Planning

GUIDE

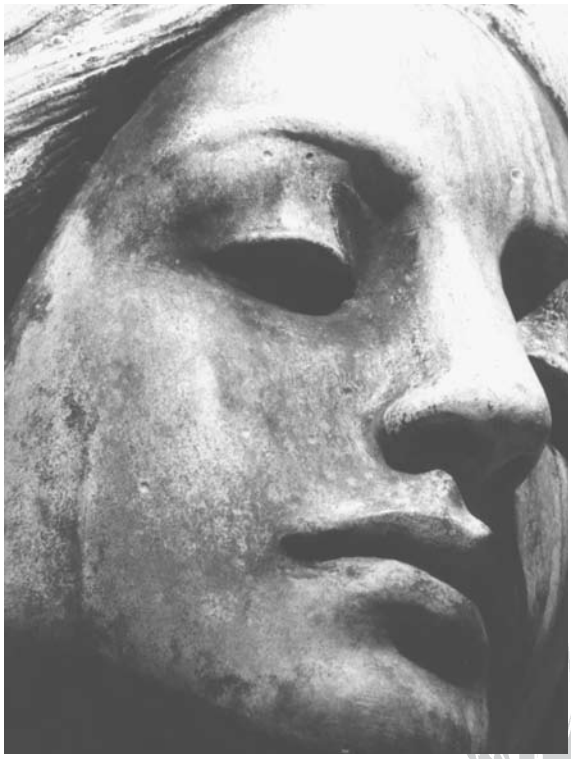
TRUST ◆ COMPASSION ◆ RESPECT

A comprehensive guide to help your family after your death

Oak Grove
CEMETERY

G U I D E

TRUST ◆ COMPASSION ◆ RESPECT



This guide will help you organize your personal and financial information. By completing it, you will help your family and loved ones at the time of your death.

Once you have completed this document, it's a good idea to meet with your family and discuss the choices you have made and the reasoning behind them. Make sure that your loved ones know where you plan to keep this guide.

Date Guide Completed

_____

Revised Date _____

Revised Date _____

Revised Date _____

Oak Grove CEMETERY

CONTENTS

Letter to your loved ones 3

Essential information
- Location of important documents 4
- Key contacts 5
- Bank accounts and investments 6
- List of assets and liabilities 8

Planning documents
- Will 12
- List of primary beneficiaries 13
- Health care directive forms 14

Benefits
- *Veteran's burial* - information from the Department of Veterans Affairs 15
- *Social Security benefits* - information from the Social Security Administration 21

Interment options
- Final Plans 24

How you want to be remembered
- Your obituary 27
- Your funeral or memorial service 29

Time of Death Issues
- Time of death to do list 30
- Information for death certificate 31

Other matters
- What family should know 32
- Organ donation 33

About Oak Grove Cemetery
- Programs and Services 34
- Map of Oak Grove Cemetery 36

Letter
TO MY LOVED ONES:

Because I love you, I have completed this planning kit. My goal is to relieve your anxiety at the time of my death.

List additional messages:

Signature: _____ Date: _____

Location
OF IMPORTANT DOCUMENTS

It may be helpful to make copies of these other important documents and include them with your planning guide. There is room for them in the back pocket of this guide.

	Location of original(s)	Copy attached?	
Will	_____	yes	no
Advanced Directives/Living Will	_____	yes	no
Birth certificate	_____	yes	no
Passport	_____	yes	no
Citizenship papers	_____	yes	no
Social Security card	_____	yes	no
Marriage license	_____	yes	no
Divorce, annulment or separation documents	_____	yes	no
Adoption papers	_____	yes	no
Insurance policies	_____	yes	no
Bank books	_____	yes	no
Checkbooks	_____	yes	no
Automobile titles	_____	yes	no
Stock and bond certificates	_____	yes	no
Income tax records	_____	yes	no
Military discharge certificates	_____	yes	no
Deed to burial property	_____	yes	no
Funeral arrangement documents	_____	yes	no
Pension plan information	_____	yes	no
Home information			
Abstract/Title Insurance Policy	_____	yes	no
Property tax records	_____	yes	no
Valuation	_____	yes	no

Do you have a safe deposit box? yes no

If yes, bank name & location _____

The location of the key: _____

Key CONTACTS

Attorney's name: _____
Address: _____
_____

Telephone number: _____
E-mail: _____

Financial advisor's name: _____
Address: _____
_____

Telephone number: _____
E-mail: _____

Insurance company: _____
Type of policy: _____
Policy owner: _____
Face amount of policy: _____
Name of agency: _____
Name of agent: _____
Telephone number: _____
Beneficiary: _____
Where stored: _____

Insurance company: _____
Type of policy: _____
Policy owner: _____
Face amount of policy: _____
Name of agency: _____
Name of agent: _____
Telephone number: _____
Beneficiary: _____
Where stored: _____

Insurance company: _____
Type of policy: _____
Policy owner: _____
Face amount of policy: _____
Name of agency: _____
Name of agent: _____
Telephone number: _____
Beneficiary: _____
Where stored: _____

Bank
ACCOUNTS & INVESTMENTS

Savings account number: _____
Institution: _____
Location: _____

Savings account number: _____
Institution: _____
Location: _____

Checking account number: _____
Institution: _____
Location: _____

Checking account number: _____
Institution: _____
Location: _____

Certificates of deposit: _____
Institution: _____
Location: _____

Certificates of deposit: _____
Institution: _____
Location: _____

Certificates of deposit: _____
Institution: _____
Location: _____

Certificates of deposit: _____
Institution: _____
Location: _____

Individual Retirement Accounts: _____
Institution: _____
Location: _____

Bank Acounts & Investments (Continued)

Money market account number: _____
Institution: _____
Location: _____

Money market account number: _____
Institution: _____
Location: _____

Money market account number: _____
Institution: _____
Location: _____

Money market account number: _____
Institution: _____
Location: _____

Stocks: _____
Investment Security Firm: _____
Location: _____

Stocks: _____
Investment Security Firm: _____
Location: _____

Stocks: _____
Investment Security Firm: _____
Location: _____

Stocks: _____
Investment Security Firm: _____
Location: _____

Additional Investments:

_____
_____
_____
_____
_____
_____

Assets
AND LIABILITIES

List of assets:

Personal residence:
Address: _____
_____

Description (e.g., single family home, condominium):
_____
_____
_____

Mortgage balance,
if any: $_____ Financial Institution: _____

Other personal residence or vacation homes:
_____
Address: _____
Description (e.g., single family home, condominium):
_____
_____
_____

Mortgage balance,
if any: $_____ Financial Institution: _____

Motor Vehicles (list):
_____
_____
_____
_____
_____
_____

Valuable jewelry (list): Approximate value:

_____ $_____
_____ $_____
_____ $_____

Assets & Liabilities (Continued)

Valuable antiques (list): Approximate value:

_____ $_____
_____ $_____
_____ $_____

Other valuable collections, such as coins: Approximate value:

_____ $_____
_____ $_____
_____ $_____

Additional Assets:

Asset: _____
Where is it located?: _____
_____
Are you the sole owner? __ yes __no
If no, name of co-owner: _____

Asset: _____
Where is it located?: _____
_____
Are you the sole owner? __ yes __no
If no, name of co-owner: _____

Note: You may need to attach additional pages.

Assets & Liabilities (Continued)

List current balances and current value (as of today's date) of all company-sponsored employee benefits plans such as IRAs, 401(k)s, stock purchase plans, pension plans, health coverage (including burial expenses), etc. List the beneficiary for each.

Note: the contact information for the beneficiary must be filled out on page 13.

Benefit: _____ Value: $_____
Beneficiary: _____

Benefit: _____ Value: $_____
Beneficiary: _____

Benefit: _____ Value: $_____
Beneficiary: _____

Benefit: _____ Value: $_____
Beneficiary: _____

Benefit: _____ Value: $_____
Beneficiary: _____

Benefit: _____ Value: $_____
Beneficiary: _____

Benefit: _____ Value: $_____
Beneficiary: _____

Benefit: _____ Value: $_____
Beneficiary: _____

Benefit: _____ Value: $_____
Beneficiary: _____

Benefit: _____ Value: $_____
Beneficiary: _____

Assets & Liabilities (Continued)

Personal Items:
List any personal and sentimental items that you would like specific people to have:

Item/Where Stored:	Recipient:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all liabilities (loans, credit card debt, etc.):

Liability: _____ Amount: $_____
Financial Institution:_____

Liability: _____ Amount: $_____
Financial Institution:_____

Liability: _____ Amount: $_____
Financial Institution:_____

Liability: _____ Amount: $_____
Financial Institution:_____

Liability: _____ Amount: $_____
Financial Institution:_____

Liability: _____ Amount: $_____
Financial Institution:_____

Liability: _____ Amount: $_____
Financial Institution:_____

Note: You may need to attach additional pages.

Last Will
AND TESTAMENT

Your will is perhaps the most important planning document. If you don't have a will, or haven't updated it in five years, make an appointment with your attorney.

In your will you will name an executor of your estate. This person is responsible for settling your estate by distributing your assets in the manner you have requested. Many people appoint their spouse or a family member. Another option is to appoint a professional representative. This person can help relieve family members during the period following a death.

Please include a copy of your will with these documents.

The executor of my estate is:

Name: _____

Address: _____

_____

Telephone: _____

E-mail: _____

Primary BENEFICIARIES

Please list the individuals that will be your primary beneficiaries. Double check to make sure that these are the same beneficiaries indicated in your will.

Name: _____
Age: _____
Relationship to you: _____
Address: _____
_____
Phone number: _____
E-mail: _____

Name: _____
Age: _____
Relationship to you: _____
Address: _____
_____
Phone number: _____
E-mail: _____

Name: _____
Age: _____
Relationship to you: _____
Address: _____
_____
Phone number: _____
E-mail: _____

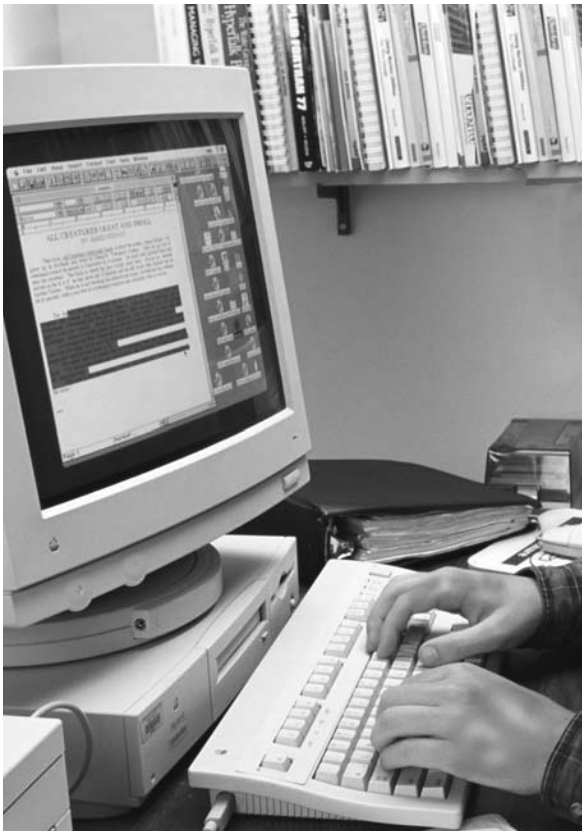
Name: _____
Age: _____
Relationship to you: _____
Address: _____
_____
Phone number: _____
E-mail: _____

Name: _____
Age: _____
Relationship to you: _____
Address: _____
_____
Phone number: _____
E-mail: _____

Health Care
DIRECTIVE FORMS

You may already have similar documents on file with your local hospital.

For your convenience, we have attached the current (Rev 12/2008) form used by both medical centers in the La Crosse Area and legal in the states of Wisconsin, Minnesota & Iowa.



Power of Attorney for Healthcare Document & Instructions for Completing This Document Page 1

The La Crosse Region Power of Attorney for Healthcare Document and The Instructions for Completing this Document

Overview

The attached power of attorney for healthcare form is a legal document, developed to meet the legal requirements for Wisconsin, Minnesota, and Iowa. This document provides a way for a person to create a power of attorney for healthcare that will meet the basic requirements for these states.

This power of attorney for healthcare form allows you to appoint another person and alternate persons to make your own healthcare decisions if you become unable to make these decisions for yourself. The person you appoint is called your **healthcare agent**. This document gives your healthcare agent authority to make your decisions only when you have been determined incapable by your physicians to make your own healthcare decisions. It does not give your healthcare agent any authority to make your financial or other business decisions. In addition, it does not give your healthcare agent authority to make certain decisions about your mental health treatment.

Before completing this power of attorney for healthcare form, take time to read it carefully. **It is also very important that you discuss your views, values, and this document with your healthcare agent.** If you do not closely involve your healthcare agent and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

If you want to document your views about future healthcare, but do not want to or cannot use this power of attorney for healthcare form, ask your health organization or attorney for advice about alternatives.

How to Complete This Document

This power of attorney for healthcare form is divided into four parts.

Part I – Appointing a Healthcare Agent
Part II – Authority of the Healthcare Agent
Part III – Statement of Desires, Special Provisions or Limitations
Part IV – Making the Document Legal

Steps to Follow:

In each of the four parts of the attached document you will find instructions. Read and follow these instructions carefully. The basic things you must do are:

1. Provide the information on page 1.
2. Appoint at least one healthcare agent on page 3.
3. Indicate choices for sections 1, 2, and 3 on page 5.
4. Indicate any written instructions you want in Part III.
5. Sign and date the document on page 10.
6. Have the document witnessed. Both witnesses must be present when you sign this document.

Power of Attorney for Healthcare Document & Instructions for Completing This Document Page 2

If you wish to donate your body after death to medical science, you should contact the closest medical school in your state and make arrangements through that medical school. Here are some places to contact.

University of Wisconsin-Madison Medical School	**(608) 262-2888**
Mayo Medical School	**7 a.m. – 4 p.m. (507) 284-2693 or (507) 284-9170**
University of Iowa Medical School	**(319) 335-7762**

After Completing This Document

After you complete the document, make copies to be given out as follows:

- One copy for yourself.
- One copy for the healthcare agent and alternates appointed in the document.
- One copy to share and discuss with your physician.
- One copy for your record at the hospital where you would go in an emergency.
- Extra copies to share with others if you wish (loved ones, your clergy, and your attorney).

A photo or fax copy is as legally valid as an original.

Need Assistance?

If you need assistance in completing this document you may contact the following places:

Gundersen Lutheran

Gundersen Lutheran Medical Center

- Pastoral Care
  (608) 782-7300, ext. 51347
  (800) 362-9567, ext. 51347
- Advance Care Planning Coordinator
  (608) 782-7300, ext. 56000
  (800) 362-9567, ext. 56000

Gundersen Lutheran, Onalaska Clinic

- Social Services
  (608) 775-8159
  (800) 362-9567, ext. 58159

Or call the Gundersen Lutheran Regional Clinic or affiliate in your community

Franciscan Skemp Healthcare

Mayo Health System

La Crosse Medical Center
(608) 392-9754
(800) 362-5454, ext. 9505

Elder Services La Crosse
(608) 392-9505

Home Health Services/Hospice
(608) 392-9790
(800) 362-5454, ext. 9790

Or call the Franciscan Skemp Healthcare affiliate in your community. All Franciscan Skemp Healthcare service sites can be accessed through a toll-free number: (800) 362-5454.

Power of Attorney for Healthcare forms Page 1

Power of Attorney for Healthcare

for

Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

Copies of this document are being or have been given to following health organizations and people (Provide copies to your hospital, physician, and health care agents and copies might also be given to close family, friends and clergy.):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Power of Attorney for Healthcare Document

Notice to the Person Making This Document:

You have the right to make decisions about your healthcare. No healthcare may be given to you over your objection, and necessary healthcare may not be stopped or withheld if you object.

Because your healthcare providers in some cases may not have had the opportunity to establish a long-term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your healthcare.

In order to avoid this problem, you may sign this legal document to specify a person who you would want to make healthcare decisions for you if you become unable to make those decisions personally. That person is known as your healthcare agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons you might specify. You may state in this document any types of healthcare that you do or do not desire, and you may limit the authority of your healthcare agent. If your healthcare agent is unaware of your desires with respect to a particular healthcare decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make healthcare decisions for you. It revokes any prior power of attorney for healthcare that you may have made. If you wish to change your Power of Attorney for Healthcare, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses.
If you revoke, you should notify your agent, your healthcare providers and any other person to whom you have given a copy. If your agent is your spouse and your marriage is annulled or you are divorced after signing this document, the designation of your spouse as healthcare agent shall no longer be valid.

You may also use this document to make or refuse to make any anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift you may have made. You may revoke or change any anatomical gift that you make in this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it.

It is suggested that you keep the original of this document on file with your physician.

Part I – Appointing a Person to Make My Healthcare Decisions When I Can't Make My Own Healthcare Decisions

If I am no longer able to make my own healthcare decisions, this document names the person I choose to make these choices for me. This person will be my healthcare agent. This person will make my healthcare decisions when I am determined to be incapable to make healthcare decisions as provided under state law.

Instructions for Completing This Part:

When selecting someone to be your healthcare agent, pick someone who knows you well, who you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Make sure that you pick someone who will closely follow what you want and will be a good advocate for you. Whatever you do, take time to discuss this document and your views with the person(s) you pick to be your agent(s).

Your healthcare agent should be at least 18 years or older and should not be one of your healthcare providers or an employee of your healthcare provider unless they are a close relative. Space has been provided for a second and third alternate healthcare agent.
The person I choose as my Healthcare Agent is:

Name: _____

Day phone: _____ Evening phone: _____

Cell phone: _____

Address: _____

City: _____ State: _____ ZIP code: _____

If this healthcare agent is unable or unwilling to make these choices for me, or if my spouse is designated as my healthcare agent and our marriage is annulled or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

Second choice (1st Alternate Agent)

Name: _____

Day phone: _____ Evening phone: _____

Cell phone: _____

Address _____

City: _____ State: _____ ZIP code: _____

If this alternate healthcare agent is unable or unwilling to make these choices for me, or if my spouse is designated as my healthcare agent and our marriage is annulled or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

Third choice (2nd Alternate Agent)

Name: _____

Day phone: _____ Evening phone: _____

Cell phone: _____

Address _____

City: _____ State: _____ ZIP code: _____

Part II – General Authority of the Healthcare Agent

I want my healthcare agent to be able to do the following (Please cross out anything you do not want your healthcare agent to do that is listed below):

- To make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment has already been started, my healthcare agent can keep it going or have it stopped depending upon my stated instructions or my best interests.
- To interpret any instruction I have given in this form or given in other discussions according to my healthcare agent's understanding of my wishes and values.
- To review and release my medical records and personal files as needed for my medical care.
- To arrange for my medical care and treatment in Wisconsin, Minnesota and Iowa or any other state, as my healthcare agent thinks appropriate.
- To determine which health professionals and organizations provide my medical treatment.
- To make decisions about organ/tissue or body donation decisions (anatomical gifts) after my death according to my known wishes or values.

Power of Attorney for Healthcare forms Page 5

Instructions for Completing These Sections:

Put your initial on the line (e.g. DJ) to indicate you have selected a "yes", "no" or "not applicable" in the next three sections. Draw a line through the statements you do not select (e.g. ~~No, my healthcare…~~). If you do not initial any line in a section and make no clear choice, the statute in Wisconsin says your choice is considered to be "no." This means if you do not indicate a choice, in Wisconsin only a court may make such a decision and not your healthcare agent.

1. **Agent authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care:**

_____ **Yes**, my healthcare agent has authority, if necessary, to admit me to a nursing home or community-based residential facility for a long-term stay, subject to any limits I have set forth in this document.

_____ **No**, my healthcare agent does not have authority to admit me to a Wisconsin nursing home or a community-based residential facility for a long-term stay. *If I initialed "no," or leave this section blank, I cannot be admitted to a Wisconsin long-term care facility without a court order.*

2. **Agent authority to order the withholding or withdrawal of feeding tube and IV hydration:**

_____ **Yes**, my healthcare agent has authority to have a feeding tube or IV hydration withheld or withdrawn from me subject to any limits I have set forth in this document.

_____ **No,** my healthcare agent does not have authority to have a feeding tube or IV hydration withheld or withdrawn from me. *If I initialed "no," or leave this section blank, feeding tubes or IV hydration cannot be withheld or withdrawn from me in Wisconsin without a court order.*

3. **Agent authority to make decisions if I am pregnant:**

_____ **Yes,** my healthcare agent has authority to make decisions for me if I am pregnant, subject to any limits I have later set forth in this document.

_____ **No,** my healthcare agent does not have authority to make decisions for me if I am pregnant. *If I initialed "no," or leave this section blank, healthcare decisions cannot be made for me during my pregnancy without a court order.*

_____ **Not applicable,** because I am either a male or no longer capable of becoming pregnant.

Part III – Statement of Desires, Special Provisions, or Limitations

My healthcare agent shall make decisions consistent with my stated desires and values and is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my healthcare agent and/or physician providing my medical care. If there are conflicts among my known values and goals, I want my agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this Power of Attorney for Healthcare, or my healthcare agent cannot be contacted, I want the instructions below to be followed based on my common law and constitutional right to direct my own healthcare.

Instructions for Completing This Part:

You are **not required** to provide any written instructions or make any selections in Part III. If you choose **not** to provide any instructions, your healthcare agent will make decisions based on your oral instructions or what is considered your best interest. If you choose **not** to provide any instructions, it is recommended that you draw a line and write "no instructions" across the page.

Stopping Attempts of Life-Prolonging Treatments:

[Either put your initial (e.g. DJ) *on the line next to each statement if you agree or draw a line through the statement if you do not agree.]*

_____ If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with myself, my family, friends, and environment, I want to stop or withhold **all** treatments that might be used to prolong my existence. Treatments I would not want if I were to reach this point include but are not limited to tube feedings, IV hydration, respirator/ventilator, CPR, and antibiotics.

Pain and Symptom Control:

If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable. The following are important to me for comfort: (If you don't write specific wishes, your physician and nurses will provide the best standard of care possible.)

Power of Attorney for Healthcare forms Page 7

Cardiopulmonary Resuscitation (CPR):

My CPR choice listed below may be reconsidered by my healthcare agent in light of my other instructions or new medical information, if I become incapable of making my own decisions. If I do not want CPR attempted, my physician should be made aware of this choice. If I indicate below that I do not want CPR attempted, this choice, in itself, will not stop emergency personnel from attempting CPR in an emergency. Other documents may be needed to control the actions of emergency personnel.

(Initial one of the following statements and draw a line through the statements that you do not want.)

_____ I want CPR attempted unless my physician determines any one of the following:

- I have an incurable illness or injury and am dying; OR
- I have no reasonable chance of survival if my heart stops; OR
- I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.

_____ I want CPR attempted if my heart stops.

_____ I do not want CPR attempted if my heart stops, but rather, want to permit a natural death.

Other Instructions or Limitations I Want My Healthcare Agent to Follow:

Power of Attorney for Healthcare forms Page 8

If it is possible, when I am Nearing My Death and Cannot Speak, I Want My Friends and Family to Know I have the Following Thoughts and Feelings:

If I am Nearing My Death, I Want the Following: (List the type of care, ceremonies, etc. that would make dying more meaningful for you.)

Power of Attorney for Healthcare forms Page 9

Persons I Want My Agent to Include in the Decision Process:

I ask that my healthcare agent make reasonable attempts to include the following persons in my healthcare decisions if there is time: _____

_____.

Religion:

I am of the _____ faith, and am a member of the _____ congregation, synagogue, or worship group. Phone number of congregation, synagogue, or worship group (if known): _____.
Please attempt to notify them.

Upon My Death:

After my death the following are my instructions. If my healthcare agent does not have authority to make these decisions, I ask that my next of kin and physician follow these requests if possible.

Autopsy:

(Initial both the first and second choice, or just one choice, and draw a line through the statements that you do not want.)

_____ I would accept an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future healthcare decisions.

_____ I would accept an autopsy if it can help the advancement of medicine or medical education.

_____ I do not want an autopsy performed on me.

Donation of My Organs or Tissue: (Examples of organs are kidney, liver, heart, lung and examples of tissue are eye, skin, bone, heart valve.)

(Initial one and draw a line through the statements that you do not want.)

_____ I consent to donate only the following organs or parts if possible (name the specific organs or tissue):
_____.

_____ I consent to donate any organs or tissue if I am a candidate.

_____ I do not want to donate any organ or tissue.

Part IV – Making the Document Legal

Instructions for Completing This Part:

Wisconsin residents must have this document signed and dated in the presence of two witnesses. Minnesota or Iowa residents may have this document signed and dated in the presence of two witnesses or a notary public.

I am thinking clearly; I agree with everything that is written in this document and I have made this document willingly.

_____ _____

My signature (or my signature signed by the person named below) Date

If I cannot sign my name, I can ask someone to sign this document for me.

_____

Signature of the person who I asked to sign this document for me

_____

Print the name of the person who I asked to sign this document for me.

Statement of Witnesses

I know this person to be the individual identified in the document. I believe him or her to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- **Not related to the person signing this document by blood, marriage or adoption.**
- Not a healthcare agent appointed by the person signing this document.
- Not directly financially responsible for that's person's healthcare.
- Not a healthcare provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain) of a healthcare provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness number 1:

_____ _____

Signature Date

_____

Print name

_____

Address

Witness number 2:

_____ _____

Signature Date

_____

Print name

_____

Address

Power of Attorney for Healthcare forms Page 11

Instructions for Notarization:

Residents of Iowa and Minnesota may have the document signed by a notary public authorized in their state instead of having two witnesses.

Notary Public

In my presence on _____ (date) _____ (name) acknowledged his or her signature on this document or acknowledged that he or she authorized the person signing this document to sign on his or her behalf. I am not named as a healthcare agent or alternate healthcare agent in this document.

(Notary Stamp)

_____
Signature of Notary

Veteran's BURIAL

The following information is from the Veteran's Administration.

A VA burial allowance is a partial reimbursement of an eligible veteran's burial and funeral costs. When the cause of death is not service-related, the reimbursement is generally described as two payments: (1) a burial and funeral expense allowance, and (2) a plot interment allowance.

You may be eligible for a VA burial allowance if:

- you paid for a veteran's burial or funeral AND
- you have not been reimbursed by another government agency or some other source, such as the deceased veteran's employer AND
- the veteran was discharged under conditions other than dishonorable.

In addition, at least one of the following conditions must be met:

- the veteran died because of a service-related disability OR
- the veteran was receiving VA pension or compensation at the time of death OR
- the veteran was entitled to receive VA pension or compensation but decided not to reduce his/her military retirement or disability pay OR
- the veteran died in a VA hospital or while in a nursing home under VA contract

For a service-related death on or after September 1, 2001, the VA will pay $2,000. If the veteran is buried in a VA national cemetery, some or all of the cost of moving the deceased may be reimbursed.

Veteran's Burial (Continued)

The following information is from the Veteran's Administration.

For a nonservice-related death — VA will pay up to $300 for the funeral expenses and up to $300 for a plot allowance. If the death happened while the veteran was in a VA hospital or a VA contracted nursing home care, some or all of the costs for transporting the deceased's remains may be reimbursed.

You can apply by filling out **"http://www.vba.va.gov/pubs/candpforms.htm"**>VA Form 21-530, Application for Burial Allowance. You should attach proof of the veteran's military service (DD 214), a death certificate, and copies of funeral and burial bills you have paid. Mail the completed form and documents to the nearest VA Regional office.

If a veteran is pre-arranging their burial, they can visit their local Veterans Service Office to pre-arrange what will be placed on their military marker.

For more information call 1-800-827-1000 or your local Veterans Service Office.

Service Serial Number: _____

Location of nearest Veteran's Administration Office: _____

Surviving relatives who contact the Veteran's Administration Office will need to bring discharge papers, Service Serial Number, marriage license, children's birth certificates and death certificate.

For your convenience, we have attached additional information from the VA.

INSTRUCTIONS FOR COMPLETING APPLICATION FOR BURIAL BENEFITS (UNDER 38 U.S.C., CHAPTER 23)

IMPORTANT - READ THESE INSTRUCTIONS CAREFULLY

1. RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

PRIVACY ACT INFORMATION: The responses you submit are considered confidential, (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs(VA) only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies.

2. GENERAL
   a. BURIAL ALLOWANCE - An amount towards the expenses of the funeral and burial of the veteran's remains. Burial includes all recognized methods of interment.
   b. PLOT ALLOWANCE - Plot means the final resting place of the remains. The allowance is payable towards:
      (1) Expenses incurred for the plot or interment if burial was not in a national cemetery or other cemetery under the jurisdiction of the United States; OR
      (2) Expenses payable to a State (or political subdivision) if the veteran died from nonservice-connected causes and was buried in a State-owned cemetery or section used solely for the remains of persons eligible for burial in a national cemetery.
   c. BURIAL ALLOWANCE FOR SERVICE-CONNECTED DEATH - When the veteran's death occurred as the result of a service-connected disability, a special "service-connected" rate is payable.
   d. TRANSPORTATION EXPENSES - The cost of transporting the body to the place of burial may be paid in addition to the burial allowance when:
      (1) The veteran died of a service-connected disability or had a compensable service-connected disability and burial is in a national cemetery; OR
      (2) The veteran died while in a hospital, domiciliary or nursing home to which he/she had been properly admitted under authority of VA; OR
      (3) The veteran died en route while traveling under prior authorization of VA for the purpose of examination, treatment or care.

3. WHO SHOULD FILE A CLAIM
   a. CREDITOR - If expenses have not been paid, the claim should be filed by the funeral director or crematory service by completing Parts I, II, and IV. If the funeral director or crematory service has paid or advanced funds for or furnished the plot or interment expenses, inclusion of these items on the statement of account will serve as claim for the plot allowance. If cemetery owner or other creditor has not been paid for the plot and related interment expenses, he/she may file claim by completing Parts I, III, and IV. If both the funeral director and cemetery owner are unpaid, each must submit a separate VA Form 21-530 signed by the person who authorized services.
   b. PERSON WHOSE FUNDS WERE USED - If all creditors have been paid, the claim should be filed by the person or persons whose personal funds were used by completing Parts I, II, and IV.

Application For Burial Benefits - INSTRUCTIONS *Page 2*

c. VETERAN'S ESTATE - If the expenses were paid from the veteran's estate, the claim should be filed by the executor/ administrator by completing Parts I, II, IV. Submit a copy of the letters of administration or letters testamentary certified over the signature and seal of the appointing court.

d. STATE - If a veteran whose death is nonservice-connected was buried without charge for plot or interment in a State-owned cemetery or section used for persons eligible in a national cemetery, the claim may be filed by the State official completing Parts I, III (Items 23 and 24), and IV.

4. TIME LIMIT FOR FILING A CLAIM - A claim for nonservice-connected burial expenses or plot allowance must be filed with VA within 2 years from the date of the veteran's permanent burial or cremation. If a veteran's discharge was corrected after death to "Under Conditions Other Than Dishonorable," the claim must be filed within 2 years from the date of correction. The 2-year limitation does not apply to service-connected burial benefits, transportation expenses or reimbursement of headstone expenses.

5. COMPLETING CLAIM BY A FIRM OR STATE AGENCY - The claim must be executed in the full name of the firm or State agency, and show the official position or connection of the individual who signs on its behalf.

6. PROOF OF DEATH TO ACCOMPANY CLAIM - Death in a government institution does not need to be proven. In other cases, the claimant must forward a copy of the public record of death. If proof has previously been furnished VA, it need not be submitted again.

7. STATEMENT OF ACCOUNT MUST ACCOMPANY CLAIM

a. FUNERAL DIRECTOR - A statement of account on the funeral director's letterhead must show the name of the veteran; the nature and cost of services, including any payments made to another funeral home (show name and address); all credits; and the name of the person or persons by whom payment in whole or in part was made.
b. TRANSPORTATION - If transported by common carrier, a receipt must accompany the claim. All receipts for transportation charges should show the name of the veteran, the name of the person who paid and the amount of the charges. The itemized statement of account should show the charges made for transportation. Failure to itemize charges may result in delay or payment of a lesser amount.
c. ACCOUNT PAID IN FULL - The statement of account should be receipted in the name of the firm or individual performing the services. Bills or receipts filed in support of this claim become a part of the permanent record and will not be returned, unless specifically requested.
d. PLOT ALLOWANCE ONLY - In a claim for the plot allowance only, the statement of account must show the cost of the veteran's individual gravesite, the mausoleum vault, or the columbarium niche.

8. BURIAL ASSOCIATION OR BURIAL INSURANCE - If the veteran was a member of a burial association or if any insurance company is obligated to pay all or part of the burial expenses, Item 22 should be answered "Yes." It will be necessary to support the claim with a statement from the association or insurance company setting forth the terms of the contract and how and with whom settlement was made.

9. SERVICE RECORD - The original or certified copy of the veteran's service separation document (DD214 or equivalent) which contains information as to the length, time, and character of service will permit prompt processing.

10. TOLL FREE TELEPHONE ASSISTANCE - You can call us toll-free within the U.S. by dialing 1-800-827-1000. If you are located in the local dialing area of a VA regional office, you can also call us by checking your local telephone directory. For the hearing impaired, our TDD number is 1-800-829-4833.

Application For Burial Benefits - FORM *Page 1*

OMB Approved No. 2900-0003
Respondent Burden: 20 minutes

Department of Veterans Affairs

(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

APPLICATION FOR BURIAL BENEFITS
(Under 38 U.S.C. Chapter 23)

IMPORTANT - Read instructions carefully before completing form. YOUR COMPLIANCE WITH ALL INSTRUCTIONS WILL AVOID DELAY. Type or print all information.

1. FIRST, MIDDLE, LAST NAME OF DECEASED VETERAN

2. SOCIAL SECURITY NUMBER OF VETERAN | 3. VA FILE NUMBER

4. FIRST, MIDDLE, LAST NAME OF CLAIMANT | 5. TELEPHONE NUMBER(S) (Include Area Code) — A. DAYTIME | B. EVENING

6. MAILING ADDRESS OF CLAIMANT *(Number and street or rural route, city or P.O., State and ZIP Code)*

PART I - INFORMATION REGARDING VETERAN

7A. DATE OF BIRTH | 7B. PLACE OF BIRTH

8A. DATE OF DEATH | 8B. PLACE OF DEATH | 8C. DATE OF BURIAL

SERVICE INFORMATION *(The following information should be furnished for the periods of the VETERAN'S ACTIVE SERVICE)*

9A. ENTERED SERVICE DATE	9A. ENTERED SERVICE PLACE	9B. SERVICE NUMBER	9C. SEPARATED FROM SERVICE DATE	9C. SEPARATED FROM SERVICE PLACE	9D. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE

10. IF VETERAN SERVED UNDER NAME OTHER THAN THAT SHOWN IN ITEM 1, GIVE FULL NAME AND SERVICE RENDERED UNDER THAT NAME

11. ARE YOU CLAIMING THAT THE CAUSE OF DEATH WAS DUE TO SERVICE?
☐ YES ☐ NO

PART II - CLAIM FOR BURIAL BENEFITS AND/OR INTERMENT ALLOWANCE IF PAID BY CLAIMANT

NOTE - If claiming Plot Allowance Only, do not complete Part II, but complete Parts III and IV on reverse.

12. PLACE OF BURIAL OR LOCATION OF CREMAINS

13. WAS BURIAL (WITHOUT CHARGE FOR PLOT OR INTERMENT) IN A STATE OWNED CEMETERY, OR SECTION THEREOF, USED SOLELY FOR PERSONS ELIGIBLE FOR BURIAL IN A NATIONAL CEMETERY?
☐ YES ☐ NO *(IF "No," complete Items 15 and 16)*

14. WAS BURIAL IN A NATIONAL CEMETERY OR CEMETERY OWNED BY THE FEDERAL GOVERNMENT?
☐ YES ☐ NO *(If "No," complete Items 15 and 16)*

15. BURIAL PLOT, MAUSOLEUM VAULT, COLUMBARIUM NICHE, ETC. COST IS: *(CHECK ONE)*
☐ PAID BY ANOTHER PERSON(S) ☐ PAID BY CLAIMANT FOR BURIAL
☐ DUE FUNERAL DIRECTOR ☐ NONE
☐ DUE CEMETERY OWNER

16. IF PLOT/INTERMENT EXPENSES ARE UNPAID, WHO WILL FILE CLAIM FOR EXPENSES? *(Name and Address)*

17. TOTAL EXPENSE OF BURIAL, FUNERAL, TRANSPORTATION, AND IF CLAIMED, BURIAL PLOT
$

18. AMOUNT PAID
$

19. WHOSE FUNDS WERE USED?

20A. HAS PERSON WHOSE FUNDS WERE USED BEEN REIMBURSED?
☐ YES ☐ NO *(If "Yes," complete Items 20B and 20C)*

20B. AMOUNT OF REIMBURSEMENT
$

20C. SOURCE OF REIMBURSEMENT

21A. HAS ANY AMOUNT BEEN, OR WILL ANY AMOUNT BE ALLOWED ON EXPENSES BY LOCAL, STATE, OR FEDERAL AGENCY?
☐ YES ☐ NO *(If "Yes," complete Items 21B and 21C)*

21B. AMOUNT
$

21C. SOURCE(S)

22. WAS THE VETERAN A MEMBER OF A BURIAL ASSOCIATION OR COVERED BY BURIAL INSURANCE?
☐ YES ☐ NO *(Before answering, read and comply with Instruction 8)*

VA FORM **21-530** SEP 1995 EXISTING STOCK OF VA FORM 21-530, JUN 1992, WILL BE USED.

Application For Burial Benefits - FORM

PART III - CLAIM FOR PLOT COST ALLOWANCE

IMPORTANT - Complete only if burial was NOT in a national cemetery or cemetery owned by the Federal Government.

23. WAS BURIAL (WITHOUT CHARGE FOR PLOT OR INTERMENT) IN A STATE OWNED CEMETERY, OR SECTION THEREOF, USED SOLELY FOR PERSONS ELIGIBLE FOR BURIAL IN A NATIONAL CEMETERY?	24. PLACE OF BURIAL OR LOCATION OF CREMAINS	
25A. COST OF BURIAL PLOT *(Individual Grave Site, Mausoleum Vault, or Columbarium Niche)* $	25B. DATE OF PURCHASE	25C. DATE OF PAYMENT

26A. HAVE BILLS BEEN PAID IN FULL? ☐ YES ☐ NO *(If "No," complete Items 26B and 27)*	26B. AMOUNT PAID $	27. WHOSE FUNDS WERE USED?
28A. HAS PERSON WHOSE FUNDS WERE USED BEEN REIMBURSED? ☐ YES ☐ NO *(If "Yes," complete Items 28B and 28C)*	28B. AMOUNT OF REIMBURSEMENT $	28C. SOURCE OF REIMBURSEMENT
29A. HAS ANY AMOUNT BEEN, OR WILL ANY AMOUNT BE ALLOWED ON EXPENSES BY STATE OR FEDERAL AGENCY? ☐ YES ☐ NO *(If "Yes," complete Items 29B and 29C)*	29B. AMOUNT $	29C. SOURCE

PART IV - CERTIFICATION AND SIGNATURE

I CERTIFY THAT the foregoing statements made in connection with this application on account of the named veteran are true and correct to the best of my knowledge and belief.

30A. SIGNATURE OF CLAIMANT *(If signed by mark, complete Items 36A thru 37B) (If signing for firm, corporation, or State agency, complete Items 30B thru 31)*	30B. OFFICIAL POSITION OF PERSON SIGNING ON BEHALF OF FIRM, CORPORATION OR STATE AGENCY

31. FULL NAME AND ADDRESS OF THE FIRM, CORPORATION, OR STATE AGENCY FILING AS CLAIMANT

NOTE - Where the claimant is a firm or other unpaid creditor, Items 32A thru 35 MUST be completed by the individual who authorized services.

I CERTIFY THAT the foregoing statements made by the claimant are correct to the best of my knowledge and belief.

32A. SIGNATURE OF PERSON WHO AUTHORIZED SERVICES *(If signed by mark, complete Items 36A thru 37B)*	32B. NAME OF PERSON AUTHORIZING SERVICES *(Type or Print)*

33. ADDRESS *(Number and street or rural route, city or P.O., State and ZIP Code)*

34. DATE	35. RELATIONSHIP TO VETERAN

WITNESS TO SIGNATURE IF MADE BY "X" MARK

NOTE - Signature made by mark must be witnessed by two persons to whom the person making the statement is personally known, and the signatures and addresses of such witnesses must be shown below.

36A. SIGNATURE OF WITNESS	36B. ADDRESS OF WITNESS
37A. SIGNATURE OF WITNESS	37B. ADDRESS OF WITNESS

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false.

DEPARTMENT OF VETERANS AFFAIRS HEADSTONES AND MARKERS

The Department of Veterans Affairs will furnish, upon request, a Government headstone or marker at the expense of the United States for the unmarked graves of certain individuals eligible for burial in a national cemetery, but not buried there. These individuals include any veteran with an other than dishonorable discharge who dies after service or any serviceman or servicewoman who dies on active duty. Certain other individuals may also be eligible for the headstone or marker. Headstones or markers for all individuals in a national or post cemetery are furnished automatically without request from the family.

For additional information and an application, contact the nearest VA office.

Social SECURITY BENEFITS

It's a good idea to have a copy of your Social Security statement. If you don't have a copy, the following information from the Social Security Administration will help facilitate the process.

The Social Security Statement is a valuable document that estimates your future Social Security benefits and tells you how to qualify for those benefits.

Your Social Security Statement will include:
A record of your earnings history and an estimate of how much you and your employer paid in Social Security taxes; and estimates of benefits you (and your family) may be eligible for now and in the future.

To request your Social Security Statement, you will need:
* Your name as shown on your Social Security Card
* Your Social Security Number
* Your date of birth
* Your place of birth
* Your mother's maiden name- last name only (to help identify you)

Optional:
It will help the SSA give you better benefit estimates if you also give them:
* Your last years' earnings and an estimate of your current and future earnings
* Age at which you plan to stop work

Request Your Social Security Statement Online:
Log on to the Social Security Administration web site at **www.socialsecurity.gov** to request a statement online.

Request Your Social Security Statement through the mail:
Use the attached document.

For more information:
Call the Social Security Administration's toll-free number at 1-800-772-1213.

Social Security Burial Benefits - INTRODUCTION

WHAT TO DO WHEN A BENEFICIARY DIES:

A family member or other person responsible for the beneficiary's affairs should do the following:

- Promptly notify Social Security of the beneficiary's death by calling SSA toll-free at 1-800-772-1213.
- If monthly benefits were being paid via direct deposit, notify the bank or other financial institution of the beneficiary's death. Request that any funds received for the month of death and later be returned to Social Security as soon as possible.
- If benefits were being paid by check, DO NOT CASH any checks received for the month in which the beneficiary died or thereafter. Return the checks to Social Security as soon as possible.

One-time Lump Sum Death Benefit:

A one-time payment of $255 is payable to the surviving spouse if he or she was living with the beneficiary at the time of death, OR if living apart, was eligible for Social Security benefits on the beneficiary's earnings record for the month of death.

If there is no surviving spouse, the payment is made to a child who was eligible for benefits on the beneficiary's earnings record in the month of death.

Benefits for Survivors

Monthly survivors benefits can be paid to certain family members, including the beneficiary's widow or widower, dependent children and dependent parents. The following booklets contain more information about filing for benefits and can be downloaded by clicking on the title.

Survivors Benefits (Publication No.05-10084)

Social Security: Understanding the Benefits (Publication No.05-10024)

Form Approved
OMB No. 0960-0446 SP

Request for *Social Security Statement*

☐ Please check this box if you want to get your *Statement* in Spanish instead of English.

Please print or type your answers. When you have completed the form, fold it and mail it to us. If you prefer to send your request using the Internet, go to *www.socialsecurity.gov.*

1. Name shown on your Social Security card:

First Name _____ Middle Initial _____

Last Name Only _____

2. Your Social Security number as shown on your card:

☐☐☐-☐☐-☐☐☐☐

3. Your date of birth (Mo.-Day-Yr.)

☐☐-☐☐-☐☐☐☐

4. Other Social Security numbers you have used:

☐☐☐-☐☐-☐☐☐☐

☐☐☐-☐☐-☐☐☐☐

5. Your Sex: ☐ Male ☐ Female

For items 6 and 8, show only earnings covered by Social Security. Do NOT include wages from state, local or federal government employment that are NOT covered by Social Security or that are covered ONLY by Medicare.

6. Show your actual earnings (wages and/or net self-employment income) for last year and your estimated earnings for this year.

A. Last year's actual earnings: *(Dollars Only)*

$ ☐☐☐,☐☐☐.00

B. This year's estimated earnings: *(Dollars Only)*

$ ☐☐☐,☐☐☐.00

7. Show the age at which you plan to stop working:

☐☐ *(Show only one age)*

8. Below, show the average yearly amount (not your total future lifetime earnings) that you think you will earn between now and when you plan to stop working. Include performance or scheduled pay increases or bonuses, but not cost-of-living increases.

If you expect to earn significantly more or less in the future due to promotions, job changes, part-time work or an absence from the work force, enter the amount that most closely reflects your future average yearly earnings.

If you don't expect any significant changes, show the same amount you are earning now (the amount in 6B).

Future average yearly earnings: *(Dollars Only)*

$ ☐☐☐,☐☐☐.00

9. Do you want us to send the *Statement:*
   - To you? Enter your name and mailing address.
   - To someone else (your accountant, pension plan, etc.)? Enter your name with "c/o" and the name and address of that person or organization.

"C/O" or Street Address (Include Apt. No., P.O. Box, Rural Route) _____

Street Address _____

Street Address (If Foreign Address, enter City, Province, Postal Code) _____

U.S. City, State, ZIP code (If Foreign Address, enter Name of Country only) _____

NOTICE:
I am asking for information about my own Social Security record or the record of a person I am authorized to represent. I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I authorize you to use a contractor to send the *Social Security Statement* to the person and address in item 9.

▶ _____

Please sign your name (Do Not Print)

Date _____ (Area Code) Daytime Telephone No. _____

Form **SSA-7004-SM** (06-2008) EF (06-2008)
10-2006 edition may be used

Printed on recycled paper

Final

PLANS

Cremation:
Cremation is an increasingly popular choice, for reasons ranging from religious beliefs or ethnic customs to cost. Many people select the process simply because of personal preference.

Some people are surprised to learn how many choices they have, including:

- **Cremation following a traditional visitation and funeral:** This choice involves a funeral director and a visitation or viewing with a funeral ceremony and church or memorial services. In Wisconsin, funeral homes are permitted to rent caskets for viewing and services.

- **Family Direct cremation:** (Wisconsin Statute 69.18) The family arranges to bring the deceased directly to the crematorium, such as Oak Grove Cemetery. A funeral director is not involved. A memorial service can still be held.

There are also a variety of options for the final disposition of cremains.

- Urns or other containers may be placed in a niche at a cemetery. Oak Grove has niches available in the Garden Mausoleum, Historic Mausoleum, Chapel and Columbarium.
- Families may elect to bury the urn in a family plot or cemetery or keep it in another place of personal significance, such as the home.
- The family may wish to scatter the cremains in a place that was significant to the deceased. Please check with your local and state laws first. Oak Grove Cemetery also provides an area for scattering.

Full Body:
If you choose not to be cremated, there are still several choices for your interment. You can be:

* Buried in the ground in a traditional grave
* Entombed in an above-ground mausoleum

Oak Grove Cemetery offers both choices for individuals.

My interment preference is: ❑ Cremation ❑ Full Body

Cremation

If you choose an option other than Family Direct Cremation, please list your preference for a funeral home director:_____

_____

If you choose to be cremated, please indicate your preferences for the following:
Type of urn: _____

What would you like your loved ones to do with your cremains? _____

_____

Final Plans (Continued)

Full Body

❑ above ground/mausoleum ❑ below ground

If you choose to be buried in the ground, please indicate your preferences for the following:
Type of casket: _____
Type of vault: _____

Type of headstone: _____

Pre-arrangement:
Whatever you decide, you should know that you can make your final plans now, and prepay some of those costs. The staff of Oak Grove Cemetery or your funeral director of choice can help you with these decisions. Pre-arranging is a thoughtful gift to your family.

I have made pre-arrangement plans:

❑ yes ❑ no

If yes,
Name of Cemetery or Funeral Home: _____
Address: _____
Telephone: _____

Name of contact person: _____

My interment preference is (cremation or full body): _____
_____

Final Plans (Continued)

Do you own burial property? ❑ Yes ❑ No

If yes:

Burial Property Location: _____

Name of Cemetery/Mausoleum: _____

Address: _____

Telephone: _____

Description of property: _____

_____

Name of contact person: _____

Location of deed: _____

Additional Information: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Obituary

INFORMATION

Information for your obituary

Name of spouse: _____

Year and place of marriage: _____

Name(s) of Children and spouses' names:

(Children)	(Spouse)
(Children)	(Spouse)
(Children)	(Spouse)
(Children)	(Spouse)
(Children)	(Spouse)
(Children)	(Spouse)
(Children)	(Spouse)

Names of grandchildren:

Obituary Information *(Continued)*

Other survivors:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

People who preceded you in death:

_____ _____
_____ _____
_____ _____

Birthplace and date: _____

Schools attended: _____
_____

Years: _____
Degrees: _____

Professional positions: _____
Companies: _____
_____
Years: _____

Clubs, fraternities, associations: _____
_____

Years: _____
Positions held: _____

Military/branch of service: _____
Years: _____
Rank: _____

Civic or public offices held: _____
Years: _____
Rank: _____

Special achievements or recognitions: _____
_____

Where memorials should be directed: _____
_____

Your

FUNERAL OR MEMORIAL SERVICE

Funeral/Memorial Service Preferences:

Do you want a visitation? ❑ Yes ❑ No

If yes, provide photo for Funeral Director use.

Clothing you wish to wear: _____

_____

_____

Jewelry you wish to wear: _____

_____

If you wear glasses, would you like them on during the visitation? ❑ Yes ❑ No

Where would you like the memorial service to be held? (e.g., your church, funeral home, cemetery chapel) _____

Clergy or person to officiate: _____

Favorite flower: _____

Reading (e.g., psalm, poem or passage): _____

Songs: _____

Pallbearers: _____

_____

_____

_____

_____

I would like memorials directed to:

_____

_____

_____

_____

To Do

LIST

Time of death to do list

- ❑ Notify immediately:
  - Doctor or doctors
  - Funeral director
  - Cemetery
  - Relatives
  - Friends
  - Employer of deceased
  - Employers of relatives who will miss work
  - Insurance agents

- ❑ Select cemetery
- ❑ Meet with funeral home director or cemetery/crematorium representative
- ❑ Order death certificate (determine number needed before ordering)
- ❑ Arrange the service
  - Select clergy to officiate
  - Select individual to give eulogy and provide information
  - Arrange for music and visitation
- ❑ Make lodging arrangements for people coming to the memorial service from out of town
- ❑ Prepare obituary and submit to newspaper
- ❑ Arrange for honor guard, if deceased is a veteran

To Do List (Continued)

Information for Death Certificate:

The Board of Health will need this information before they can issue a death certificate.

Full name: _____

Address: _____

Date of birth: _____ Resided in county since: _____

Birthplace: _____

Are you a United States citizen? ❑ Yes ❑ No

Marriage date and place: _____

Name of father: _____

Birthplace of deceased: _____

Maiden name of mother: _____

Social Security number: _____ Occupation: _____

Veteran Information, if applicable:

Branch of service: _____

Location of veteran discharge: _____

DD214 or serial number: _____

Time pronounced dead: _____

Age: _____

County of death: _____

Marital status: _____

State of birth: _____

Name of surviving spouse: _____

What
FAMILY SHOULD KNOW

Please describe any other facts or matters that have not been covered in this document that you want your family to know about:

Organ DONATION

For more information regarding organ donation, please go to ***www.rotaryclubofla crosse.com*** *and click on Organ Donor.*

Programs AND SERVICES

Oak Grove Cemetery was established in 1852 by the founding fathers of La Crosse, Wisconsin. Since then, we have been able to assist thousands of people through the emotional period after the death of a loved one. Our 80 landscaped acres provide a setting where families can visit and find peace. Grave markers, mausoleum buildings providing above-ground crypts and niches, compelling statues and other artistic features blend with landscaped grounds to create a park-like setting. The cemetery is a serene place to honor memories.

Pre-arrangement Counseling
Advanced planning helps to avoid unnecessary emotional and financial problems faced when a loved one dies. Knowing that your family will not be burdened by hasty decisions, and that your plans have been made according to your wishes is one of the most thoughtful expressions of love and concern that you can show your family. By planning ahead, you can do your research and compare prices. Another advantage is that you can pay for sevices at today's prices and avoid the effects of inflation.

Burial Services and Chapel
Oak Grove can work closely with the family member handling the arrangements or the funeral home director of your choice to plan the services at the time of death. Our beautiful chapel is available for services. Contact Oak Grove Cemetery for more information.

Grave Sites
Contrary to popular belief, there is still plenty of room at Oak Grove Cemetery for those wishing a traditional in-ground burial. We have sites for upright monuments as well as beveled and flat markers. The choice is yours.

Monuments and Markers
A monument or marker is a lasting tribute to the deceased. At Oak Grove, we have literally thousands of samples on our grounds. We offer a beautiful line of granite markers and monuments for purchase and can help you design a new marker or match an existing marker or monument. We can also provide inscriptions on markers already in place. For individuals choosing cremation, we offer a variety of urns.

Programs and Services (Continued)

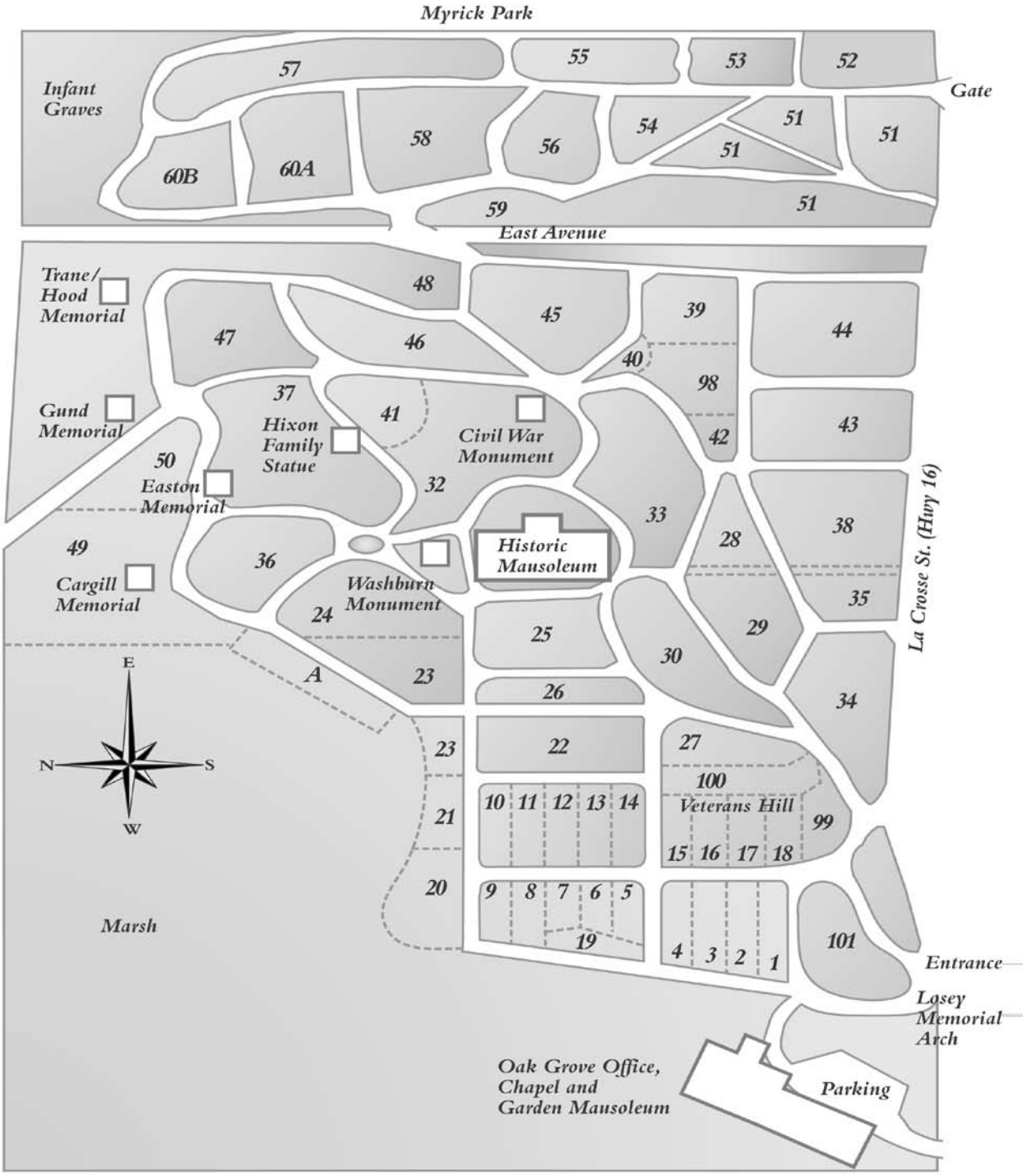
Seasonal Décor
There are other ways to memorialize your loved one in addition to markers and monuments. For example, we offer seasonal flowers, plants and vases. Our "Special Care" program establishes a fund where flowers are placed on the lot year after year.

Cremation Services
Every year more and more individuals are choosing cremation. Oak Grove Cemetery has a crematorium onsite. We also offer a number of burial options for the cremated remains, both in-ground and above ground.

Alternatives to in-ground burial
Oak Grove Cemetery has two mausoleums, the Historic Mausoleum and the Garden Mausoleum. We offer niches for cremains in both mausoleums, the Chapel, Columbaria and Scattering Garden, as well as full-sized crypts in our Garden Mausoleum.

To find out more about Oak Grove:
For more information, including pricing, visit our web site: **www.oakgrovecemetery.com** or call us at (608) 782-6956.

Map
OF OAK GROVE CEMETERY



ABOUT OAK GROVE CEMETERY