MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILD FATALITY REVIEW PROGRAM

AUTOPSY INVOICE

INSTRUCTIONS

This form must be completed in its entirety for each case in order for you to receive payment. Incomplete forms will be returned. Please send invoice and complete autopsy report to the address below:

Department of Social Services
Child Fatality Review Program
PO Box 208
Jefferson City, MO 65102-0208

CONTRACT AGENCY NAME	INVOICE DATE
ADDRESS	DATE SERVICE PERFORMED
PATHOLOGIST NAME	PATHOLOGIST CASE NUMBER (REQUIRED)
SERVICE COUNTY	AT A RATE OF $

CHILD/VICTIM INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	DATE OF DEATH

By signing this document, I certify that I have provided consulting services to the Department of Social Services, and request reimbursement for those services as outlined above.

CONTRACTOR SIGNATURE

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FOR STATE OFFICE USE

CONTRACTOR VENDOR NUMBER	
HEAD OF HOUSEHOLD NAME (LAST, FIRST, MIDDLE INITIAL)	
HEAD OF HOUSEHOLD DCN	CHILD'S DCN