

1442²⁰²⁵

SOEP Survey Papers
Series A – Survey Instruments (Erhebungsinstrumente)

SOEP-Core – 2022: The Deceased Person (A-R+IAB-SOEP-M1-M8b)

infas

Running since 1984, the German Socio-Economic Panel (SOEP) is a wide-ranging representative longitudinal study of private households, located at the German Institute for Economic Research, DIW Berlin.

The aim of the SOEP Survey Papers Series is to thoroughly document the survey's data collection and data processing. The SOEP Survey Papers is comprised of the following series:

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Series E – SOEPmonitors
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Please cite this paper as follows:

infas, 2025. SOEP-Core – 2022: The Deceased Person (A-R+IAB-SOEP-M1-M8b). SOEP Survey Papers 1442: Series A – Survey Instruments (Erhebungsinstrumente). Berlin: DIW Berlin/SOEP



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ISSN: 2193-5580 (online)

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SOEP-Core – 2022: The Deceased Person (A-R+IAB-SOEP-M1-M8b)

infas

2025

Questionnaire

The Deceased Person

Verstorbene Personen

Dear Study Participant,

First of all, we – the “Living in Germany” team – would like to extend our sincere condolences on the loss of your family member.

For many people, it is difficult to talk about death and dying, especially with strangers. Yet because science still knows so little about this topic, we would like to ask you a few questions about the last stage of your loved one's life.

We cordially request that you either

- provide our staff member with an interview
- or if you prefer, that you carefully complete this questionnaire yourself.

This questionnaire is to be filled out by
(*ggf. vom Interviewer auszufüllen*):

First name:

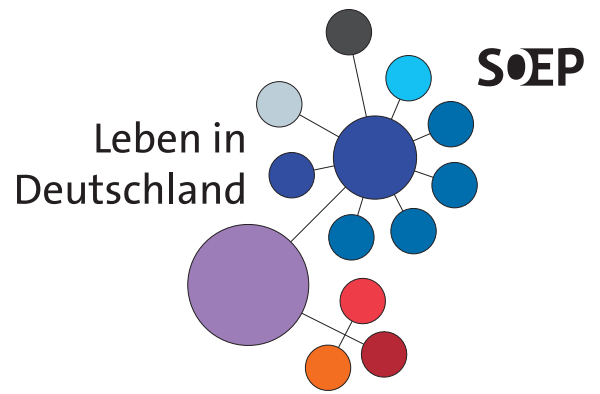
<Vorname>

Please only fill out this questionnaire if you are asked to do so in the "Individual" questionnaire.



EN





Questionnaire

The Deceased Person


Verstorbene Personen

We also offer an online questionnaire as an alternative to the paper version.

To complete the questionnaire online, please enter the following address into your Internet browser:

Your personal access code is:

If you completed the questionnaire online, you don't need to return this printed questionnaire.

 Falls eine Interviewerin/ein Interviewer vor Ort, bitte angeben:

LFD

Interviewernummer

. .

Datum (Tag . Monat . Jahr)

infas

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7704/VP_EN/2022

<LFD/Personen-Nr>

How should the questionnaire be filled out?

Make an X in the box next to the answer option that you think comes the closest. If you make a mistake, clearly cross out the wrong answer and make an X in the correct box.

Example:

Yes ~~☒~~
No

If you change your mind and decide that you want to select the answer that you just crossed out, you will need to clearly cross out the second mistake and then make a circle around the box you had crossed out first.

Example:

Yes ~~☒~~
No


When filling out the questionnaire, please pay attention to the instructions for each question:

Example:

 Please select one answer only.

If there is a blank for you to write your answer in, please print your answer in the blank.

Example:

Country: 

Sometimes you are asked to give numerical answers.

Please enter your answer by aligning numbers to the right in the spaces provided:

Example:

Number:

If you should skip certain questions, there will be specific instructions:

Example:

Yes → **Continue with question 11**

Please make sure:

 that you fill out the questionnaire in black pen only.

 that your answers are clearly legible.

 and that your answers are inside the boxes.


This makes our work much easier. Thank you very much!

Further information

If you have any questions about filling out the questionnaire or about your participation in the study, you are welcome to contact us at infas.



You can call us during normal business hours at our toll-free number, 0800–6677876, or send us an e-mail at LiD@infas.de. We will respond to e-mails as quickly as possible. For more information on the study, please see the infas homepage at: www.leben-in-deutschland.de

1 Please give the first name and birthdate of the deceased person(s):


 Please answer the following questions in columns: first, all of the questions for the first deceased person, then for the second deceased person, and so on.

	1st deceased person:	2nd deceased person:	3rd deceased person:
First name:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day and month of birth:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Year of birth:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Sex:			
Male	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
Female	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
Nonbinary (<i>divers</i>)	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
2 What was your relationship to the deceased?			
The deceased was...			
... my mother / father	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
... my spouse / life partner	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
... my daughter / son	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
... other	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
→ please specify:	<input type="text"/>	<input type="text"/>	<input type="text"/>
3 How old was your family member when he/she died?			
years	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
4 Did the deceased person(s) live in this household?			
Yes	1 <input type="checkbox"/> → Question 9	1 <input type="checkbox"/> → Question 9	1 <input type="checkbox"/> → Question 9
No	2 <input type="checkbox"/> → Question 5	2 <input type="checkbox"/> → Question 5	2 <input type="checkbox"/> → Question 5
5 Do you know if the deceased ever took part in the study "Living in Germany"?			
Yes, took part	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
No, did not take part	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
Don't know	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>




 Please state the first names of the deceased person(s) from question 1 again:

		1st deceased person:	2nd deceased person:	3rd deceased person:
First name:		<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<p>What was the deceased person's main living environment for the last year of his/her life?</p> <p> Please select one answer only.</p>			
	Alone in own household	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
	Together with spouse / partner in private household	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
	Together with other family members in private household	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
	Accommodation geared to the needs of senior citizens (assisted living, etc.)	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
	Retirement home / Nursing home	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>
	Clinic, hospital	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>
	Other environment	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>
7	<p>Where did the deceased person(s) live?</p> <p> Please select one answer only.</p>			
	Here in this house	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
	In the neighborhood	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
	Nearby (within an hour on foot)	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
	Further away in Germany	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
	In a foreign country	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>

 Please state the first names of the deceased person(s) from question 1 again:

	1st deceased person:	2nd deceased person:	3rd deceased person:
First name:	<input type="text"/>	<input type="text"/>	<input type="text"/>
8 In the last twelve months of their life, how often were you normally in personal contact with the deceased person(s), either by visiting, talking on the phone, or writing?			
Every day	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
At least once a week	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
At least once a month	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
Less often	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
Never	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>
9 Where did your family member pass away?			
 Please select one answer only.			
At home	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
In another private household	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
In a hospital	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
In a retirement home / nursing home	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
In hospice	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>
Another place	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>
Don't know	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>

 Please state the first names of the deceased person(s) from question 1 again:

	1st deceased person:	2nd deceased person:	3rd deceased person:
First name:	<input type="text"/>	<input type="text"/>	<input type="text"/>
10 Can you tell us what the cause of death was?  Please select all that apply.			
	1	1	1
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe infectious disease (pneumonia, flu, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 please specify:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Did the deceased person(s) have any of the following documents on file as a precautionary measure?  Please give an answer in each line.			
A testament, last will	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3
Living will (advance directive regarding future medical care)	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3
Lasting power of attorney (in case of loss of mental capacity, etc.)	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3
Advance funeral wishes (with details on burial, etc.)	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't know <input type="checkbox"/> 3


 Please state the first names of the deceased person(s) from question 1 again:

	1st deceased person:	2nd deceased person:	3rd deceased person:
First name:	<input type="text"/>	<input type="text"/>	<input type="text"/>
12 Had the deceased person(s) suffered any severe losses of mental capacity (memory loss, etc.)?			
Yes	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
No	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
Don't know	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
13 How would you describe the health of the deceased person(s) about three months before his / her death?			
Very good	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
Good	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
Satisfactory	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
Poor	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
Bad	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>
14 Was the deceased person in need of assistance or care approximately three months before death?			
Yes	1 <input type="checkbox"/> → Question 15	1 <input type="checkbox"/> → Question 15	1 <input type="checkbox"/> → Question 15
No	2 <input type="checkbox"/> → Question 16	2 <input type="checkbox"/> → Question 16	2 <input type="checkbox"/> → Question 16

 Please state the first names of the deceased person(s) from question 1 again:

	1st deceased person:	2nd deceased person:	3rd deceased person:
First name:	<input type="text"/>	<input type="text"/>	<input type="text"/>

15 Which of the following activities did the deceased person(s) need help with?

 Please select all that apply.

Needed help with ...

... Shopping and errands

1

1

1

... Doing housework, preparing meals and drinks

... Basic personal care, such as, dressing and undressing, bathing, combing hair, shaving

... More complex care activities, such as getting in and out of bed , going to the toilet, etc.

None of the above

Please state the first names of the deceased person(s) from question 1 again:

	1st deceased person:	2nd deceased person:	3rd deceased person:
First name:	<input type="text"/>	<input type="text"/>	<input type="text"/>

16 Think about the period of time before your family member passed away. How satisfied do you think he or she was with his or her life at that time, all things considered?

Please answer on a scale from 0 (completely dissatisfied) to 10 (completely satisfied).

Completely dissatisfied

Completely satisfied

	About a year before death	About three months before death	About a year before death	About three months before death	About a year before death	About three months before death
0 <input type="checkbox"/>	0 <input type="checkbox"/>	0 <input type="checkbox"/>	0 <input type="checkbox"/>	0 <input type="checkbox"/>	0 <input type="checkbox"/>	0 <input type="checkbox"/>
1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>
6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>
7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>
8 <input type="checkbox"/>	8 <input type="checkbox"/>	8 <input type="checkbox"/>	8 <input type="checkbox"/>	8 <input type="checkbox"/>	8 <input type="checkbox"/>	8 <input type="checkbox"/>
9 <input type="checkbox"/>	9 <input type="checkbox"/>	9 <input type="checkbox"/>	9 <input type="checkbox"/>	9 <input type="checkbox"/>	9 <input type="checkbox"/>	9 <input type="checkbox"/>
10 <input type="checkbox"/>	10 <input type="checkbox"/>	10 <input type="checkbox"/>	10 <input type="checkbox"/>	10 <input type="checkbox"/>	10 <input type="checkbox"/>	10 <input type="checkbox"/>

17 Finally, a question for you personally: To what extent has your life changed as a result of your family member's death?

Please select one answer only.

I have had to restructure my life completely

1

1

1

Some things in my life have changed

2

2

2

Nothing has really changed in my life

3

3

3

A Finally, please provide the following information.

What is your date of birth?

<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day	Month		Year						

B Are you...

... male	1	<input type="checkbox"/>
... female	2	<input type="checkbox"/>
... nonbinary (<i>divers</i>)	3	<input type="checkbox"/>

C When did you finish filling out the questionnaire?

Date:	<input type="text"/>	<input type="text"/>	Time:	<input type="text"/>	<input type="text"/>
	Day	Month		Hour	Minute

D Approximately how long did it take you to complete this questionnaire?

<input type="text"/>	<input type="text"/>	<input type="text"/>	Minutes
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E Were other persons present while you were filling out the questionnaire?

 Please select all answers that apply.

Yes, spouse / partner	1	<input type="checkbox"/>	} → Continue with question F
Yes, other person, who lives in the same household		<input type="checkbox"/>	
Yes, other person, who does not live in the same household		<input type="checkbox"/>	
No		<input type="checkbox"/>	→ End of questionnaire

F Did any of the aforementioned people disturb you while filling out the questionnaire?

Yes	1	<input type="checkbox"/>
No	2	<input type="checkbox"/>

Thank you for taking part.

Please give the completed questionnaire to our interviewer or send it back to infas in the enclosed postage-paid envelope:

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53154 Bonn