



COLES COUNTY SHERIFF'S DEPARTMENT
 701 7th Street, Charleston, IL 61920 (217) 348-0585

BOOKING REPORT

Date Printed: 9/27/2024

MARINE, BRYAN

SO#: 2024-0103

Book #: 0924-0987

Inmate Bio Information

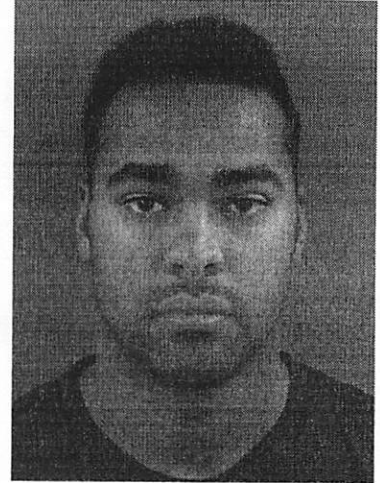
SSN: _____
 Address: _____
 RIVERTON, IL 62561

DOB: _____
 FBI#: _____
 SID#: _____
 Phone: _____

Place of Birth: NY

Sex: M Race: B Hgt: 5-11 Wgt: 190 Hair: BLK Eyes: BRO

Occupation: _____
 Employer: _____
 Emergency Notification: _____



Arrest Information

Arrest Date: 09/27/2024

Time: 8:00 PM

Location: _____

Arresting Agency: Charleston Police Department

Arresting Officer: AKER, LOGAN

Charge Information

Hold Type	Warrant/Case No.	Offense	Degree	Arrest Date
LW	2024CF536	Aggravated Criminal Sexual Abuse - Victim is 13-16 yoa and Offender is at least 5 yrs. Older than t	2	09/27/2024
LW	2024CF536	Child Pornography	X	
LW	2024CF536	Child Pornography	3	
LW	2024CF536	Grooming - Distribute Photographs Depicting Sex Organs of Child	4	

◀ END OF LIST ▶

PRISONER PROPERTY AND ADMISSION CONTROL REPORT

PROPERTY

Searched by: Reno, Tharen Date: 09/27/2024

I certify that the below listed property is a true and complete accounting of all personal property taken from me at the time I was committed to this facility.

Signature:  Date: 9/27/2024

Refused to Sign

Witness: _____ Date: 9/27/2024

I certify that I have received all property listed below and due me following my release from this facility.

Signature: _____ Date: 9/27/2024

Refused to Sign

Witness: _____ Date: 9/27/2024

MAIL

I authorize officials of this jail the right to examine for contraband all mail, packages, and other items which are sent to me while I am confined in this facility.

Signature:  Date: 9/27/2024

Witness: _____ Date: 9/27/2024

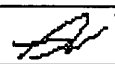
Name: MARINE, BRYAN
SSN: 105-86-7184
SO#: 2024-0103
Booking#: 0924-0987

TELEPHONE CALL

I certify that I have been given the opportunity to contact the following individuals by telephone:

Person Called:

Witness: _____

Signature: 

Time: _____

MEDICAL TREATMENT

I certify that I have refused medical treatment. I release the Agency, its staff and the Sheriff from any and all liability which might arise as a result of such a refusal.

Date: 9/27/2024

Inmate: _____

Witness: _____

MEDICAL AUTHORIZATION

I hereby authorize any medical provider treating me while I am confined in this facility to release medical records arising from such treatment to the Agency.

Date: 9/27/2024

Inmate: 

QTY	ITEM DESCRIPTION	LOCATION	BIN/BOX
1	BLK HAT	PROPERTY	LOCKER 058
1	BLK SHIRT	PROPERTY	LOCKER 058
1	BLK PANTS	PROPERTY	LOCKER 058
1	UNDERWEAR	PROPERTY	LOCKER 058
2	BLK SOCKS	PROPERTY	LOCKER 058
2	BLK SANDALS	PROPERTY	LOCKER 058
1	BLK RING	PROPERTY	LOCKER 058