

Willpower Radio, LLC
Application for Pro-Forma Transfer
July 2021

Pro-Forma Transfer of License

Willpower Radio, LLC has two members, each holding fifty percent voting and equity interests: William J. Stanley and Barbara L. Stanley, husband and wife.

William Stanley passed away on June 21, 2021. Under the law, Mr. Stanley's interest passed automatically to Ms. Stanley. Because the proposed transfer is solely due to the death of Mr. Stanley, the filing of this application for pro-forma transfer of license from William J. Stanley to Barbara L. Stanley is appropriate.

A copy of the death certificate is attached.

STATE FILE NUMBER

1. NAME: FIRST		MIDDLE		LAST		2. SEX: MALE <input checked="" type="checkbox"/> 1 FEMALE <input type="checkbox"/> 2		3A. DATE OF DEATH: MONTH DAY YEAR		3B. HOUR	
William J. Stanley								06 21 2021		02:50 PM	
4A. PLACE OF DEATH: (Check one)		HOSPITAL DOA <input type="checkbox"/>		HOSPITAL OUTPATIENT <input type="checkbox"/>		HOSPITAL INPATIENT <input type="checkbox"/>		NURSING HOME <input type="checkbox"/>		PRIVATE RESIDENCE <input checked="" type="checkbox"/>	
4C. NAME OF FACILITY: (If not facility, give address)		73 Primrose Hill Road		4D. LOCALITY: (Check one and specify)		CITY VILLAGE TOWN		Rhinebeck Town		4E. COUNTY OF DEATH: Dutchess	
4F. MEDICAL RECORD NO. DC21-0773		4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state)		NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>							
5. DATE OF BIRTH: MONTH DAY YEAR		6A. AGE IN YEARS: 72 yrs.		6B. IF UNDER 1 YEAR: ENTER: months days		6C. IF UNDER 1 DAY: ENTER: hours minutes		7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province)		7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:	
06 22 1948								Detroit, Michigan			
8. SERVED IN U.S. ARMED FORCES? (Specify years) NO YES <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1		9. DECEDENT OF HISPANIC ORIGIN? (Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino)		A <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino B <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano		10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be:		A <input checked="" type="checkbox"/> White/Caucasian B <input type="checkbox"/> Black or African American C <input type="checkbox"/> Asian Indian D <input type="checkbox"/> Chinese			
				C <input type="checkbox"/> Yes, Puerto Rican D <input type="checkbox"/> Yes, Cuban				E <input type="checkbox"/> Filipino F <input type="checkbox"/> Japanese G <input type="checkbox"/> Korean H <input type="checkbox"/> Vietnamese			
				E <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino (Specify)				J <input type="checkbox"/> Native Hawaiian K <input type="checkbox"/> Guamanian or Chamorro M <input type="checkbox"/> Samoan			
								N <input type="checkbox"/> American Indian or Alaska Native (specify)			
								P <input type="checkbox"/> Other Asian (specify)		R <input type="checkbox"/> Other Pacific Islander (specify)	
								S <input type="checkbox"/> Other (specify)			
11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death		1 <input type="checkbox"/> < 8th grade		2 <input type="checkbox"/> 9th-12th grade, no diploma		3 <input type="checkbox"/> High school graduate or GED					
		4 <input type="checkbox"/> Some college credit, but no degree		5 <input type="checkbox"/> Associate's degree		6 <input checked="" type="checkbox"/> Bachelor's degree					
		7 <input type="checkbox"/> Master's degree		8 <input type="checkbox"/> Doctorate/Professional degree							
12. SOCIAL SECURITY NUMBER: 381-48-8417		13. MARITAL STATUS: NEVER MARRIED <input type="checkbox"/> 1 MARRIED <input checked="" type="checkbox"/> 2 WIDOWED <input type="checkbox"/> 3 DIVORCED <input type="checkbox"/> 4 SEPARATED <input type="checkbox"/> 5				14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated: Barbara York					
15A. USUAL OCCUPATION: (Do not enter retired) Radio Station Owner/Operator		15B. KIND OF BUSINESS OR INDUSTRY: Radio				15C. NAME AND LOCALITY OF COMPANY OR FIRM: WKZE Red Hook, NY					
16A. RESIDENCE: (State or Country if not USA) NY		16B. County or Region/Province if not USA: Dutchess		16C. LOCALITY: (Check one and specify) CITY VILLAGE TOWN		Rhinebeck Town		16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, SPECIFY TOWN:			
16D. STREET AND NUMBER OF RESIDENCE: 73 Primrose Hill Road				16E. ZIP CODE: 12572							
17. BIRTH NAME OF FATHER / PARENT: FIRST MI LAST		Watson Stanley		18. BIRTH NAME OF MOTHER / PARENT: FIRST MI LAST		Elizabeth Ann Eckert					
19A. NAME OF INFORMANT: Barbara Stanley		19B. MAILING ADDRESS: (include zip code) 99 NW 117th Street, Ocala, FL 34475									
20A. 1 <input type="checkbox"/> BURIAL 2 <input checked="" type="checkbox"/> CREMATION 3 <input type="checkbox"/> REMOVAL 4 <input type="checkbox"/> HOLD DAY 5 <input type="checkbox"/> DONATION YEAR		20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Wiltwyck Crematory		20C. LOCATION: (City or town and state): Kingston, New York							
21A. NAME AND ADDRESS OF FUNERAL HOME: Burnett & White Funeral Homes 00249		7461 S Broadway, Red Hook, NY 12571		21B. REGISTRATION NUMBER: 00249							
22A. NAME OF FUNERAL DIRECTOR: Bruce J Troy		22B. SIGNATURE OF FUNERAL DIRECTOR: Bruce J Troy Electronically Signed		22C. REGISTRATION NUMBER: 13607							
23A. SIGNATURE OF REGISTRAR: Jon Emilio Gautier Electronically Signed		23B. DATE FILED: MONTH DAY YEAR		24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Jon Emilio Gautier		24B. DATE ISSUED: MONTH DAY YEAR		06 29 2021			
		06 29 2021									
ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER											
25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.											
Certifier's Name: Kia K Newman, MD		License No.: 261197		Signature: Kia K Newman, MD Electronically Signed		Month Day Year		06 22 2021			
Certifier's Title: 0 <input type="checkbox"/> Attending Physician 0 <input type="checkbox"/> Physician acting on behalf of Attending Physician 1 <input type="checkbox"/> Coroner 2 <input checked="" type="checkbox"/> Medical Examiner / Deputy Medical Examiner		Address: 168 Washington Street, Poughkeepsie, NY 12601									
25B. If coroner is not a physician, enter Coroner's Physician's name & title:		License No.:		Signature:		Month Day Year					
25C. If certifier is not attending physician, enter Attending Physician's name & title:		License No.:		Address:							
26A. Attending physician attended deceased: FROM MONTH DAY YEAR TO MONTH DAY YEAR		26B. Deceased last seen alive by attending physician: MONTH DAY YEAR		26C. Pronounced Dead: ON MONTH DAY YEAR AT TIME		06 21 2021 02:50 PM					
27. MANNER OF DEATH: NATURAL CAUSE ACCIDENT HOMICIDE SUICIDE UNDETERMINED CIRCUMSTANCES PENDING INVESTIGATION		28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 <input type="checkbox"/> NO 1 <input checked="" type="checkbox"/> YES		29A. AUTOPSY? NO YES REFUSED		29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES					
CONFIDENTIAL SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH CONFIDENTIAL											
30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C))											
PART I. IMMEDIATE CAUSE: (A) Atherosclerotic cardiovascular disease											
DUE TO OR AS A CONSEQUENCE OF: (B) <<<<<>>											
DUE TO OR AS A CONSEQUENCE OF: (C) <<<<<>>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A), <<<<<>>											
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 <input checked="" type="checkbox"/> NO 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> PROBABLY 3 <input type="checkbox"/> UNKNOWN											
31A. IF INJURY, DATE: MONTH DAY YEAR		HOUR:		31B. INJURY LOCALITY: (City or town and county and state)		31C. DESCRIBE HOW INJURY OCCURRED:		31D. PLACE OF INJURY:		31E. INJURY AT WORK? YES NO <input type="checkbox"/> YES <input type="checkbox"/> NO	