



4. The said joint tenant, WILLIAM H. MAXWELL, died on December 19, 2008, as shown on the death certificate attached hereto as Exhibit A and incorporated herein by reference. At the time of his death, the said WILLIAM H. MAXWELL and Grantor were husband and wife, being continuously married from the date of the deed referenced in the preceding paragraph and never having been divorced.

Further Affiant saith not.

  
SHIRLEY MAXWELL

Subscribed and sworn to before me this 19<sup>th</sup> day of March, 2009.

(Seal)

  
Notary Public

**KATHY HENDERSON**  
Notary Public - Notary Seal  
State of Missouri  
County of Bates  
My Commission Expires May 30, 2010  
#06396349

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**STATE OF TEXAS**  
**CERTIFICATION OF VITAL RECORD**

**CITY OF HARLINGEN**  
**BUREAU OF VITAL STATISTICS**

1. LEGAL NAME OF DECEASED (Include AKA's, if any) (First, Middle, Last) <b>WILLIAM H MAXWELL</b>		2. DATE OF DEATH - ACTUAL OR PRESUMED <b>12/18/2008</b>	
3. SEX <b>MALE</b>	4. DATE OF BIRTH <b>12/30/1938</b>	5. AGE - Last Birthday (Year) <b>68</b>	6. US BIRTHPLACE (City & State or Foreign Country) <b>KANSAS CITY, MO</b>
7. SOCIAL SECURITY NUMBER <b>8265</b>	8. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		9. BURNING SPOUSE'S NAME (If valid, give name prior to first marriage) <b>SHIRLEY PYLES</b>
10A. RESIDENCE STREET ADDRESS <b>RT 2 BOX 73</b>		10B. APT. NO.	10C. CITY OR TOWN <b>BUTLER</b>
10D. COUNTY <b>BATES</b>	10E. STATE <b>MISSOURI</b>	10F. ZIP CODE <b>64730</b>	10G. INSURE CITY LIMITED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11. FATHER'S NAME <b>ALVIS MAXWELL</b>		12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE <b>MARGURITTE HARD</b>	
13. PLACE OF DEATH (CHECK ONLY ONE) <input type="checkbox"/> DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DCA <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL			
14. COUNTY OF DEATH <b>CAMERON</b>		15. CITY/TOWN, ZIP CODE (If outside city limits, give precinct no.) <b>HARLINGEN, 78550</b>	16. FACILITY NAME (If not institution, give street address) <b>HARLINGEN MEDICAL CENTER</b>
17. INFORMANT'S NAME & RELATIONSHIP TO DECEASED <b>SHIRLEY MAXWELL - WIFE</b>		18. MAILING ADDRESS OF INFORMANT (Street and Number, City, State, Zip Code) <b>RT 2 BOX 73, BUTLER, MO 64730</b>	
19. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation		20. SIGNATURE AND LICENSE NUMBER OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH <b>MARIA CAROLINA ELIZONDO, BY ELECTRONIC SIGNATURE-7807</b>	
21. PLACE OF DISPOSITION (Name of Cemetery, tractatory, other place) <b>SACRED PARK CREMATORIUM</b>		22. LOCATION (City/Town, and State) <b>MERCEDES, TX</b>	
23. NAME OF FUNERAL FACILITY <b>ELIZONDO MORTUARY AND CREMATION SERVICE, LLC</b>		24. COMPLETE ADDRESS OF FUNERAL FACILITY (Street and Number, City, State, Zip Code) <b>5220 N. CONWAY, MISSION, TX 78574</b>	
25. CERTIFIER (Check only one) <input checked="" type="checkbox"/> Certifying physician - To the best of my knowledge, death occurred due to the specified and manner stated. <input type="checkbox"/> Medical Examiner/Assistant of the Peace - On the basis of examination, autopsy investigation, or post-mortem study performed at the time, date, and place, and due to the cause(s) and manner stated.			
27. SIGNATURE OF CERTIFIER <i>[Signature]</i>		28. DATE CERTIFIED (mm/dd/yyyy) <b>12 22 2008</b>	29. LICENSE NUMBER <b>L9827</b>
31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) <b>D. Daniel Martinez 702 N Ed Carey Drive Harlingen, TX 78550</b>		32. TITLE OF CERTIFIER <b>MD</b>	
33. PART 1: ENTER THE CHAIN OF EVENTS - DISEASES, INJURIES, OR COMPLICATIONS - THAT DIRECTLY CAUSED THE DEATH. DO NOT ENTER TERMINAL EVENTS SUCH AS CARDIAC ARREST, RESPIRATORY ARREST, OR VENTRICULAR FIBRILLATION WITHOUT SHOWING THE ETIOLOGY. DO NOT ABBREVIATE. ENTER ONLY ONE CAUSE ON EACH LINE. IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>a. Pending</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):			
34. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
36. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	38. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to one year before death <input type="checkbox"/> Unknown if pregnant within the past year	
39a. DATE OF INJURY (mm/dd/yyyy)	39b. TIME OF INJURY	39c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	39d. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, wooded area)
40a. LOCATION (Street and Number, City, State, Zip Code)			
41. DESCRIBE HOW INJURY OCCURRED			
42a. REGISTRAR FILE NO. <b>03-0972</b>	42b. DATE RECEIVED BY LOCAL REGISTRAR <b>December 22, 2008</b>	42c. SIGNATURE OF LOCAL REGISTRAR <i>Becky A. Infante</i>	

**AMENDMENT TO MEDICAL CERTIFICATION OF CERTIFICATE OF DEATH**

STATE OF TEXAS		STATE FILE NUMBER	
ENTER NAME OF DECEASED AND PLACE OF DEATH EXACTLY AS SHOWN ON ORIGINAL DEATH CERTIFICATE			
NAME OF DECEASED <b>William H. Maxwell</b>		DATE OF DEATH <b>12-19-2008</b>	
PLACE OF DEATH (City or Town and County) <b>Harlingen Cameron</b>		IS THE DATE OF DEATH BEING CORRECTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. CERTIFIER (Check only one): <input checked="" type="checkbox"/> Certifying Physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner/Assistant of the Peace - On the basis of examination, autopsy investigation, or post-mortem study performed at the time, date, and place, and due to the cause(s) and manner stated.			
27. SIGNATURE OF CERTIFIER <i>[Signature]</i>		28. DATE CERTIFIED (mm/dd/yyyy) <b>01/08/2009</b>	29. LICENSE NUMBER <b>L9827</b>
31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) <b>Daniel Martinez 702 N. Ed Carey Drive Harlingen, Texas 78550</b>		32. TITLE OF CERTIFIER <b>MD</b>	
33. PART 1: ENTER THE CHAIN OF EVENTS - DISEASES, INJURIES, OR COMPLICATIONS - THAT DIRECTLY CAUSED THE DEATH. DO NOT ENTER TERMINAL EVENTS SUCH AS CARDIAC ARREST, RESPIRATORY ARREST, OR VENTRICULAR FIBRILLATION WITHOUT SHOWING THE ETIOLOGY. DO NOT ABBREVIATE. ENTER ONLY ONE CAUSE ON EACH LINE. IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>a. pericardial tamponade</b> Due to (or as a consequence of): <b>b. pericarditis</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):			
34. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
36. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	37. DID TOBACCO CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	38. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	
39a. DATE OF INJURY (mm/dd/yyyy)	39b. TIME OF INJURY	39c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	39d. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, wooded area)
40a. LOCATION (Street and Number, City, State, Zip Code)			
41. DESCRIBE HOW INJURY OCCURRED			
42a. REGISTRAR FILE NO. <b>03-0972</b>	42b. DATE RECEIVED BY LOCAL REGISTRAR <b>January 8, 2009</b>	42c. SIGNATURE OF LOCAL REGISTRAR <i>Becky A. Infante</i>	

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BK- 0409  
 PG- 3786  
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THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT REPRODUCTION OF THE ORIGINAL RECORD AS RECORDED IN THIS OFFICE. ISSUED UNDER AUTHORITY OF SECTION 191.051, HEALTH AND SAFETY CODE.

DATE ISSUED: **JAN 08 2009**

*Becky A. Infante*  
 BECKY A. INFANTE, LOCAL REGISTRAR  
 HARLINGEN, TEXAS

