4

LIVING WILL DECLARATION

Declaration made this 9th day of June, 2000.

I, Carolyn Bonds DeLaughter, being at least eighteen years old and of sound mind, willfully and voluntarily make known my desires about whether my dying shall or shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that I have an incurable injury, disease or illness, that my death will occur within a short time, and that the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that my wishes set out below be followed.

I understand that Indiana law does not authorize me:

- to direct that comfort care be withheld,
- to direct what healthcare I should receive if I am diagnosed to be in a permanent coma.

However, I request that all directions I set out in this document, including those that go beyond what Indiana authorizes, be respected and followed in keeping with my right to direct my own healthcare as guaranteed by the U.S. Constitution.

If I am diagnosed to have a terminal condition, I direct that:

- all comfort care be provided, even if it would also have the effect of prolonging my life.
- all additional life-prolonging treatment be withheld, including: blood and blood products, cardio-pulmonary resuscitation (CPR), diagnostic tests, dialysis, drugs, respirator and surgery .

I have additional specific wishes regarding food and water if I am diagnosed to have a terminal condition:

_____ I wish to receive artificially-supplied nutrition and hydration, even if the effort to sustain my life is futile or excessively burdensome to me.

X CBD I do not wish to receive artificially-supplied nutrition and hydration if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially-supplied nutrition and hydration, leaving the decision to my healthcare representative appointed under IC 16-36-1-7 or my attorney-in-fact with healthcare powers under IC 30-5-5.

If I am diagnosed to be in a permanent coma, I direct that:

- all comfort care be provided, even if it would also have the effect of prolonging my life.
- all additional life-prolonging treatment be withheld, including: blood and blood products, cardio-pulmonary resuscitation (CPR), diagnostic tests, dialysis, drugs, respirator and surgery .

I have additional specific wishes regarding food and water if I am diagnosed to be in a permanent coma:

_____ I wish to receive artificially-supplied nutrition and hydration, even if the effort to sustain my life is futile or excessively burdensome to me.

X CBD I do not wish to receive artificially-supplied nutrition and hydration if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially-supplied nutrition and hydration, leaving the decision to my healthcare representative appointed under IC 16-36-1-7 or my attorney-in-fact with healthcare powers

2000 041220

16.00
4.1

under IC 30-5-5.

SEVERABILITY

If any of the specific directions in this document are held invalid, that shall not affect other directions that can be given effect without the invalid direction.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this Declaration be honored by my family and physician as the final expression of my legal right to request or refuse medical or surgical treatment and to accept the consequences of this decision.

I understand the full import of this Declaration.

Signed Carolyn Bonds DeLaughter
Crown Point, Lake County, Indiana

City, County and State of Residence

Date: June 9, 2000

The Declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the Declarant's signature above for or at the direction of the Declarant. I am not a parent, spouse, or child of the Declarant. I am not entitled to any part of the Declarant's estate or directly financially responsible for the Declarant's medical care. I am competent and at least eighteen years old.

Witness: Marie L Kolesa

Date: 06/09/2000

Witness: William James DeLaughter

Date: 9 June 2000

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

To my family, friends, physicians, healthcare providers, community care facilities and any other person who may have an interest in my medical care:

I, Carolyn Bonds DeLaughter, being of sound mind, voluntarily create this Durable Power of Attorney for Healthcare.

APPOINTMENT OF ATTORNEY-IN-FACT

If I become unable to make healthcare decisions for myself, I appoint the following person as my attorney-in-fact with authority to make healthcare decisions for me as I direct in this document.

Name: David Thomas DeLaughter

Address: Union University, Jackson, Tn., 38305

Day telephone: 1 (901) 664-7822

Evening telephone: [lw_proxy_ephone]

APPOINTMENT OF ALTERNATE ATTORNEY-IN-FACT

If that person is unable or unwilling to act as my attorney-in-fact for the purpose of making healthcare decisions, I appoint the following person to serve.

Name: Joyce Kleinhans

Address: 302 Pratt Street, Crown Point, IN., 46307

Day telephone: (219) 663-3204

Evening telephone: as above

WHEN EFFECTIVE

This Durable Power of Attorney for Healthcare shall:

- become effective when I sign it.
- not be affected by my subsequent disability or incompetence.
- remain in effect until my death, or until I revoke it.

AUTHORITY I GRANT MY ATTORNEY-IN-FACT

I grant my attorney-in-fact full authority to enforce the instructions I have set out in the Living Will Declaration to which this Durable Power of Attorney For Healthcare is attached. The authority I grant to my attorney-in-fact shall include the authority to:

- hire and fire medical personnel.
- visit me in a hospital or other medical care facility.
- review and receive any information regarding my physical or mental health, including medical and hospital records.
- sign any releases or other documents required to obtain this information.
- sign any documents required to request, withdraw or refuse medical treatment or to be released or transferred from a hospital or other medical facility.

• sign any waiver or release from liability required by a hospital or physician.

I authorize my attorney-in-fact to make decisions in my best interest concerning withdrawal or withholding of healthcare. If, at any time, based on my previously expressed preferences and the diagnosis and prognosis, my attorney-in-fact is satisfied that certain healthcare is or would not be excessively burdensome, then my attorney-in-fact may express my consent on my behalf that any or all healthcare be discontinued or not instituted, even if death may result.

My attorney-in-fact must try to discuss this decision with me. However, if I am unable to communicate, my attorney-in-fact may make such a decision for me, after consultation with my physician or physicians and other relevant healthcare givers. To the extent appropriate, my attorney-in-fact may also discuss this decision with my family and others, to the extent they are available.

Executed this 9th day of June, 2000

Signature: William James DeLaughter

Place: Crown Point, Lake Co., Indiana
(City or County and State)

DECLARATION OF WITNESSES

I am at least 18 years old. I declare that the person who signed or asked another to sign this document in my presence is personally known to me, and appears to be of sound mind and acting willingly and free from duress.

Witness: _____

Address: _____

NOTARIZATION

State of: Indiana

County of: Lake

On June 9 2000, before me, William E. Carpenter a Notary Public, personally appeared Carolyn Bonds DeLaughter, personally known to me or proved on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument, and acknowledged and executed the same.

Notary Public

My commission expires: WILLIAM E. CARPENTER
Notary Public, Lake County, Ind.
My Comm. Expires Sept. 25, 2005