RETURN TO DANIEL L. SHOAF
19490 LARONG Rd
SHERIDAN IN 46069

BT800411

2008 022820

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.

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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 10th day of August, 2007.

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

Notary Public

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

GEORGE G. SLATER MY COMMISSION EXPIRES May 22, 2014 NOTARY SEAL NOTARY PUBLIC, STATE OF INDIANA HAMILTON COUNTY

County of Residence:

Hamilton

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

GEORGE G. SLATER NOTARY SEAL HAMILTON COUNTY NOTARY PUBLIC, STATE OF INDIANA

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

ATTENTION ESTATE: The Social Security # i
ng requested by this state agency in order t
rsue its statutory responsibility. Disclosure i
untary and there will be no penalty for refusal.

Local No. 6734

HAMILTON COUNTY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

State No. 0806411

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

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Lewis D. Shoaf	Male	10:40A$_M$	September 7, 2007

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
[redacted]	88			August 3, 1919	Covington, Indiana

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
No	N/A	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
19490 Lamong Road	Sheridan	Hamilton

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Annalee Hershberger	Plant Production	Steel Manufacturing

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Hamilton	Sheridan	19490 Lamong Road

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46069	☒ No ☐ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Ora Shoaf	Helen Cole

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
David Shoaf	500 Clover Lane, Bolingbrook, IL 60440	Son

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	September 11, 2007 Memory Lane Memorial Park	Schererville, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
John Renner	FD01010656	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FD01010656	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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Probable Cerebral Vascular Accident	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF)	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.	27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
PARKINSON DISEASE	NO	NO	N/A

29a. CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN. To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.

☐ 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.

☒ 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
Thurl T Cecil Jr Coroner Hamilton Co	N/A	09-14-2007

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Thurl T Cecil, Jr. | Hamilton Co. Sq 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	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide	09-07-07	10:40AM	NO	Found Unresponsive

34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Home	19490 Lamong Rd Sheridan IN

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
09-07-2007	NO

SDH06-004 State Form 10110 (R5/1-99)

09/07

Charles Harris, MD

Hamilton County Health Officer

DATE SEP 17 2007

This photocopy is a true copy of the record on file with the Hamilton County Health Dept.