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Filed for record at the request of:
Shirley M. Boyd
986 NW Rock Creek Dr.
Apt. 213
Stevenson, WA 98648

Living Will, Health Care P.O.A. &
DURABLE POWER OF ATTORNEY

I, Shirley M. Boyd, resident of the State of Washington, revoke any powers of attorney I may have given in the past and give Connie J. Davis (referred to below as "the agent") a durable power of attorney. I intend that it not be limited by any disability I may have in the future.

1. POWERS

A. The agent shall act on my behalf and for my benefit, and shall have all powers over my estate that I have or acquire. These shall include, but not be limited to, the following: the power to make deposits to, and payments from, any account in my name in any financial institution; the power to open and remove items from any safe deposit box in my name; the power to sell, exchange or transfer title to stocks, bonds or other securities; the power to sell, convey or encumber any real or personal property.

B. The agent shall have the power to consent to, or to withhold consent from, medical treatment, shall have all powers necessary or desirable to provide for my support, maintenance, health and comfort; the agent shall be entitled to obtain and use any of my medical records or other individually identifiable health information to the same extent as I would myself. This is intended as a full release of all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. I authorize the agent to revoke any community property agreement and to transfer any property to my spouse or registered domestic partner as a gift. _____ (*Initial* here if revocation of a community property agreement and gifts to a spouse or registered domestic partner are authorized. If they are not authorized, cross out all of paragraph C.) S MB

D. I authorize the agent to make gifts of my property to the following person or persons: _____.
Gifts under this paragraph may be:
_____ in any amount
_____ not more than $_____ per year

(If gifts are authorized under paragraph D, either *initial* next to "in any amount" or *initial* next to "no more than" and fill in a dollar amount. If gifts are not authorized, cross out all of paragraph D.)

No gift may be made under this power of attorney, except to a spouse or registered domestic partner if authorized under paragraph 1(C), unless authorized by this paragraph.

2. EFFECTIVE DATE, REVOCATION AND DISPOSITION OF REMAINS

A. This power of attorney shall become effective (initial the choice that applies):

SMB immediately

_____only when my agent certifies in writing that I lack the mental capacity to make important decisions independently. (This certification may be made using the box at the end of this document, or may be made in a separate writing.)

B. It shall remain in effect until revoked or until my death.

C. After my death, my agent shall have the authority to act as my representative for purposes of controlling the disposition of my remains, as authorized under RCW 68.50.160, if I have not otherwise made lawful provision for their disposition.

D. I may revoke this power of attorney by giving written notice to the agent and, if the power of attorney has been recorded, by recording the written instrument of revocation in the county office where deeds are recorded.

E. If I give notice of revocation after my agent has certified that I lack the mental capacity to make important decisions, then my agent's power of attorney shall be suspended unless and until a court determines that the revocation was not effective.

3. RIGHTS AND DUTIES OF THE AGENT

A. My estate shall hold the agent harmless from, and indemnify the agent for, all liability for acts done for me in good faith based on this power of attorney.

B. The agent shall be required to account to any subsequently appointed personal representative.

4. NOMINATION OF GUARDIAN

I nominate the agent for consideration by the court as my guardian or limited guardian in the event that any guardianship proceeding for my person or estate should be commenced.

5. SUBSTITUTE AGENT

I appoint Harold Ralph Davis to serve as substitute agent in place of the agent named in paragraph 1 above, if the agent named in paragraph 1 is unable or unwilling to serve. A statement signed by the substitute agent, affirming that the agent named in paragraph 1 is unable or unwilling to serve shall be sufficient to establish that the agent is unable or unwilling to serve.

(If no substitute agent is named, this paragraph should be crossed out.)

Dated: 5-29-2014

Shirley M. Boyd

On 5/29/14, a person I know to be Shirley M. Boyd appeared before me in person, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned above.

Dated: 5/29/2014

Melissa A. Anderson

Notary Public, State of Washington,

residing at: Stevenson

Commission expires: 8-19-2016

MELISSA A. ANDERSON NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 8-19-16

Certification of Incapacity

I certify that the principal lacks the mental capacity to make important decisions independently.

dated: _____

_____
signature

printed name: _____

address: _____

_____

_____

telephone: _____

your SSI

Living Will *with Health Care Power of Attorney*

1. If I am unable to give directions about the use of life-sustaining treatment, I want my family and any physician to honor this directive as the final assertion of my legal right to refuse medical treatment.

2. I direct any physician to withhold or withdraw life-sustaining treatment and to let me die *if* at any time I should either

> A. have, in the written opinion of my attending physician, an incurable injury, disease, or illness, causing an irreversible terminal condition that will cause death within a reasonable period of time, and if the use of life-sustaining treatment would serve only to artificially prolong the process of dying, *or*
>
> B. be diagnosed in writing by two physicians, one of whom is my attending physician and both of whom have personally examined me, to be in a permanent unconscious condition.

3. I do not want either cardiopulmonary resuscitation (manual or mechanical efforts to restore heartbeat or breathing after they have stopped) or assisted ventilation (use of a respirator to help keep a person breathing) under the circumstances described in 2(A) or (B) above.

4. [redacted] (I **do not**) [*circle one and cross out the other*] want tube feeding (use of a tube through the nose or abdomen for feeding a person who can't take food by mouth) under the circumstances described in 2(A) or (B) above.

5. [redacted] (I **do not**) [*circle one and cross out the other*] want artificial hydration (giving liquids by tube or intravenously to a person who can't drink) under the circumstances described in 2(A) or (B) above unless it is necessary for my comfort.

Under no circumstances will I accept Blood SMB

Health Care Power of Attorney

6. I give a durable power of attorney to Connie J. Davis or Harold R. Davis to make decisions for me, consistent with my living will, about medical treatment, including the withholding or withdrawal of medical treatment, in the event that my treating physician determines I have lost the mental capacity to make such decisions for myself.

Date: 5-29-2014

Shirley M. Boyd
Signature

Printed name: SHIRLEY M. BOYD

Address: 986 NW Rock Ck Dr. Stevenson, Wa. 98648
street address city state

Statement of Witnesses

The maker of this living will (the "declarer") signed it in my presence. He or she has been personally known to me and I believe him or her to be capable of making health care decisions, to understand this living will, and to have signed it voluntarily. I am not related by blood or marriage to the declarer, and I am not now entitled to receive any portion of the declarer's estate, either by will or by operation of law, or as a result of any claim against the declarer. I am not the declarer's attending physician or an employee of that physician or of a health facility in which the declarer is a patient.

Date: 5/29/2014

Witness: [signature] 246 Roosevelt ST. Stevenson, WA 98648
Signature/Address

Witness: Diana Midland 882 Kanaka Ck Rd Stevenson WA 98648
Signature/Address

[See Revised Code of Washington 70.122.030] [CLS 9/02]

STATE OF WASHINGTON, } ss.
County of Skamania

ACKNOWLEDGMENT - Individual

On this day personally appeared before me Shirley Marie Boyd to me known to be the individual(s) described in and who executed the within and foregoing instrument, and acknowledged that She signed the same as her free and voluntary act and deed, for the uses and purposes therein mentioned.

GIVEN under my hand and official seal this 28th day of May 2014.

MELISSA A. ANDERSON
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
8-19-16

Notary Public in and for the State of Washington, residing at

My appointment expires 8-19-2016

STATE OF WASHINGTON, } ss.
County of

ACKNOWLEDGMENT - Corporate

On this ____ day of _____, ____, before me, the undersigned, a Notary Public in and for the State of Washington, duly commissioned and sworn, personally appeared _____ and _____ to me known to be the _____ President and _____ Secretary, respectively, of _____ the corporation that executed the foregoing instrument, and acknowledged the said instrument to be the free and voluntary act and deed of said corporation, for the uses and purposes therein mentioned, and on oath stated that _____ authorized to execute the said instrument and that the seal affixed (if any) is the corporate seal of said corporation.

Witness my hand and official seal hereto affixed the day and year first above written.

Notary Public in and for the State of Washington, residing at

My appointment expires _____

WA-46A (11/96)

This jurat is page 3 of 3 and is attached to Living Will dated 3/28/14.