



compassion & choices

Care & Choices at the End of Life.

# Advance Directive

Planning for Important  
Healthcare Decisions

Missouri



# Missouri Durable Power of Attorney for Healthcare

I, \_\_\_\_\_  
(name of principal)

\_\_\_\_\_  
(address)

hereby designate \_\_\_\_\_  
(name of attorney in fact)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(home telephone number) (work telephone number)

as my attorney in fact.

In the event the person I designate above is unable, unwilling or unavailable to act as my attorney in fact, I hereby appoint \_\_\_\_\_  
(name of alternate attorney in fact)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(home telephone number) (work telephone number)

**THIS IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY ATTORNEY IN FACT SHALL NOT TERMINATE IF I BECOME DISABLED OR INCAPACITATED.**

This power of attorney becomes effective upon certification by two licensed physicians that I am incapacitated and can no longer make my own medical decisions. The powers and duties of my attorney in fact shall cease upon certification that I am no longer incapacitated. This determination of incapacity shall be periodically reviewed by my attending physician and my attorney in fact.

I authorize my attorney in fact and successor attorney in fact to make any and all health-care decisions for me, including decisions to withhold or withdraw any form of life support. I expressly authorize my attorney in fact (and alternate attorney in fact) to make all decisions regarding the provision, the withholding or the withdrawing of artificially

*(Continued)*



supplied nutrition and hydration in all medical circumstances.’

I, \_\_\_\_\_,  
the principal, sign my name to this instrument this \_\_\_\_\_ day of \_\_\_\_\_  
\_\_20 \_\_\_\_, and being first duly sworn, do hereby declare to the undersigned authority  
that I sign it willingly, that I execute it as my free and voluntary act for the purposes there  
in expressed, and that I am eighteen years of age or older, of sound mind, and under no  
constraint or undue influence.

\_\_\_\_\_  
(principal)

The State of Missouri

The County of \_\_\_\_\_

Subscribed, sworn to, and acknowledged before me by \_\_\_\_\_,  
the principal, this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

(seal)

\_\_\_\_\_  
(notary public)



# Missouri Declaration

I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying process. By this declaration I express to my physician, family and friends my intent. If I should have a terminal condition it is my desire that my dying not be prolonged by administration of death-prolonging procedures. If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw medical procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain. It is not my intent to authorize affirmative or deliberate acts or omissions to shorten my life, rather only to permit the natural process of dying.

Other directions:

Signed this \_\_\_\_\_ day of \_\_\_\_\_.

(day)

(month, year)

Signature \_\_\_\_\_

City, County and State of residence \_\_\_\_\_

\_\_\_\_\_

*(Continued)*



The declarant is known to me, is eighteen years of age or older, of sound mind and voluntarily signed this document in my presence.

Witness \_\_\_\_\_

Address \_\_\_\_\_

Witness \_\_\_\_\_

Address \_\_\_\_\_