises, as fully to all intents and purposes as I, MARGARET J. MORGAN, might or could do if personally present, hereby ratifying and confirming all that said attorney shall lawfully do or cause to be done by virtue of these presents.

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DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I appoint KAREN LEE MORGAN or, if she is not reasonably available or is unwilling to serve, STEVEN WADE MORGAN, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to NRS 449.540 to 449.690, inclusive, and Sections 2 through 12, inclusive, of the Uniform Act on Rights of the Terminally Ill approved and adopted by the 1991 Nevada Legislature.

** (If the person or persons I have so appointed are not reasonably available or are unwilling to serve, I direct my attending physician, pursuant to those sections, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.) **

IF YOU WISH TO INCLUDE THIS STATEMENT YOU MUST INITIAL THE STATEMENT ON THE LINE PROVIDED. MJM

** (I direct my attending physician not to withhold or withdraw artificial nutrition and hydration by way of the gastro-intestinal tract if such withholding or withdrawal would result in my death by starvation or dehydration.) **

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IF YOU WISH TO INCLUDE THIS STATEMENT YOU MUST INITIAL THE STATEMENT ON THE LINE PROVIDED. _____

SIGNED this 5th day of August, 1991.

DECLARANT:

Margaret J. Morgan

MARGARET J. MORGAN
1355 Bishop Circle
Gardnerville, Nevada 89410

The Declarant voluntarily signed this writing in my presence.

WITNESS:

Wendy J. Sherrill

WENDY J. SHERRILL
1401 Leonard Rd.
Gardnerville, Nevada 89410

Milani G. Watson

MILANI G. WATSON
804 Chernus Dr.
Carson City, Nevada 89703

DESIGNEES:

KAREN LEE MORGAN
1322 Kingslane
Gardnerville, Nevada 89410

STEVEN WADE MORGAN
P. O. Box 765
Minden, Nevada 89423

I direct that my attorney-in-fact communicate to my attending physician this Declaration so that it will become operative if I am determined by my attending physician to be in a terminal condition and no longer able to make decisions regarding administration of life sustaining treatment. My attorney in fact is hereby directed, when this Declaration becomes operative, to insure that my attending physician and other providers of health care, act in accordance with its

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provisions, or, if my attending physician or other provider of health care is unwilling to comply with my Declaration, then my attorney in fact is to insure that my attending physician or other provider of health care shall take all reasonable steps as practicable to transfer my care to another physician or provider of health care who is willing to comply with this Declaration.

mjm

I hereby declare that I am a qualified patient; it having been explained to me that a qualified patient means a patient eighteen (18) or more years of age who has executed a Declaration similar to the one I have executed, and who has been determined by the attending physician to be in a terminal condition.

mjm

I understand that I may revoke this Declaration at any time and in any manner, without regard to my mental or physical condition. I understand that my revocation would be effective upon its communication to my attending physician or other provider of health care by me, or a witness to my revocation. Should I so choose to revoke this Declaration, I direct that my attending physician or other provider of health care make the revocation of this Declaration a part of my medical record.

mjm

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DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR ATTORNEY-IN-FACT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE CONSENT, REFUSAL OR CONSENT OR WITHDRAWAL OF CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.

2. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.

3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF THE PERSON YOU DESIGNATE TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.

4. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST INDEFINITELY FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE

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DECISIONS FOR YOURSELF, THIS POWER WILL CONTINUE TO EXIST UNTIL A TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

5. 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 IF YOU OBJECT.

6. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THAT PERSON OF THE REVOCATION ORALLY OR IN WRITING.

7. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THE TREATING PHYSICIAN, HOSPITAL, OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

8. THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

9. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

10. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

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MICHAEL SMILEY ROWE
Attorney at Law
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1. DESIGNATION OF HEALTH CARE AGENT:

YOU MAY NOT DESIGNATE AS YOUR ATTORNEY-IN-FACT: (1) your treating provider of health care, (2) an employee of your treating provider of health care, (3) an operator of a health care facility, and (4) an employee of an operator of a health care facility.

I, MARGARET J. MORGAN do hereby designate and appoint KAREN LEE MORGAN of 1322 Kingslane, Gardnerville, Nevada 89410 with telephone number of (702) 782-7754 as my attorney-in-fact to make health care decisions for me as authorized in this document.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE:

By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED:

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, subject only to the limitations and special provisions, if any, set forth hereinbelow in paragraph 4 or 6.

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4. SPECIAL PROVISIONS AND LIMITATIONS:

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on her attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, the authority of my attorney-in-fact is subject to the following special provisions and limitations: (IF NONE, WRITE NONE AND INITIAL) None MJM

5. DURATION:

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to

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exist until the time when I become able to make health care decisions for myself.

IF APPLICABLE: I wish to have this power of attorney end on the following date:_____

6. STATEMENT OF DESIRES:

With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.

(If the statement reflects your desires, initial the box next to the statement.)

1. I desire that my life be prolonged to the greatest extent possible, without regard to my conditions, the chances I have for recovery or long-term survival, or the cost of the procedures. ____

2. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging

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treatments not be used. In this connection, I refer by this reference to my Declaration contained hereinabove, and incorporated herein, and the provisions of NRS 449.540 to 449.690, inclusive, where applicable and consistent with my desires. mjm

3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life sustaining or prolonging treatments not be used. In this connection, I refer by this reference to my Declaration contained hereinabove, and incorporated herein, and the provisions of NRS 449.540 to 449.690, inclusive, where applicable and consistent with my desires. mjm

4. I direct my attending physician not to withhold or withdraw artificial nutrition and hydration by way of the gastro-intestinal tract if such a withholding or withdrawal would result in my death by starvation or dehydration. ____

5. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of life. mjm

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IF YOU WISH TO CHANGE YOUR ANSWER, YOU MAY DO SO BY DRAWING AN "X" THROUGH THE ANSWER YOU DO NOT WANT, AND CIRCLING THE ANSWER YOU PREFER.

Other or additional statements of desires:_____

_____

_____

7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT:

You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1, page 8, in the event that he or she is unable or unwilling to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

First alternative attorney-in-fact:

Name: STEVEN WADE MORGAN

Address: P. O. Box 765, Minden, Nevada 89423

Telephone Number: (702) 782-8526

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Second alternative attorney-in-fact:

Name: _____

Address: _____

_____

Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED:

I revoke any prior durable power of attorney for health care.

YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY

I sign my name to this Durable Power of Attorney for Health Care on August 5th, 1991, at Minden, State of Nevada.

Margaret J. Morgan
MARGARET J. MORGAN

THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

STATE OF NEVADA)
) ss.
COUNTY OF DOUGLAS)

On this 5th day of August, in the year 1991, before me, MICHAEL SMILEY ROWE, personally appeared MARGARET J. MORGAN 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 she executed it. I

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declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

MICHAEL SMILEY ROWE
Notary Public — Nevada
Douglas County
My Appointment Expires Feb. 2, 1992

NOTARY PUBLIC

STATEMENT OF WITNESSES

You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized you must use two (2) qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the attorney-in-fact, (2) a provider of health care, (3) an employee of an operator of a health care facility, (4) the operator of health care facility, (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.

I declare under the pains and penalties of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable 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 attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of

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health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

Signature: Wendy J. Sherrill Residence: 1401 Leonard Rd. Gardnerville, Nevada 89410

Print Name: WENDY J. SHERRILL

Date: August 5th, 1991.

Signature: Milani G. Watson Residence: 804 Chernus Dr. Carson City, Nevada 89703

Print Name: MILANI G. WATSON

Date: August 5th, 1991.

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that 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.

Signature: Wendy J. Sherrill

Signature: Milani G. Watson

Name: WENDY J. SHERRILL Address: 1401 Leonard Rd. Gardnerville, Nevada 89410

Name: MILANI G. WATSON Address: 804 Chernus Dr. Carson City, Nevada 89703

Print Names: WENDY J. SHERRILL Date: August 5th, 1991.

MILANI G. WATSON Date: August 5th, 1991.

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COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.

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REQUESTED BY
Michael Smiley Rowe
IN OFFICIAL RECORDS OF
DOUGLAS CO., NEVADA

'91 AUG -5 P2:47

SUSANNE BROADHEAD
RECORDER

$20.00 PAID DEPUTY

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