I, Ruby C. Hylton, being of sound and disposing mind and memory, do hereby make, publish and declare this to be my last will and testament, hereby revoking any and all wills by me at any time heretofore made.

FIRST: I direct that all my just debts be paid, including all taxes and costs of administration that might be assessed against my estate.

SECOND: I give, devise and bequeath all of my estate, both real and personal, to my husband, Joseph G. Hylton, for his lifetime and having full confidence in my husband, I give him full and complete authority to sell and dispose of any or all of my estate in any way that he may desire and at my husband's death, I give, devise and bequeath all of my estate, if any remains, to our children, Joseph G. Hylton, Jr. and Miles T. Hylton.

THIRD: I nominate and appoint my husband, Joseph G. Hylton, as Executor of this my last will and testament and I direct that no security be required on his bond as Executor and in the event my husband should predecease me or for any reason be unable to serve as Executor, then I nominate and appoint F. Vernon Clarkson as Executor of this my last will and testament and direct that no security be required on his bond as Executor.

Given under my hand this 6th day of February, 1969.

Ruby C. Hylton

The above signature of the testatrix was made and the foregoing will was acknowledged by the said testatrix in the presence of us, two competent witnesses, present at the same time; and we, the said witnesses, do hereunto subscribe the said will in the presence of the said testatrix and of each other, at the request of the said testatrix, this 6th day of February, 1969.

Sara D. Munsey

Robert L. Powell

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION
PHYSICIANS / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
ROOM 165, 350 CAPITOL STREET, CHARLESTON, WV 25301

009014

STATE FILE NUMBER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEDENT'S NAME (First, Middle, Last): RUBY CLARKSON HYLTON

2. SEX: F

3 DATE OF DEATH (Month, Day, Year): MAY 26, 2009

4 SOCIAL SECURITY NUMBER: 229-32-1746

5a AGE-Last Birthday (Years): 94

5b UNDER 1 YEAR (Months / Days):

5c UNDER 1 DAY (Hours / Minutes):

6 DATE OF BIRTH (Month, Day, Year): JULY 19, 1914

7 BIRTHPLACE (City and State or Foreign Country): MONROE COUNTY, WV

8 WAS DECEDENT EVER IN US ARMED FORCES? (Yes or no): NO

9a PLACE OF DEATH (Check only one - see instructions on other side): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA OTHER ☒ Nursing Home ☐ Residence ☐ Other (Specify)

66

9b FACILITY NAME (If not institution, give street and number): COUNTRY VIEW ASSISTED LIVING

9c CITY, TOWN, OR LOCATION OF DEATH: PETERSTOWN

9d COUNTY OF DEATH: MONROE

VA 751

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): WIDOWED

11 SURVIVING SPOUSE (If wife, give maiden name):

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): TEACHER 231

12b KIND OF BUSINESS/INDUSTRY: SCHOOL SYSTEM 786

13a RESIDENCE—STATE: VIRGINIA

13b COUNTY: GILES

13c CITY, TOWN, OR LOCATION: PEARISBURG

13d STREET AND NUMBER: 1202 HOGE STREET

13e INSIDE CITY LIMITS? (Yes or no): YES

13f ZIP CODE: 24134

14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify:

15 RACE—American Indian, Black, White, etc (Specify): WHITE

16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) 16A; College (1-4 or 5+) 16B 5+

NAME OF DECEDENT: For use by physician or institution

PARENTS

17 FATHER'S NAME (First, Middle, Last): OLIVER MARSHALL CLARKSON

18 MOTHER'S NAME (First, Middle, Maiden Surname): PEARL HOKE

INFORMANT

19a INFORMANT'S NAME (Type/Print): DR. JOSEPH GORDON HYLTON

19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1601 CONCORD DRIVE, CHARLOTTESVILLE, VA 22901

DISPOSITION

20a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify)

20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): BIRCHLAWN BURIAL PARK

20c LOCATION—City or Town, State: PEARISBURG, VA

21 SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: James A. Ryan

22 NAME AND ADDRESS OF FACILITY: GIVENS FUNERAL HOME 110 Woodlawn St., PEARISBURG, VA 24134

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-b only when certifying physician is not available at time of death to certify cause of death

23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title: Paul A. Olson MD

23b DATE SIGNED (Month, Day, Year): 6/9/09

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 0400 AM

25 DATE PRONOUNCED DEAD (Month, Day, Year): 5/26/09

26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

CAUSE OF DEATH

27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): → a Sudden cardiac death

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): b Ischemic cardiomyopathy

DUE TO (OR AS A CONSEQUENCE OF): c Coronary Artery Disease

d

T251

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Hypertension Hyperlipidemia

28a WAS AN AUTOPSY PERFORMED? (Yes or no): NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NA

29. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

30a DATE OF INJURY (Month, Day, Year):

30b TIME OF INJURY:

30c INJURY AT WORK? (Yes or No):

30d DESCRIBE HOW INJURY OCCURRED:

30e PLACE OF INJURY — At home, farm, street, factory, office building, etc (Specify):

30f LOCATION (Street and Number or Rural Route Number, City or Town, State):

CERTIFIER

31a CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER/CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place and due to the cause(s) and manner as stated.

31b SIGNATURE AND TITLE OF CERTIFIER: Paul A. Olson MD

31c DATE SIGNED (Month, Day, Year): 6/9/09

32 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Paul A. Olson MD 219 Buchanan St Pearisburg, VA 24134

REGISTRAR

33. REGISTRAR'S SIGNATURE: Lela Boggess

34 DATE FILED (Month, Day, Year): JUN 10 2009

Form VS-002 (Rev. 6/92)

STATE COPY

I, Joseph G. Hylton, being of sound and disposing mind and memory, do hereby make, publish and declare this to be my last will and testament, hereby revoking any and all wills by me at any time heretofore made.

FIRST: I direct that all my just debts be paid, including all taxes and costs of administration that might be assessed against my estate.

SECOND: I give, devise and bequeath all of my estate, both real and personal, to my wife, Ruby C. Hylton, for her life-time and having full confidence in my wife, I give her full and complete authority to sell and dispose of any or all of my estate in any way that she may desire and at my wife's death, I give, devise and bequeath all of my estate, if any remains, to our children, Joseph G. Hylton, Jr. and Miles T. Hylton.

THIRD: I nominate and appoint my wife, Ruby C. Hylton, as Executrix of this my last will and testament and I direct that no security be required on her bond as Executrix and in the event my wife should predecease me or for any reason be unable to serve as Executrix, then I nominate and appoint F. Vernon Clarkson as Executor of this my last will and testament and direct that no security be required on his bond as Executor.

Given under my hand this 6th day of February, 1969.

Joseph G Hylton

The above signature of the testator was made and the foregoing will was acknowledged by the said testator in the presence of us, two competent witnesses, present at the same time; and we, the said witnesses, do hereunto subscribe the said will in the presence of the said testator and of each other, at the request of the said testator, this 6th day of February, 1969.

Sara D. Pierson

Robert L. Powell

COMMONWEALTH OF VIRGINIA—CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH—BUREAU OF VITAL RECORDS AND HEALTH STATISTICS—RICHMOND

COPY A FOR BUREAU OF VITAL STATISTICS

REGISTRATION AREA NUMBER: 223 | CERTIFICATE NUMBER: 1212 | STATE FILE NUMBER:

DECEDENT

1. FULL NAME OF DECEASED: JOSEPH (first) GORDON (middle) HYLTON (last)
2. SEX: male XX female ☐
3. RACE: White
4. DATE OF DEATH (mo.) (day) (year): Oct. 2,1983
5. AGE: 77 years | IF UNDER 1 YEAR: months, days | IF UNDER 1 DAY: hours, minutes
6. DATE OF BIRTH (mo.) (day) (year): Aug. 26,1906
7. WAS DECEDENT EVER IN U.S. ARMED FORCES? yes ☒ no ☐

PLACE OF DEATH

8. NAME OF HOSPITAL OR INSTITUTION OF DEATH (If none, so state): Roanoke Memorial Hospital | DOA ☐ | Out pat./Emer. Rm. ☐ | Inpatient XX
9. COUNTY OF DEATH (If independent city, leave blank):
10. CITY OR TOWN OF DEATH: Roanoke | inside city or town limits? yes ☒ no ☐
11. STREET ADDRESS OR RT. NO. OF PLACE OF DEATH: Belleview & Jefferson Streets

USUAL RESIDENCE OF DECEDENT

12. STATE (OR FOREIGN COUNTRY) OF DECEASED'S RESIDENCE: Virginia
13. COUNTY OF DECEASED'S RESIDENCE (If independent city, leave blank): Giles
14. CITY OR TOWN OF RESIDENCE: Pearisburg | inside city or town limits? yes XX no ☐
15. STREET ADDRESS OR RT. NO. OF RESIDENCE: 1202 Hoge Street
ZIP CODE: 24134

PERSONAL DATA OF DECEDENT

16. NAME OF FATHER OF DECEASED: James Solomon Hylton
17. MAIDEN NAME OF MOTHER OF DECEASED: Polly Carter
18. CITIZEN OF WHAT COUNTRY: U.S.A.
19. BIRTHPLACE (State or country): Virginia
20. NEVER MARRIED ☐ DIVORCED ☐ MARRIED ☒ WIDOWED ☐
21. IF MARRIED OR WIDOWED, NAME OF SPOUSE (If divorced leave blank): Ruby Clarkson Hylton
22. SOCIAL SECURITY NUMBER: 234-28-9356
23. USUAL OR LAST OCCUPATION: Millwright
24. KIND OF BUSINESS OR INDUSTRY: Textile
25. INFORMANT - OR SOURCE OF INFORMATION: Mrs. Ruby C. Hylton

MEDICAL CERTIFICATION

TO PHYSICIAN:

Complete and sign medical certification (item 26) and return both copies to funeral director as soon as possible after determination of cause.

NOTE: If "Pending" must be indicated, so state in part I and notify registrar of final decision as soon as possible.

26. CAUSE OF DEATH (Enter only one cause per line for (A), (B), and (C).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (A): Cardiorespiratory arrest - sudden
DUE TO (B):
Conditions, if any, which gave rise to immediate cause (A), stating the underlying cause last.
DUE TO (C):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (A): Mitral Regurgitation, Pericarditis

26a. AUTOPSY? AUTHORIZED BY: yes ☐ no ☐

26b. IF FEMALE, WAS THERE A PREGNANCY IN PAST 3 MONTHS? yes ☐ no ☐ unknown ☐

26c. IF EXTERNAL CAUSE, IT WAS PRIMARY ☐ or CONTRIBUTING ☐ TO CAUSE OF DEATH. NOTE: IF EXTERNAL CAUSE, NOTIFY MED. EXAMINER

26d. DESCRIBE HOW INJURY RELATING TO DEATH OCCURRED

26e. TIME OF INJURY (mo.) (day) (year) A.M. P.M.

26f. INJURY OCCURRED while at work ☐ not while at work ☐

26g. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)

26h. (city or town) (county) (state)

26i. To the best of my knowledge, death occurred at 11:59 PM (a.m.) (p.m.) on the date and place and from the cause(s) stated.

ACTUAL SIGNATURE ▶ L. F. Gunzenhauser MD

DATE SIGNED: October 20, 1983

NAME OF ATTENDING PHYSICIAN (Type or Print): L. F. Gunzenhauser, MD

ADDRESS OF ATTENDING PHYSICIAN: 1111 S. Jefferson, Roanoke, Va.

FUNERAL DIRECTOR

27. BURIAL ☒ REMOVAL ☐ CREMATION ☐

28. PLACE OF BURIAL, REMOVAL, ETC. (name of cemetery or crematory) (city or county) (state): Birchlawn Burial Park, Pearisburg

29. (Signature of funeral director or person legally filing this certificate) ▶ John H. Givens

NAME OF FUNERAL HOME AND ADDRESS: Givens Funeral Home, Pearisburg, Va. 24134-0445

REGISTRAR

30. (Signature of registrar) ▶ Kathy M. Hartman, Deputy

DATE RECORD FILED: Oct. 20, 1983

IMPORTANT: Use black ribbon in typewriter or print legibly with ball point pen having black unfading ink. This is a permanent record and subject to reproduction by microfilm and other photographic process.

MARGIN RESERVED FOR BINDING

VS 2 1/80

This is to certify that this is a true and correct reproduction of the original record filed with the Roanoke City Health Department, Roanoke, Virginia and bearing the impressed seal of this department.

Date Issued 10-20-83 Kathy M. Hartman

(Seal) Deputy Registrar

ANY REPRODUCTION OF THIS DOCUMENT IS PROHIBITED BY STATUTE

Do not accept unless the impressed seal of the Roanoke City Health Department is clearly affixed. Section 32.1-272, Code of Virginia.