Missouri Living Will

9 CSR 10-5.180

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.

Signed this _____ day of _____, 20_____.

_____ _____

Printed Name of Declarant Signature of Declarant

Address: _____

_____

WITNESSETH

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 #1: ***Witness #2:***

_____ _____

Signature Signature

_____ _____

Printed Name Printed Name

_____ _____

Address, Line 1 Address, Line 1

_____ _____

Address, Line 2 Address, Line 2

REVOCATION PROVISION

I hereby revoke the above declaration.

_____ _____

Printed Name of Declarant Signature of Declarant

Date: _____

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 S HALL 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 healthcare 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 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)