

*★* RETURN TO DANIEL L. SHOAF  
19490 CAMONG Rd  
SHERBORN Ind 46069

BT800411

2008 062822

**GENERAL DURABLE POWER OF ATTORNEY  
OF  
ANNA L. SHOAF**

**BY THIS POWER OF ATTORNEY**, I name my attorney-in-fact, with power to act on my behalf pursuant to Indiana Code 30-5, as it exists now and is amended in the future.

**SINGLE ATTORNEY-IN-FACT.** As my attorney-in-fact, I name my husband, Lewis D. Shoaf.

**SUCCESSOR ATTORNEY-IN-FACT.** As my successor attorney-in-fact, I name my son, Daniel L. Shoaf.

**SECOND SUCCESSOR ATTORNEY-IN-FACT.** As my second successor attorney-in-fact, I name my son, David L. Shoaf.

**LIABILITY LIMITED.** My attorney-in-fact shall only be liable for actions undertaken in bad faith.

**FEE.** My attorney-in-fact shall be entitled to a reasonable fee for services provided as my attorney-in-fact, and shall be entitled to recover expenses.

**EFFECTIVE IMMEDIATELY.** This power of attorney shall be effective as of the day it is signed.

**POWERS.** I give to my attorney-in-fact the powers specified in this section to be used on my behalf, PROVIDED that my attorney-in-fact shall not have any power which would cause my attorney-in-fact to be treated as the owners of any interest in my property:

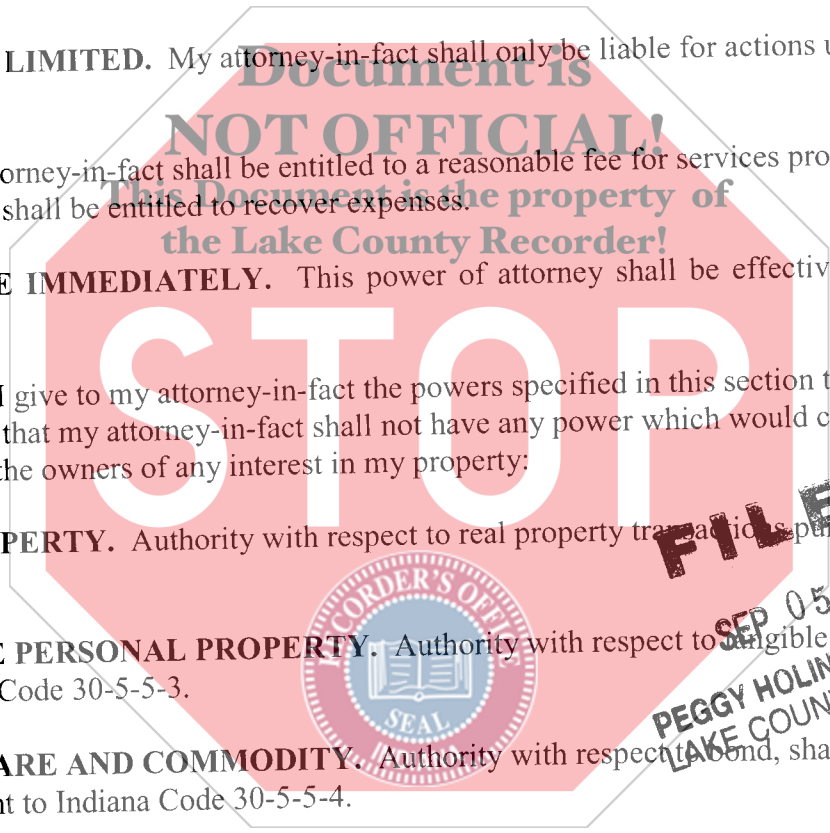
**REAL PROPERTY.** Authority with respect to real property transactions pursuant to Indiana Code 30-5-5-2.

**TANGIBLE PERSONAL PROPERTY.** Authority with respect to tangible personal property pursuant to Indiana Code 30-5-5-3.

**BOND, SHARE AND COMMODITY.** Authority with respect to bond, share and commodity transactions pursuant to Indiana Code 30-5-5-4.

**RETIREMENT PLANS.** Authority with respect to retirement plans pursuant to Indiana Code 30-5-5-4.5.

**BANKING.** Authority with respect to banking transactions pursuant to Indiana Code 30-5-5-5.



**FILED**

SEP 05 2008

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

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**BUSINESS.** Authority with respect to business operating transactions pursuant to Indiana Code 30-5-5-6.

**INSURANCE.** Authority with respect to insurance transactions pursuant to Indiana Code 30-5-5-7 provided that references in Indiana Code 30-5-5-7(a)(2) and (3) to "section 8" are changed to "section 9."

**BENEFICIARY.** Authority with respect to beneficiary transactions pursuant to Indiana Code 30-5-5-8.

**GIFTS.** Authority with respect to gift transactions pursuant to Indiana Code 30-5-5-9.

**FIDUCIARY.** Authority with respect to fiduciary transactions pursuant to Indiana Code 30-5-5-10.

**CLAIMS AND LITIGATION.** Authority with respect to claims and litigation pursuant to Indiana Code 30-5-5-11.

**FAMILY MAINTENANCE.** Authority with respect to family maintenance pursuant to Indiana Code 30-5-5-12.

**MILITARY SERVICE.** Authority with respect to benefits from military service pursuant to Indiana Code 30-5-5-13.

**RECORDS, REPORTS AND STATEMENTS.** Authority with respect to records reports and statements pursuant to Indiana Code 30-5-5-14, including the power to execute on my behalf any specific power of attorney required by any taxing authority to allow my attorney-in-fact to act on my behalf before any taxing authority on any return or issue.

**ESTATE TRANSACTIONS.** Authority with respect to estate transactions pursuant to Indiana Code 30-5-5-15.

**HEALTH CARE.** Authority with respect to health care pursuant to Indiana Code 30-5-5-16.

**HEALTH CARE REPRESENTATIVE APPOINTMENT WITH POWER TO STOP HEALTH CARE.** I appoint my attorney-in-fact as my health care representative, with authority to act for me in all matters of health care in accordance with Indiana Code 16-36-1 et seq. as shown by the appointment attached to this power of attorney pursuant to Indiana Code 30-5-5-16 (b)(2) and Indiana Code 30-5-5-17. I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164, and all other applicable state and federal law.

**DELEGATE.** Authority with respect to delegating authority pursuant to Indiana Code 30-5-5-18.

**ALL OTHER MATTERS.** Authority with respect to all other matters pursuant to Indiana Code 30-5-5-19.

**SUPERSEDES PRIOR POWERS OF ATTORNEY.** This power of attorney supersedes all other powers of attorney I have executed prior to the date of this power of attorney.

**TERMINATION AT DEATH.** Without regard to my mental or physical condition, this power of attorney shall continue in effect until revoked or until my death whichever occurs first.

I have executed this instrument on this 10<sup>th</sup> day of August, 2007.

*Anna L. Shoaf*  
\_\_\_\_\_  
Anna L. Shoaf

STATE OF INDIANA        )  
  )  
COUNTY OF HAMILTON    )

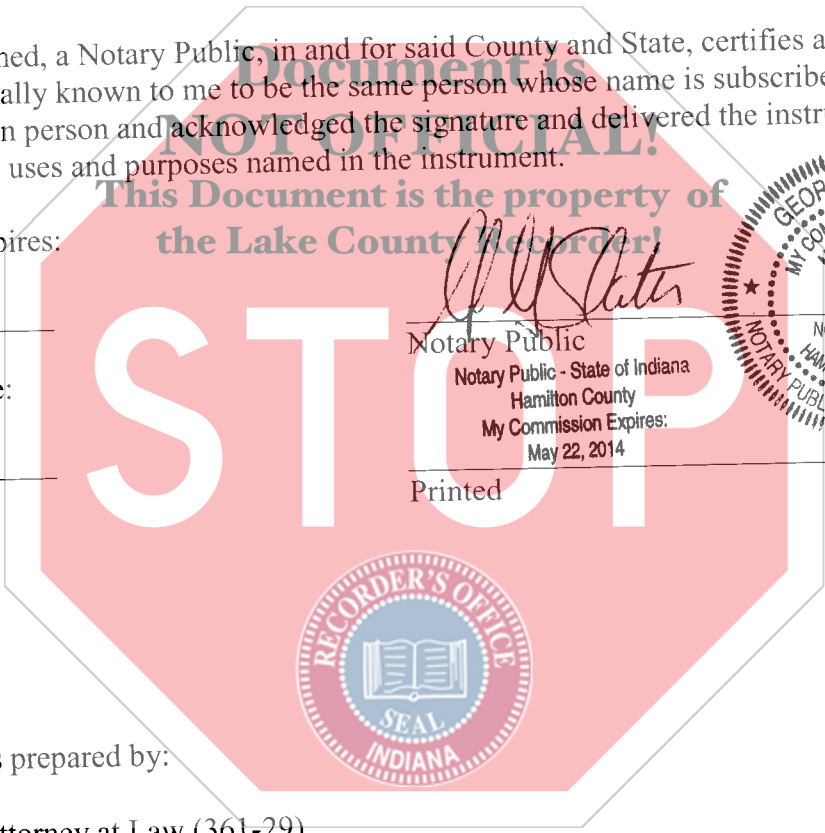
The undersigned, a Notary Public, in and for said County and State, certifies and witnesses that the above signed, personally known to me to be the same person whose name is subscribed to this instrument, appeared before me in person and acknowledged the signature and delivered the instrument as a free and voluntary act, for the uses and purposes named in the instrument.

My Commission Expires:

5-22-14

County of Residence:

Hamilton



*George G. Slater*  
Notary Public  
Notary Public - State of Indiana  
Hamilton County  
My Commission Expires:  
May 22, 2014

Printed

This instrument was prepared by:

George G. Slater, Attorney at Law (361-29)  
SLATER & ASSOCIATES  
301 East Carmel Drive  
Building G, Suite 100  
Carmel, Indiana 46032  
(317) 571-9600

**APPOINTMENT OF HEALTH CARE REPRESENTATIVE  
FOR ANNA L. SHOAF**

**PURSUANT TO INDIANA CODE 16-36-1 et seq.**, as amended, I hereby appoint my husband, Lewis D. Shoaf, as my health care representative to act for me in matters affecting my health care whenever I am incapable of so acting.

**SUCCESSOR HEALTH CARE REPRESENTATIVE.** I hereby appoint my son, Daniel L. Shoaf, as my successor health care representative.

**SECOND SUCCESSOR HEALTH CARE REPRESENTATIVE.** I hereby appoint my son, David L. Shoaf, as my second successor health care representative.

**HIPAA REGULATIONS.** My health care representative is to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164, and all other applicable state and federal law. This authority shall supersede any prior agreement I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my health care representative has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

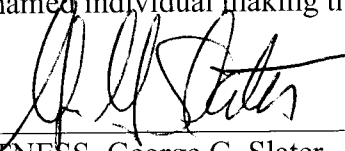
**WITHDRAWAL OF HEALTH CARE.** I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

**CONSULTATIONS.** My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent available. I authorize my health care representative, or successor to delegate all or part of this authority to any eligible individual who has not been disqualified.

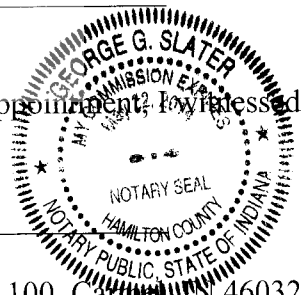
DATE: August 10, 2007

  
Anna L. Shoaf

I declare that at the request of the above named individual making the appointment, I witnessed the signing of this document.

  
WITNESS, George G. Slater  
Address: 301 E. Carmel Drive, G-100, Carmel, IN 46032

Notary Public - State of Indiana  
Hamilton County  
My Commission Expires:  
May 22, 2014



ATTENTION ESTATE: The Social Security # is requested by this state agency in order to issue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

# HAMILTON COUNTY HEALTH DEPARTMENT

BR806411

## CERTIFICATE OF DEATH

State No. ....

Local No. 9734

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

1 DECEASED—NAME (First, Middle, Last) Lewis D. Shoaf		2 SEX Male	3a TIME OF DEATH 10:40A	3b DATE OF DEATH (Month, Day, Yr) September 7, 2007
4 *SOCIAL SECURITY NUMBER <del>000000</del>	5a AGE—Last Birthday (Years) 88	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) August 3, 1919
7 BIRTHPLACE (City and State or Foreign Country) Covington, Indiana	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) 19490 Lamong Road	9c CITY, TOWN OR LOCATION OF DEATH Sheridan	9d COUNTY OF DEATH Hamilton		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Annalee Hershberger	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Plant Production	12b KIND OF BUSINESS/INDUSTRY Steel Manufacturing	
13a RESIDENCE—STATE Indiana	13b COUNTY Hamilton	13c CITY, TOWN, OR LOCATION Sheridan	13d STREET AND NUMBER 19490 Lamong Road	
13e ZIP CODE 46069	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc (Specify) White
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		18 FATHER'S NAME (First, Middle, Last) Ora Shoaf	19 MOTHER'S NAME (First, Middle, Maiden Surname) Helen Cole	
20a INFORMANT'S NAME (Type/Print) David Shoaf	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Clover Lane, Bolingbrook, IL 60440	20c Relationship Son		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) September 11, 2007 Memory Lane Memorial Park	21c LOCATION—City or Town, State Schererville, Indiana		
22a EMBALMER'S NAME John Renner	22b EMBALMER'S LICENSE NO. FD01010656	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>	24b LICENSE NUMBER (of Licensee) FD01010656	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Road Highland, Indiana FH10300021		
26 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Probable Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____  Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last				Approximate Interval Between Onset and Death
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I PARKINSON DISEASE				27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO
				28a WAS AN AUTOPSY PERFORMED? (Yes or no) NO
				28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A
29a CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER 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) as stated. <input checked="" type="checkbox"/> CORONER 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.	29b SIGNATURE AND TITLE OF CERTIFIER Thur J Cecil, Jr. Coroner Hamilton Co	29c MEDICAL LICENSE NO. N/A	29d DATE SIGNED (Month, Day, Year) 09-14-2007	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Thur J Cecil, Jr. Hamilton Co, 59 Ste 52 Noblesville, IN 46060				
31 HEALTH OFFICER'S SIGNATURE Charles Harris, MD				32 DATE FILED (Month, Day, Year) SEP 17 2007
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	34a DATE OF INJURY (Month, Day, Year) 09-07-07	34b TIME OF INJURY 10:40AM	34c INJURY AT WORK? (Yes or no) NO	34d DESCRIBE HOW INJURY OCCURRED Found unresponsive
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) Home			34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 19490 Lamong Rd Sheridan IN	
34g DATE PRONOUNCED DEAD (Month, Day, Year) 09-07-2007	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. NO			

09/07

Charles Harris, MD

Hamilton County Health Officer

DATE SEP 17 2007

True copy of the record on file with the Hamilton County Health Dept.