DURABLE POWER OF ATTORNEY FOR HEALTH CARE & HEALTH CARE DIRECTIVE

	his document on	DAY YEAR
Signature		
Print name	SS No	
Address		
The person who signed this document is in our presence. Each of the undersigne		•
Signature	Signature	
Print name	Print name	
Address	Address	
Notarization required		
STATE OF MISSOURI)) SS	
COUNTY OF	,	
On this day of before me the person signing, known by and acknowledged it as his/her free act	y me to be the person who con	_, personally appeared appleted this document
IN WITNESS WHEREOF, I have set m		•
, State of	Missouri, the day and year first	st above written.